

MEDICARE OUTLIER PAYMENTS TO HOSPITALS

HEARING

BEFORE A

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MEDICARE OUTLIER PAYMENTS TO HOSPITALS

TUESDAY, MARCH 11, 2003

U.S. SENATE,
SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN
SERVICES, AND EDUCATION, AND RELATED AGENCIES,
COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 9:38 a.m., in room SD-192, Dirksen Senate Office Building, Hon. Arlen Specter (chairman) presiding.
Present: Senators Specter, Harkin, and Landrieu.

OPENING STATEMENT OF SENATOR ARLEN SPECTER

Senator SPECTER. Good morning, ladies and gentlemen. The Appropriations Subcommittee on Labor, Health and Human Services, and Education will now proceed to a hearing on a technical subject known as outlier costs. Medicare pays hospitals a set amount for each of more than 500 patient illnesses or procedures, separated into different diagnosis-related groups called DRGs.

Under that system, hospitals have a financial incentive to avoid extremely costly patients and to counter that incentive, Medicare makes additional payments called outlier payments which compensate hospitals for costs of cases that are far more expensive than the average for each diagnostic-related group. In order for a hospital to receive outlier payments, their costs must exceed a fixed loss amount, yearly set by Medicare. The outlier payment is 80 percent of the excess over the fixed loss amount.

Congress has mandated a range of 5 to 6 percent, of total Medicare DRG payments for outliers, and I just asked Mr. Scully informally if that was a realistic figure, and he assured me it was.

There had been a schedule established by CMS to put a rule into effect immediately, and this subcommittee intervened because of concerns we heard from many hospitals across the country that there would be a great hardship on hospitals to have a new rule put into effect abruptly, especially without giving the hospitals an opportunity to be heard, and so CMS has established a procedure where OMB released the regulation on February 28, and it was made public on March 5, and the comment period will extend until April 4, and then a date for it to be put into operation will be set thereafter, so there will be an opportunity for hospitals to respond and some period to make an accommodation.

Hospitals are obviously struggling yet under the impact of the Balanced Budget Act of 1997, and steps have been taken by Congress to ameliorate the impact. Most recently, on the fiscal year

2003 omnibus appropriation bill, having found out that a Medicare payment cut was due to take effect on March 1, we prevented any reduction until September to give us an opportunity to review the matter further.

So this is another of the ongoing hearings by this subcommittee and others to try to come to grips with these very complex issues, to see to it that hospitals have a fair opportunity to be adequately paid, an opportunity to adjust to changing rules and to enable the Department of Health & Human Services and CMS to stay within the mandates and guidelines which Congress has expressed.

I now yield to my distinguished colleague, Senator Harkin.

OPENING STATEMENT OF SENATOR TOM HARKIN

Senator HARKIN. Thank you very much, Mr. Chairman, for having this hearing. The outlier problem has a broad impact on the Medicare program, and some hospitals legitimately rely on these to help offset high-cost payments. However, because the outlier payments are taken from the base payments to all hospitals, any misuse of the program ultimately hurts all hospitals, especially those in low-reimbursement, high-efficiency States that have little need for outliers—I am talking about Iowa—so we also have an interest in this issue, too, Mr. Chairman, and I thank you for having this hearing.

So I look forward to hearing from the administration and the witnesses about their plans to address this outlier program problem.

If I might just take a couple of minutes, Mr. Chairman, I also want to raise another issue that I am sure Mr. Scully knows I will be raising, and in my first questions I will ask him about it. Six weeks ago we had a hearing on a number of Medicare issues. I again raised my concerns at that time about the geographic disparity in Medicare reimbursements between rural and urban States. As I mentioned then, my State of Iowa has had a severe competitive disadvantage, because our providers and hospitals, as I pointed out then, are number 50 in the Nation, bottom in terms of per-beneficiary reimbursement for Medicare.

Mr. Scully, you testified at that time that the administration is aware of our concerns. You even suggested that you agreed that some rural States like Iowa are underreimbursed for some services. You indicated that I would be happy with some of the President's Medicare reform proposals because his plan would, in addition to creating a drug benefit for all beneficiaries, provide some assistance to rural States. Well, I am sure it comes as no surprise to you that I am anything but happy with the President's Medicare proposal, and I am sure that that is true across the spectrum of those of us who represent the State of Iowa, regardless of political party.

First, the plan does nothing to address the geographic inequity issue. This, despite the fact that the President personally came to Iowa last year and committed to supporting efforts to increase Iowa's Medicare reimbursement. But worse than the fact that the President's plan does nothing to help address the geographic disparity is that the President's prescription drug proposal will hurt Iowans—hurt Iowans. According to the administration's plan, Iowans who elect to stay in fee-for-service will receive a meager

drug benefit. Seniors with the lowest income and higher drug costs will receive added protection, but the bottom line is, only seniors who go into an HMO will receive the drug coverage they need and deserve.

Now, why is that bad for Iowa? Because we do not have one Medicare HMO in the entire State of Iowa. That means that all the money that is going to be used for this program would go to private HMOs in other States.

Now, the President emphasized that seniors should have choices, but I hope the President realizes that fewer than 20 percent of rural residents in America have access to Medicare HMOs, fewer than 20 percent, one out of five, and as I said, in Iowa, we do not even have one, so not only does the administration's proposal fail to modernize Medicare for all seniors in terms of geographic disparity, it actually takes a step backward for seniors in rural States like Iowa.

So Mr. Scully, I know we are here to talk about outlier, and I want to make it clear that it is also an important issue to us in Iowa because of the effect it will have on reimbursements and on payments—you take away from the base—but I also wanted to ask you when my time comes to ask questions about the, again, the geographic disparity and the prescription drug proposal.

Thank you very much.

Senator SPECTER. Thank you very much, Senator Harkin.

STATEMENT OF THOMAS A. SCULLY, ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Senator SPECTER. We now turn to the distinguished Administrator of the Centers for Medicare and Medicaid Services, Mr. Thomas Scully. He has held this position since May 2001. Prior to the appointment, he served as president and chief executive officer of the Federation of American Hospitals. He was a partner at Patton Boggs, and also served as deputy assistant to the President and counselor to the Director of the Office of Management and Budget. A law degree from Catholic University and a bachelor's degree from the University of Virginia.

Mr. Scully, thank you for joining us here, and we look forward to your testimony.

Mr. SCULLY. Thank you Mr. Chairman and Senator Harkin, and my testimony is all about outliers, but I would be very anxious to explain the positive impact of the President's plan, which I was very involved in developing, on the rural areas in Iowa.

Anyway, thank you for inviting me here to discuss the incredibly complex subject of hospital outlier payments. Outlier payments, Mr. Chairman, as you mentioned, are available to hospitals to help ensure that the sickest and most complex Medicare beneficiaries receive high-quality health care in hospitals. I know that this issue, and how it works out in Pennsylvania's hospitals and Iowa's, is important to both of you, and it is very important to CMS.

Medicare basically, as you mentioned, pays DRG payments for every hospital payment, a little bit under \$100 billion a year, and we pay additional add-ons for outliers, because, as I mentioned, they are complex cases. The law requires CMS to set outlier payment thresholds at between 5 and 6 percent a year. We take that

out of the \$100 billion total hospital pot we set aside. Traditionally in the last 10 years, 5.1 percent has been the amount that is set aside. The 5.1 percent is required to meet a budget projection that is supposed to be budget-neutral, so we set a threshold for outliers that will result in spending only 5.1 percent of that whole hospital pot on these high-cost cases.

As I mentioned, this past year the 5.1 percent threshold was supposed to work out to \$3.7 billion for 2002, but instead we spent \$5.3 billion, so we missed the target by \$1.6 billion. We started overshooting the mark without understanding really why in 1997. In 1997, the outlier payment target was \$3.6 billion, but we spent \$300 million more than that. In 1998, the outlier payments were \$4.4 billion when the target was supposed to be \$3.4 billion, so we spent \$1 billion more than we were expected to.

In 1999, we spent \$5.2 billion, which was \$1.8 billion more than we were supposed to spend under the law. In 2000, we spent \$5.3 billion, again \$1.8 billion more than we were supposed to under the law. In 2001, we spent \$5.5 billion, which was \$1.9 billion more than expected and, as I mentioned, again last year we spent \$1.6 billion more than the target. So overall from 1997 to 2002 this thing steamrolled and developed without the Agency understanding why we had spent \$8.4 billion more than Congress had authorized us to spend. We consistently missed the targets. We did not understand why. We kept raising the bar to get into this outlier pot on the theory that if we raised the bar we would actually get closer to the target, and we kept missing and missing, and really never understood the dynamics.

In 2000, for example, the outlier threshold to get these extra payments was \$14,050 per case, in 2002 we raised it to \$21,025 per case, and last year we raised it to \$33,560 per case, consistently raising the bar, thinking that would result in us getting closer to our target of 5.1 percent of overall hospital payments, and obviously we did not understand what the dynamics here were, and we kept missing.

It was not until the rule finally came out on October 1 for this year that raised the threshold to \$33,560 that this outlier problem was discovered in two ways. One is, hospitals that were losing because they were getting less outlier payments. As Senator Harkin said, I do not believe there is an outlier hospital in Iowa, but they were getting paid less by virtue of other people getting paid more. Some hospitals called me and flagged this and started to essentially tell us how the dynamics were working for some of their competitors that were taking advantage of this, and they also called some Wall Street analysts. On October 27, a Wall Street analyst wrote a fairly high-profile explanation of this dynamic and it resulted in a lot of attention, a lot of press attention, on the fact that a relatively small number of hospitals were getting a hugely disproportionate share of outlier payments, and that was what was, in fact, driving up the totals.

As I mentioned, in the last full fiscal year, 2002, we were supposed to spend 5.1 percent of DRG payments, and we spent 6.9 percent. On average, the average hospital should be getting about 5.1 percent of their total Medicare payments in outlier payments. What we found was that 3 percent of hospitals, 123 hospitals out of

5,000, roughly, acute care hospitals in the country had outlier payments of more than 20 percent.

There were some particularly egregious offenders, and I listed a few in the testimony in the addendum, but just to illustrate how badly this problem can get out of hand, how much some hospitals took advantage of it, Doctors Hospital in Modesto, California—and Modesto's Doctors Hospital is not a high-cost teaching hospital, it is a pretty standard community hospital—received \$29 million in 2002 in regular standard Medicare payments. They received \$62.5 million of outlier payments, so 215 percent. Instead of 5 percent they got 215 percent of outlier payments. If they had gotten the national average they would have gotten \$1.5 million in outlier payments. Instead, they got \$61 million more, more than double their basic payments, and it is a pretty standard hospital.

Redding Medical Center, which is also a pretty standard hospital in Redding, California, that has had some other problems that have been in the press lately, received \$47 million in regular Medicare payments and \$56 million in outlier payments, so obviously, again, more than 100 percent. If they had gotten the standard amount of 5.1 percent, which to be honest with you, a hospital of that type of structure probably should get the average because it is not a teaching hospital, they should have gotten about \$2.5 million, so they got \$53.5 million more than they should have.

I would note that both of those hospitals are run by Tenet Healthcare, which probably drew the most press attention on this. Hospitals, under the regulation and under the law, can still bill us for this. It is arguable whether it is legal or not, but arguably, under existing regulations it is. I would note that Tenet, as a result of repeated contact from CMS, has voluntarily quit billing for this, and it has cost them \$57 million a month, or \$750 million a year that they were getting from this program. As of January 1, they are voluntarily complying with this regulation and not billing us any more.

But just to show that it is not just Tenet, they were about a third of the problem nationally. They own about 115 hospitals. Community Medical Center in Toms River, New Jersey, receives \$113 million in regular DRG payments, again, this is a community hospital, and got \$87.6 million in outlier payments. Again if you looked at the national average, they should have gotten \$4.7 million in outlier payments, so they picked up \$83 million this year in outlier payments that to us seem to be way out of line.

Again, when you look down the line, 3 percent of hospitals, about 123, have outlier payments that are way, way beyond anything that is rational or understandable to us.

The impact of this is not just that it helps the hospitals that figured out the way to game the system. The impact is that it hurts other people, and on the charts, I attach just one, Thomas Jefferson Hospital, for instance, in Philadelphia, lost about \$2 million last year compared to what their normal outliers would have been. In past years, before we started to raise the bar, it received about 18 percent, which is what you would expect a big teaching hospital like Thomas Jefferson would get. But their outlier payments have been dropping, because as we raised the bar to get into the pool, they got less for each true high-cost patient. If they had lowered

the outlier threshold through this current year to what last year's was, they would have gotten, just to be precise, \$1.6 million more this year, if last year's rule was still in effect. But because of these abuses, we kept raising the bar, and it hurts all the community hospitals that have not gotten this.

Hershey Medical Center in Pennsylvania, for instance, would have lost about half a million dollars this year, due to this. The University of Iowa, if it were under last year's threshold instead of this year's threshold, would get \$1.5 million more.

So the 3 percent of hospitals that have been taking advantage of the program are basically taking money away from the other 97 percent that are not, and we do not think that is fair, and that is why we thought that we should close this, what we consider to be loophole, immediately.

We sought to do this, after the chairman understandably inquired about the impact on some Pennsylvania hospitals—and generally, the disproportionate number of the hospitals are in New Jersey, California, and Pennsylvania, for reasons we still do not really understand. Those were where the highest number were, and we sought to close it immediately, but we obviously, as you mentioned, turned it into a draft rule to get 30 days' comment from the hospitals that are going to be affected. We expect that shortly, after we consider the comments from hospitals we will put out a final rule. We are certainly respectful of the concerns of the chairman and ranking member, but as I mentioned to you earlier, the Ways and Means Committee, both Mr. Stark and Mr. Thomas in the House have expressed a strong interest in us fixing this as quickly as we possibly can.

PREPARED STATEMENT

I would just add, to close, that I ran a hospital association for 6 or 7 years. I did not understand this dynamic. I am a little embarrassed that I did not figure this out for the first 2 years I was on the job and, in fact, that my agency went for 5 years without understanding this, but we really believe that the outlier pool is a legitimate way to pay for high-cost Medicare patients. A lot of the hospitals that are taking care of these patients have not been paid appropriately, and we think, with respect to trying to be sensitive to the community needs that are involved with the hospitals that have been collecting these extra payments, that we need to fix this as fast as we reasonably can.

Thank you, Mr. Chairman.

[The statement follows:]

PREPARED STATEMENT OF THOMAS A. SCULLY

Chairman Specter, Senator Harkin, distinguished Subcommittee members, thank you for inviting me to discuss how Medicare pays for inpatient hospital outlier costs. Outlier payments are those Medicare payments that are available to hospitals to help ensure that Medicare's sickest beneficiaries continue to have access to high quality health care. We have an obligation to safeguard this access for Medicare's sickest patients, and to ensure that we are spending taxpayer funds appropriately. Medicare generally pays most hospitals a predetermined amount for a typical patient's stay, based on the average cost of providing care to a patient in a similar condition. The payment is set under a diagnostic related group (DRG) that will allow an efficiently operated hospital to earn a reasonable rate of return overall. However, Medicare law recognizes that there are some beneficiary cases that are

more complicated—and therefore more costly to treat—and requires that we pay an additional amount to hospitals for these cases known as outlier payments.

Outlier payments can be viewed as insurance for hospitals against the large losses that could result from extremely expensive cases. In addition to the fixed rate per case, hospitals receive outlier payments when the estimated costs of the case exceed a fixed-loss threshold. This fixed-loss threshold operates like the deductible in a typical insurance policy. When the cost of a case exceeds the fixed-loss threshold, we pay the hospital an additional amount equal to 80 percent of the estimated costs beyond that loss threshold—similar to coinsurance required in most insurance policies. Under the law, CMS must set outlier payments between 5–6 percent of total inpatient payments. In recent years, CMS has set the outlier threshold at a level projected to pay 5.1 percent of total payments for inpatient care for these outliers—which was projected to result in spending of \$3.7 billion in fiscal year 2002. However, in reality, we spent \$5.3 billion—a difference of \$1.6 billion.

We are particularly concerned about excessive claims for outlier payments. Each year, when we update the hospital payment rates, we set a threshold for individual outlier payments designed to keep them at the overall target of 5.1 percent of total payments. As outlier claims increased (and the agency had no idea why) the outlier threshold has skyrocketed—from \$14,050 in 2000 to \$33,560 in 2003—as the agency raised the bar to try (very unsuccessfully) to stay within the 5.1 percent target. As a direct result, more hospitals have been forced to absorb the costs of the complex cases they treat, while a relatively small number of hospitals that have been aggressively gaming the current rules benefit by getting a hugely disproportionate share of outlier payments. As you can see, the behavior of a few hundred hospitals—those that took advantage of the outlier program—are the main cause of the sharp increases in the loss threshold.

CMS sets the outlier threshold to reach a target of total outlier payments equal to 5.1 percent of DRG payments. Moreover, we found that these hospitals, in order to maintain that level of outlier reimbursement, significantly exceeded the national average in raising charges between fiscal year 1999–2001, with Hospital A's charges increasing by 111 percent, and Hospital B's charges increasing by 126 percent, compared to the national average of 18 percent. For fiscal year 2002, total outliers exceeded that target and reached 6.9 percent of total inpatient hospital payments. Hospital A in California received outlier payments equaling more than 215 percent of its DRG payments in fiscal year 2002—that's twice the amount of outlier payments to regular payments. Putting it another way, Hospital A received only approximately \$29 million in regular DRG payments, but \$62.5 million in outlier payments. However, under the target outlier amount of 5.1 percent, Hospital A would have only received \$1.5 million in outlier payments—a difference of \$61 million. Hospital B, located in New Jersey, received outlier payments of 129 percent of its DRG payments. In dollars, Hospital B received about \$113 million in regular DRG payment and \$87.6 million in outlier payments, but under the national target of 5.1 percent, would have only received about \$4.7 million in outlier payments. Again, the difference is substantial—about \$83 million.

To make sure that outlier payments are used as they were intended, we issued a proposed rule that suggests revising the current outlier policy to prevent further gaming of the system by the few hospitals that get the lion's share of these payments. I wanted to close the loophole immediately, and help the hospitals that need it the most. Instead, we put out changes for comment, partially due to the Committee's interest in evaluating the impact of the changes. I would like to discuss our new proposed rule in greater detail with you today. However, I think it's important that I first discuss the logistics of the outlier system so that I may better explain how the new regulations improve the system, safeguarding access to care for a broader number of Medicare beneficiaries.

BACKGROUND

The prospective payment system (PPS) was designed to pay hospitals appropriately while providing an incentive for hospitals to provide care as efficiently as possible. Under the inpatient PPS, Medicare pays hospitals a pre-determined, per-discharge rate for 509 patient categories called diagnosis related groups (DRGs). Each patient discharge is assigned to a DRG based on diagnosis, surgery, patient age, discharge destination and sex. Each DRG has a weight established for it based on charges submitted by hospitals for Medicare patients. Each weight reflects the relative average charge, across all hospitals, of treating cases classified in that DRG. In total, Medicare paid approximately \$100 billion in fiscal year 2002 for inpatient hospital services.

Because the PPS payment is based on an adjusted average payment rate, Medicare's payment for some beneficiary cases will be higher than the actual cost of the case while for other cases, payment will be less than the actual cost of the case. The system is designed to give hospitals the incentive to manage their operations more efficiently by evaluating those areas in which increased efficiencies can be instituted without adversely affecting the quality of care. Under inpatient hospital PPS, additional payments are made for those cases that generate extremely high costs when compared to average cases in the same DRG. These outlier payments are intended to protect hospitals from large financial losses due to unusually expensive cases.

The Medicare billing form for inpatient stays provides hospitals with the opportunity to code whether they are requesting an outlier payment. When such a code is not selected, Medicare's fiscal intermediaries (FI), the private-sector contractors that process and pay Medicare hospital claims, identify outlier cases by comparing the estimated costs for a case to a DRG-specific fixed-loss threshold amount. The fixed-loss threshold amount is the sum of the DRG payment for the case, any additional payments (new technology, indirect medical education, disproportionate share adjustment), and the fixed-loss threshold. We set the fixed-loss threshold each year at an amount that is projected to generate outlier payments equal to 5.1 percent of total payments under the PPS. Medicare then pays 80 percent of hospitals' costs above their fixed-loss threshold amounts. However, in the past few years actual outlier spending has exceeded the projected 5.1 percent. For example, outlier payments totaled 7.6 percent in 1999 (\$5.2 billion, or \$1.8 billion more than projected); 7.6 percent in 2000 (\$5.3 billion, or \$1.8 billion more than projected); 7.7 percent in 2001 (\$5.5 billion, or \$1.9 billion more than projected); and 6.9 percent in 2002 (\$5.3 billion, or \$1.6 billion more than projected). The national fixed-loss threshold for 2003 is \$33,560, up from \$21,025 in 2002. As you can see, as hospitals claim more and more outlier cases, we have been forced to raise the fixed-loss threshold to remain close to the 5.1 percent target (and we have not been close). Moreover, taxpayers spent \$7.1 billion more than Congress authorized for these payments between 1999 and 2002 because of abusive practices and our inability to track or understand the abuses—until now.

PROBLEMS WITH EXCESS OUTLIER PAYMENTS

The inpatient PPS outlier policy, prior to our publication of the new proposed rule, had a couple of major problems that allowed hospitals to claim excessive outlier payments. In order to estimate the actual costs incurred by a hospital for a given case, Medicare's FIs use the historical relationship between each hospital's costs and its charges to estimate the "true" cost of individual case. The cost-to-charge ratio is determined by using the most recently settled cost report. So long as hospital costs and hospital charges change at roughly the same rate, this estimate produces a relatively reliable result. However, if a hospital increases its charges dramatically relative to costs in its most recently settled cost report, the use of the historical relationship will yield higher outlier payments than would be appropriate.

In addition, the longer the lag between the historical data and current charges, the more likely it is that the cost-to-charge ratio estimate will be inaccurate. 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 a cursory review of the filed cost report to determine the amount of payment to be paid to the hospital if an amount is due on the as-filed cost report. 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. So if a hospital quickly starts raising its charges, the cost-to-charge ratio we use to calculate the payment does not immediately reflect that change. The increase in charges will eventually result in a lower cost-to-charge ratio; however, during this lag time, hospitals can receive higher outlier payments than if a more current cost-to-charge ratio was used. While generally there is a lag period of a little under two years, over the past several years, the lag has been slightly longer, providing hospitals with a longer timeframe within which to continue gaming the system.

For example, let's say that a hospital's cost-to-charge ratio from the settled 2000 cost report is 0.2 (meaning that the average charges were five times higher than average costs), and the patient charges for a particular case were \$300,000. The estimated cost for that case would be \$60,000 ($\$300,000 \times 0.2$), and the outlier payment would be based on that \$60,000 cost (the outlier payment is based on 80 percent of the difference between \$60,000 and \$33,560). Then, assume that hospital

starts raising its charges for that same type of patient to \$320,000. The cost-to-charge ratio used would not immediately reflect this increased cost, but would rather remain at 0.2, based on data from the 2000 cost report. So, the estimated cost for this same case would rise to \$64,000 ($\$320,000 \times 0.2$). The hospital would then receive outlier payments based on \$64,000, instead of \$60,000.

Another problem with the current outlier policy is hospitals' ability in certain cases to have the statewide average number substituted for their own cost-to-charge ratio. If the cost-to-charge ratio for a particular hospital is more than 3 standard deviations away from the national mean, the FIs will substitute the statewide average ratio to calculate costs and determine whether a hospital qualifies for outlier payments. This policy was initially adopted in 1989 in regulation to address a concern that cost-to-charge ratios falling outside such a range were probably because of faulty data reporting. However, using the statewide average instead of a hospital's cost-to-charge ratio clearly increased outlier payments for particular hospitals where there were no errors.

As an example, assume that the cost-to-charge ratio of 0.2, used in the previous example, is more than three standard deviations below the national average. The FI would then substitute the statewide average cost-to-charge ratio (0.4, for example) when calculating outlier payments. So, for the initial \$300,000 procedure, the estimated costs would rise to \$120,000 ($\$300,000 \times 0.4$), and the outlier payment would be based on the \$120,000, not \$60,000 ($\$300,000 \times 0.2$).

Let me return to my previous examples for a moment and look at how these factors affected the cost-to-charge ratios of Hospitals A and B. The current cost-to-charge ratio we used to calculate payments for Hospital A is .339. However, we found by using more current data, Hospital A's actual relationship between cost and charges to be only .093. So basically, we are paying Hospital A at 3 times the actual rate of costs to charges. For our New Jersey hospital, Hospital B, we use a cost-to-charge of .325 to determine payments. However, our analysis found that Hospital B's actual relationship between costs and charges is .291. So clearly under the current outlier policy, we are grossly overpaying these hospital, and likely many more.

CMS' INITIAL RESPONSE

Upon discovering the abuse of the outlier policy, we quickly took corrective action. Last December, we instructed FIs to take action to help mitigate any potential vulnerability with outlier payments. First, FIs were instructed to identify hospitals that received outlier payments totaling more than 10 percent of their operating and capital DRG payments for discharges during fiscal year 2002. FIs were also directed to identify other hospitals where outlier payments might be problematic. Later that month, we issued a second program memorandum that initiated a progressive compliance strategy to ensure that Medicare payments for outliers are appropriate. This was designed to ensure that the greatest level of scrutiny is placed on hospitals that appear, through data analysis, to present the greatest risk to the program. We also instructed FIs to identify those hospitals that: (1) have outlier payments of 80 percent or more of their operating and capital DRG payments for discharges during October and November 2002 (excluding outlier, indirect medical education, and disproportionate share payments); or (2) have estimated outlier payments greater than 20 percent of their operating and capital DRG payments for discharges during October and November 2002 (excluding outlier, indirect medical education, and disproportionate share payments) and an increase in average charges per case (calculated including all Medicare discharges) of 20 percent or more from 2000 to 2001 and 2001 to 2002. This comparison may be performed using either hospitals' cost reporting periods or Federal fiscal years.

For hospitals falling into the first category, FIs were instructed to perform comprehensive field audits for indirect medical education, graduate medical education, disproportionate share hospital payments, bad debts, organ acquisition costs, and any other pass through costs. FIs are also required to conduct medical reviews of a random sample of 20 hospital outpatient outlier records, and have the state Quality Improvement Organization (QIO) perform outlier reviews for inpatient stays. For hospitals falling into the second category, FIs were to perform uniform charge reviews, medical review and additional reviews by the state QIO. FIs were instructed to begin the audits by February 1, 2003, and to start all of the audits no later than July 31, 2003. The entire sample should be completed by July 31, 2004.

PROPOSED RULE

In addition to auditing hospitals with potentially problematic outlier payments, CMS recently issued a rule in the March 5, 2003, Federal Register proposing revisions to the outlier payments regulations. In this proposed rule, we suggest changes

to the methodology for determining payments for extraordinarily high-cost cases (cost outliers) made to Medicare-participating hospitals under the inpatient hospital prospective payment system. These proposed changes would be effective for discharges occurring on or after the date that we issue a final rule following this proposed rule and comment period.

Currently, we use the most recent settled cost report when determining cost-to-charge ratios for hospitals. The covered charges on bills submitted for payment during fiscal year 2003 are converted to costs by applying a cost-to-charge ratio from cost reports that began in fiscal year 2000 or, in some cases, fiscal year 1999. These covered charges reflect all of a hospital's charge increases to date, in particular those that have occurred since fiscal year 2000 and are not reflected in the fiscal year 2000 cost-to-charge ratios. If the rate-of-charge increases since fiscal year 2000 exceeds the rate of the hospital's cost increases during that time, the hospital's cost-to-charge ratio based on its fiscal year 2000 cost report will be too high, and applying it to current charges will overestimate the hospital's costs per case during fiscal year 2003. Overestimating costs may result in some cases qualifying for outlier payments that, in actuality, are not high cost cases. Overestimating costs will also result in higher outlier payments if a case does qualify for outliers.

Using our Medicare Provider Analysis and Review (MedPAR) file data from fiscal year 1999 to fiscal year 2001, we found 123 hospitals whose percentage of outlier payments relative to total DRG payments increased by at least 5 percentage points over that period, and whose case-mix adjusted charges increased at or above the 95th percentile rate of charge increase for all hospitals (46.63 percent) over the same period. We adjusted for case-mix because a hospital's average charges per case would be expected to change from one year to the next if the hospital were treating new or different types of cases. Because we use settled cost reports to compute hospitals' cost-to-charge ratios, the recent dramatic increases in charges for these hospitals are not reflected in their cost-to-charge ratios. For example, among these 123 hospitals, the mean rate of increase in charges was 70 percent. Meanwhile, cost-to-charge ratios for these hospitals, which were based on cost reports from prior periods, declined by only 2 percent.

Because a hospital has the ability to increase its outlier payments during this time lag through dramatic charge increases, in this proposed rule we are proposing to allow fiscal intermediaries to use more up-to-date data when determining the cost-to-charge ratio for each hospital. We are proposing to specify that fiscal intermediaries will use either the most recent settled or the most recent tentatively settled cost report, whichever is from the latest cost reporting period. Using cost-to-charge ratios from tentative settled cost reports would reduce the time lag for updating cost-to-charge ratios by a year or more.

However, even the more recent data calculated from the tentative settled cost reports would overestimate costs for hospitals that have continued to increase charges much faster than costs during the time between the tentative settled cost report period and the time when the claim is processed. In fact, there would still be a lag of one to two years during which a hospital's charges may still increase faster than costs. Therefore, we are proposing to add a new provision to the regulations that would allow CMS the authority to direct the fiscal intermediary 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 are proposing to allow a hospital to contact its fiscal intermediary to request that its cost-to-charge ratios be changed if it presents substantial evidence that the ratios are inaccurate. Any such requests would have to be approved by the CMS Regional Office with jurisdiction over that fiscal intermediary.

Because of hospitals' ability to increase their charges to lower their cost-to-charge ratios in order to be assigned the statewide average, we are proposing to remove the current requirement in our regulations that specify that a fiscal intermediary will assign a hospital the statewide average cost-to-charge ratio when the hospital has a cost-to-charge ratio that falls below the floor. After issuing our December 2002 Program Memorandum instructing fiscal intermediaries to identify all hospitals receiving the statewide average operating or capital cost-to-charge ratio because their cost-to-charge ratios fell below the floor of reasonable parameters, we identified 43 hospitals that were assigned the statewide average operating cost-to-charge ratio and 14 hospitals that were receiving the statewide average capital cost-to-charge ratio. Three hospitals were common to both lists. Prior to application of the statewide average cost-to-charge ratios, the average actual operating cost-to-charge ratio for the 43 hospitals was 0.164, and the average actual capital cost-to-charge ratio for the 14 listed hospitals was 0.008. In contrast, the statewide average operating cost-to-charge ratio for the 43 hospitals was 0.3425 and the statewide average capital cost-to-charge ratio for the 14 hospitals was 0.035. In the proposed rule, we sug-

gest a revision that would give hospitals their actual cost-to-charge ratios, no matter how low their ratios fall.

However, we are proposing that statewide average cost-to-charge ratios would still apply in those instances in which a hospital's operating or capital cost-to-charge ratio exceeds the upper threshold. Cost-to-charge ratios above this range are more likely to be the result of faulty data reporting or entry, and should not be used to identify and pay for outliers. In addition, hospitals that have not yet filed their first Medicare cost reports with their fiscal intermediaries would still receive the statewide average cost-to-charge ratios.

The proposed rule would greatly reduce the opportunity for hospitals to manipulate the system to maximize outlier payments by updating cost-to-charge ratios using the most recent tentative settled cost reports and using actual rather than statewide average ratios for hospitals that have cost-to-charge ratios that are more than 3.0 standard deviations below the geometric mean cost-to-charge ratio. However, these two steps would not completely eliminate all such opportunity for aggressive gaming. A hospital would still be able to dramatically increase its charges by far above the rate of increase in costs during any given year. This possibility is of great concern, given the recent findings that some hospitals that have been able to receive large outlier payments by doing just that. Therefore, we are proposing to add a provision to our regulations to provide that outlier payments will become subject to adjustment when hospitals' cost reports are settled. Payments would be processed throughout the year using operating and capital cost-to-charge ratios based on the best information available at that time. When the cost report is settled, any reconciliation of outlier payments by fiscal intermediaries would be based on operating and capital cost-to-charge ratios calculated based on a ratio of costs to charges computed from the cost report and charge data determined at the time the cost report coinciding with the discharge is settled. The language we propose to add would allow outlier payments to be adjusted to account for the time value of the money during the time period it was inappropriately held by the hospital. This adjustment would also apply in cases where outlier payments were underpaid to the hospital. In those cases, the adjustment would result in additional payments to hospitals. Any adjustment would be based upon a widely available index to be established in advance by the Secretary, and would be applied from the midpoint of the cost reporting period to the date of reconciliation (or when additional payments are issued, in the case of underpayments). This adjustment to reflect the time value of a hospital's outlier payments would ensure that the outlier payment received by the hospital at the time its cost report is settled appropriately reflects the hospital's true costs of providing the care.

CONCLUSION

Outlier payments are a vital part of the Medicare payment system because they provide hospitals with insurance against extraordinarily high patient costs and ensure access to care for Medicare's beneficiaries. However, 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. Under the existing outlier methodology some hospitals' recent rates of charge increases greatly exceed their rates of cost increases. This disparity results in an overestimation of their current costs per case. In an effort to ensure that the outlier payments are used as they were intended, we issued a proposed rule that would prevent further gaming of the system by a few hospitals that obtain the majority of these payments. We are anxious to move forward with this effort as quickly as possible and are eager to receive comments on the proposed rule so that we can return the outlier policy to its original legislative purpose, which is to safeguard access to care for a broader number of Medicare beneficiaries and ensure appropriate use of taxpayer funds. I'm embarrassed that as a longtime hospital analyst I was not able to understand this problem and I am embarrassed for the Agency that we did not catch this sooner. Nevertheless, we firmly believe that this situation demands and immediate remedy. Thank you for allowing me to discuss this very important issue with you today. I look forward to answering your questions.

Senator SPECTER. Would you call that a transition period, Mr. Scully, when you do not understand it?

Mr. SCULLY. I am sorry, Mr. Chairman.

Senator SPECTER. Would you call that a transition period, when you do not understand it? It took you 2 years, it took your agency 5 years to understand the impact.

Mr. SCULLY. I have to say, Mr. Chairman, I did not understand what was going on in this. I knew that the outlier threshold was going up, and I was a little surprised that our staff did not understand it, but it is a very complicated program.

Senator SPECTER. On the question of a phase-in period, I note that there have been very substantial past phase-ins. For example, on graduate medical education reimbursement, there was a 5-year phase-in period for the 1997 change. There was a 5-year phase-in after 1997 for the change affecting acute hospital update care, a 4-year phase-in of the 1998 change in disproportionate share hospital reimbursements, a 10-year phase-in of capital prospective payments.

With those kind of precedents, would it not seem reasonable to have some phase-in on a change in outlier payments?

Mr. SCULLY. Well, Mr. Chairman, I think in those cases, and I think I was involved in all of them, those were policy changes that were big changes, but they were phased in as conscious policy decisions. In this case, I think the administration's belief is this really was a program abuse and should never have happened, and the people that are collecting this extra money are doing it at the expense of their neighboring hospitals, and it is a totally different situation.

Senator SPECTER. Is that a no?

Mr. SCULLY. I think our view is, with respect to you, Mr. Chairman, that we are trying to balance the fact that our authorizing committees think we should shut this down immediately, and the fact that there are hospitals and States affected, but I think our preference would be to fix it immediately.

Senator SPECTER. Well, I do not think it is a matter of accommodating a House authorizing committee or the Senate Appropriations subcommittee. It is a matter of what is reasonable to allow hospitals to adjust to it, and in a context where there have been substantial phase-in periods, I would urge you to consider that.

Mr. SCULLY. Mr. Chairman, I would think if Congress, wanted to buffer the impact on these hospitals in a Medicare bill, I think we would probably be happy to work with you on that. But within the context we have to do it in a budget-neutral fashion, hospitals that really have legitimate high-cost patients, I mean, we have to fix this, we have a set pot of money, and it is hurting hospitals that have legitimate high-cost patients to have the hospitals that took advantage of what I consider a major loophole in the program. It is at their neighbors' expense.

Senator SPECTER. Mr. Scully, when you have modified the figure from 2002 of \$21,025 on the fixed loss amount threshold, raising it to \$33,565 for 2003, isn't that an excessively sharp change which again has very, very substantial impact in a sudden way on the affected hospitals?

Mr. SCULLY. It has. It has the biggest impact on the hospitals that have not been excessively billing for outliers, and that is one of the reasons I feel strongly that, and I have argued strongly with in the administration that we should lower the threshold back to \$22,000 or \$23,000, but you can understand from OMB's point of view—and I used to work there, as you know, so I agreed with them in the draft rule to leave it where it was.

Their view is, how could you possibly know what the right amount is. You have missed every year by \$1.5 billion to \$2 billion, and as of right now, for this year, we are running way over even at this current target, if we do not change this regulation, we are expected to go way beyond the existing \$3.8 billion we have set aside, so from OMB's point of view, their view is, we have been wrong 5 years in a row, how could we be right?

So we put the rule out for comment. We have encouraged strong comment from the hospitals. I happen to believe, and our actuaries believe that the correct number probably is in the midtwenties, if we fix the program abuses, I really think that fixing this will provide the other 97 percent of the hospitals that have not abused more money from it. And so I do think the outlier threshold—my personal opinion is that it probably, if we fix the abuses, would be too high, but I can understand the skepticism from our budget analysts to say we have been wrong 5 years in a row by a couple of billion dollars, how could we possibly think we are right now?

Senator SPECTER. The proposed rule change specifies that some 123 hospitals have outlier payments averaging 24 percent of their total Medicare income. That seems to me to be a relatively small number out of the 5,000 hospitals in this country. What would you consider to be a reasonable transition period to phase in the new regulations to avoid serious financial impact on certain hospitals?

Mr. SCULLY. Well, Mr. Chairman, we made a pretty strong statement. There has been a lot of communication with the AHA and all the affected hospitals since October, and I think most hospitals that have been, we believe, billing excessively and taking advantage of this program have known since October that we were going to try to close it down, and they have basically had 6 months to adjust.

I would also add that the way the outlier payments work, and I can really bore you with how this has been gamed, if you would like, but the hospitals, for example—and I explained this to Crozier Chester, which is my hometown hospital, which is one of the ones that has higher outliers. I think they are testifying later today. They are collecting about \$30 million a year from outlier payments, and they are only getting about \$40 million of base Medicare payments, so obviously it is a major problem for them to lose that overnight.

They can, in fact, continue to bill us for outliers. The way the rule works is that we would come back probably in 3 to 4 to 5 years, maybe as long as 5 years in many cases, to actually reconcile and get the money back, so theoretically, if they wanted to finance their way out of this, they could keep collecting the \$30 million a year for 5 years and would not have to pay it back until we actually closed their cost reports for 2003. Effectively they would get a Treasury bond rate loan to finance themselves out of this gradually, so they would not necessarily have to lose \$30 million immediately.

The bottom line is, at some point out in the future, we will come in and look at their real, true costs for 2003 and say, we are going to pay you outliers based on your true costs, not on the inflated costs that have been reported, and they would have to pay it back, but there is a way for them to finance their way out of this hole

which effectively gives them a self-financing transition mechanism if that is what they choose to do.

Senator SPECTER. My red light is on, so I will now defer to Senator Harkin.

Senator HARKIN. Well, Mr. Scully, this is one of those cases where on the one hand I agree with you, and on the other hand, we have a difference here. I mean, I agree with you on what you are doing on the outliers. That is a distinct problem. It is something that we have to address.

I believe the administration has correctly set out the parameters of this and is addressing it correctly. I think you are right, that some of these people, in the future, as you look back, and as you see what the real costs were, could have those costs reimbursed later on, so I do not see any real problem with that, because it is hurting us and a lot of other States where we do not have this outlier problem, because it does take away from the base, as I said earlier, so I hope we can reach a reasonable agreement on this to move ahead on the outlier problem.

Now, the part that I am now going to disagree with you on has to do with the thing that we talked about when you were here before, and that is the fact that still we have nothing done about closing this gap in the beneficiary reimbursement by Medicare.

Now, I am going to take you to task, Mr. Scully, on what you said. You said that the plan would be helpful to Iowa. How do you tell Iowans, when we do not have one Medicare HMO in the State of Iowa, that this prescription drug plan is good for them? I just do not know how you can say that, especially when we have not done anything to address the fact that we are still number 50 in terms of per beneficiary reimbursement.

Mr. SCULLY. Well, Senator Harkin, first, on the issue of geographic disparities in the existing Medicare program, I spent a good bit of the day yesterday working on next year's hospital regulation, and I think you will find, and I encourage you to keep talking to Secretary Thompson and me, that we are going to have a number of proposals out for comment on ways, in the hospital field and probably in the physician field, to make up some of the, what we perceive to be historical inequities in those. It probably will not make you happy, but I think incrementally we share some of your views, and we are at least going to put out for your consideration a number of ways that we can modify some of these geographic inequities.

On the President's plan, I would love to have the opportunity to come down and explain the details, since I was very involved in drafting it. There are no HMOs in Iowa, and we do not expect there to be some. We do think that the Medicare + Choice program, which we have changed a little bit to call Medicare Advantage, is great in big cities like Philadelphia, where it has increasingly disappeared, or Pittsburgh. It does not work in Iowa. We do not expect there to be any HMOs.

However, the new part of the program, which is Enhanced Medicare, works very much like the Federal Employee Health Benefits Plan. It is basically private fee-for-service plans and PPOs, which 70 percent of the people in the country under the age of 65 are in

those types of plans, so it will be Blue Cross of Iowa, or Mutual of Omaha, or one of those private health plans that is not an HMO.

That is exactly what the administration is proposing—it is a system of new private fee-for-service plans. And, in fact, there is a huge geographic adjustment, because we split up the payments by 10 regions, so Iowa would get paid across the board the same as everybody else in that region, which I believe is Missouri, Kansas, Nebraska. The Federal subsidy across those regions would be the same, so—

Senator HARKIN. We are talking about prescription drugs now, are we not?

Mr. SCULLY. We are talking about, if you went into a Medicare, enhanced fee-for-service Medicare plan, what we would envision doing is having people buy all across Iowa, just like Federal employees do now—and there are Federal Employee Benefits Plans available all across Iowa, in the most rural areas.

If you wanted to get into the region that included Iowa, which is Nebraska, Kansas, Iowa, Missouri, if you were Blue Cross of Iowa, or Cigna, or United Health Care, you would have to sell the same plan across that entire region to all-comers, not county-by-county, like HMOs work. It would be the entire region. You would have to offer the same Blue Cross plan for the same premium with the same subsidies, so Iowa is, in fact, I guess 46th in the country, by some counts 50th by others in subsidies, but you would basically get exactly the same subsidy level in Iowa as everybody in St. Louis and Kansas City would.

So, in fact, when you look at the cross-subsidies, the cross-subsidy disparities to Iowa would be less. You would not be getting the same as New York, but you would be getting the same as everyone else in that Midwestern region and, in fact, if you look at the dollar subsidies to Iowa, it would significantly buffer the impact on Iowa as far as increasing the relative level of subsidies in the Medicare program to Iowans.

I would be happy to come explain whatever detail you would like. In fact, I would look forward to it, if I could.

Senator HARKIN. I would like to know more about it, but I mean, it just seems to me, I do not mind if we are in with Kansas, Missouri, or whatever, but I am more concerned about the individual Medicare recipient in that region, if we are going to be in that region, compared with what the reimbursements for prescription drugs would be if they were in a State that had a Medicare HMO, say, Florida, California or New York.

The beauty of the Medicare system—this is my own philosophy—has always been that everyone is treated the same. No matter where you are in this country, you ought to be treated the same. You pay the same, you have to be treated the same.

Now, if we are going to set up a system on prescription drugs where if you are in one State that has a lot of private HMOs, you get a higher benefit than if you are in States that do not, even though we might have Blue Cross or something, and I do not know how this is going to work in terms of the reimbursement. If you are saying that when this plan is over with, that a Medicare recipient in the State of Iowa for drug A will pay the same as a Medicare

recipient in Florida, or Louisiana, or New York, or California, well then, I do not have a gripe.

Mr. SCULLY. Eighty-nine percent of the population is on traditional Medicare, which is the program that CMS runs directly—we set all the rates. It is where this outlier problem came up—and 11 percent are in HMOs. The fundamental principle in our plan is that we believe that if you look at people under 65, 70 percent of those people are not in HMOs, they are in PPOs or private fee-for-service plans all through Iowa, like Mutual of Omaha or Blue Cross, and we tried to mimic that for seniors to give them another option.

So seniors can stay on the old Medicare, they can go in HMOs, which we do not believe are going to help—outside urban areas they are never going to be that popular. But in addition, they would have the chance to join a private fee-for-service plan. In many cases they will have provider networks. They have to take any doctor, they have to take any hospital. They can have differential networks, but they have to take all providers, and those are the kinds of plans that have taken over in the commercial sector and they do not exist in Medicare, and in that case the beneficiary in Iowa would pay exactly the same premium as the beneficiary in Philadelphia or in Miami. It is a national premium, in that it is designed to be the same way as it is in the existing fee-for-service program.

Senator HARKIN. I understand paying the same premium. I am not understanding about the benefits.

Mr. SCULLY. The benefits for drugs, obviously you may have a slightly different drug benefit between Blue Cross of Florida, or Blue Cross of Pennsylvania, or Blue Cross of Iowa, but the drug benefit subsidy is virtually the same. Between the enhanced fee-for-service, the drug benefit subsidy is identical.

I mean we did not—to be honest with you, Mr. Harkin, make the final decision. Obviously, we need lots of input from Congress. They did not want us to set up every little detail because Congress wants to legislate, so the President very consciously set up a framework which did not have an awful lot of detail, but we left out all but the conceptual design. I can tell you that the subsidy for drugs is identical in the enhanced fee-for-service to what it is in the HMO.

Senator HARKIN. Thank you. Thank you, Mr. Chairman.

Senator SPECTER. Thank you very much, Senator Harkin.

One vital question, Mr. Scully, before we go on to the next panel, in our January 31 hearing, you testified that you did not intend to use more recent data to calculate Medicare reimbursement for malpractice expenses. That was despite the fact that the agency only updates geographic differences in costs every 3 years.

I am especially concerned about that for Pennsylvania, where the malpractice costs exceed the national average and have risen dramatically in the last 2 years. In our 2003 Omnibus Appropriations bill, which we passed after your January 31 testimony, there was a direction for your agency to, quote, utilize data reflecting the current cost of liability insurance to determine current Medicare payment rates, including annual updates to the malpractice, geo-

graphic practice cost index, close quote. Will you comply with that direction?

Mr. SCULLY. Yes, Mr. Chairman. I have talked to our actuaries already. We are working on next year's physician rule, and we are going to use the most recent possible update information we can.

Senator SPECTER. Thank you very much. Thank you, Mr. Scully.

Mr. SCULLY. Thank you.

STATEMENT OF JOSEPH W. MARSHALL, III, CHAIRMAN AND CEO, TEMPLE UNIVERSITY HEALTH SYSTEM

Senator SPECTER. We will call our next panel, Mr. Joseph Marshall, Dr. Gail Wolf, and Mr. Andrew Wigglesworth.

Joseph W. (Chip) Marshall, III has served as chairman and chief executive officer of Temple University Health System since 2001. Previously, he was the chairman of the board. Before joining Temple's Health System he was a founding principal at Goldman & Marshall. He holds a law degree from Temple, and a bachelor's degree also from Temple.

Welcome, Mr. Marshall, and we look forward to your testimony.

Mr. MARSHALL. Thank you, Senator. Mr. Chairman, Senator Harkin, Mr. Scully, thank you for the opportunity to testify today, and thank you for holding this hearing. Temple University Health System is a cornerstone of the health care delivery system in North Philadelphia and the surrounding region. In 2001, TUHS treated 1.2 million patients through its hospitals and physicians. To put this in perspective, the population of Philadelphia and the surrounding five-county area is approximately 3.85 million people. On any given day, approximately 500 people utilize the services of TUHS emergency rooms, and an additional 1,700 people are present for nonemergency ambulatory services.

Additionally, as one of the largest private employers in the city of Philadelphia, the health system plays a vital role in the local economy. In fiscal year 2002, TUHS employed over 7,500 full-time employees and paid over \$264 million in salaries, and an additional \$64 million in benefits.

Like many health systems today, Temple faces numerous pressures threatening the financial viability of our member institutions. These include steadily rising labor costs and dramatic increases in costs for liability insurance and medical supplies, most notably, blood and drugs.

The cost of malpractice liability insurance alone has nearly doubled since 2001, when we paid \$33 million for our systemwide liability costs to projected funding this year of \$62 million. Temple has also been subjected to pressures from both private and public payers, including the long-term effects in the Balanced Budget Act on Medicare payment to hospitals.

In addition, as a system that serves some of Philadelphia's poorest neighborhoods, Temple is the provider of last resort for many patients. Consequently, Temple is one of the largest providers of free and underreimbursed care in the Commonwealth of Pennsylvania. In fiscal year 2002, Temple provided more than \$80 million in uncompensated care systemwide, which represents a \$12 million increase over the previous year.

In this time of constrained Federal and State budgets, it is reasonable to expect that there will be little or no abatement in the need for these services. Make no mistake, Senator, this is a responsibility that Temple proudly shoulders, but one that adds significantly to the list of financial pressures that we face. The bottom line is that the Temple University Health System showed an operating loss of \$50 million in the fiscal year ending June 30, 2002.

In the face of this severe challenge, the health system has a responsibility to explore every means possible to ensure that we continue to provide quality health care to our communities. In recent years, Medicare outlier payments, which help offset the cost of treating high-cost patients, have become an increasingly important component in Temple's ability to meet that obligation. It is important to note that the increased payments to Temple for outliers were the result of accepted practices that were completely within the rules of the Medicare program.

The funding Temple receives from Medicare outlier payments has become critical to our ability to carry out our mission in Philadelphia and the region. Last fall, CMS announced its intention to drastically alter the current outlier reimbursement formula. Recently, a proposed rule appeared in the Federal Register announcing the proposed changes and providing for a 30-day period during which affected parties may comment on the rule. Temple is grateful that CMS and the administration have decided to consider input from the hospital community in developing this policy, and will be submitting its concerns in writing regarding the rules shortly.

Temple respects the decision of CMS to take these actions, and will work with CMS and our local fiscal intermediary to successfully implement the new system. However, we believe that there are two areas where the rules must be improved. First, we urge CMS to reconsider its decision not to lower the fixed loss threshold amount from its current level of \$33,560. Lowering the outlier threshold would allow more hospitals to receive payments to help offset the cost of treating high-cost patients, and would help mitigate the effects on many hospitals, like Temple University Hospital, that will otherwise see outlier payments drop dramatically.

Further, by maintaining the fixed loss threshold at this historically high level, the effect of the loss is that CMS is not merely redistributing the existing funding set aside for outlier payments, but actually removing money from the system.

Second, and most important, Temple strongly disagrees with provisions in the proposed rule calling for an immediate implementation of the new system with no transition period.

To repeat, we do not argue the administrator's right to change the rules, nor the general tenor of the proposed changes. However, we strongly urge the inclusion of a transition period to the new system to preserve the continuity of services at those hospitals that would be most affected by the new rules. Temple, like other providers, has budgeted for and is operating under the current rules of the Medicare program. A steep drop in an expected payment for outlier cases could be financially devastating, resulting in an immediate, unplanned loss of millions of dollars for TUHS in fiscal year 2003, and losses of a similar magnitude in subsequent years. Additional cutbacks could create access problems in clinics supported by

us and our physicians, and lead to the elimination of various community outreach efforts. Finally, budget shortfalls could curb the delivery of care within TUH hospitals by delaying necessary technology enhancements.

PREPARED STATEMENT

In conclusion, Temple University Health System is committed to working with CMS to ensure the successful implementation of a new outlier policy. However, we believe that an immediate transition to these rules would excessively harm many hospitals, hospitals that have not violated the law, and provide indispensable services to key communities around the country. We ask only for the time to adjust to a new system.

Mr. Chairman, thank you for the opportunity to testify on this important matter, and for your leadership on this issue.

Thank you.

[The statement follows:]

PREPARED STATEMENT OF JOSEPH W. MARSHALL

Mr. Chairman, Members of the Subcommittee, thank you for the opportunity to testify today, and thank you for holding this hearing.

Temple University Health System¹ (TUHS) is a cornerstone of the health care delivery system in North Philadelphia and the surrounding region. In 2001, TUHS treated 1.2 million patients through its hospitals and physicians. To put this in perspective, the population of Philadelphia and the surrounding five county area is approximately 3.85 million. On any given day, approximately 500 people utilize the services of TUHS emergency rooms and an additional 1,700 people present for non-emergent ambulatory services. Additionally, as one of the largest private employers in the city of Philadelphia, the Health System plays a vital role in the local economy. In fiscal year 2002, TUHS employed over 7,500 full-time employees and paid over \$264 million in salaries, and an additional \$64 million in benefits.

Like many health systems today, Temple faces numerous pressures threatening the financial viability of our member institutions. These include steadily rising labor costs, and dramatic increases in costs for liability insurance and medical supplies, most notably blood and drugs. The cost of malpractice liability insurance alone has nearly doubled since 2001 (from approximately \$33 million system-wide to a projected cost of nearly \$62 million in 2003.) Temple has also been subjected to pressures from both private and public payers, including the long-term effects of the Balanced Budget Act on Medicare payments to hospitals.

In addition, as a system that serves some of Philadelphia's poorest neighborhoods, Temple is the provider of last resort for many patients. Consequently, Temple is one of the largest providers of free and under-reimbursed care in the Commonwealth. In fiscal year 2002, Temple provided more than \$80 million in uncompensated care system-wide, which represents a \$12 million increase over the previous year. In this time of constrained federal and state budgets, it is reasonable to expect that there will be little or no abatement in the need for these services. Make no mistake, this is a responsibility that Temple proudly shoulders, but one that adds significantly to the list of financial pressures that we face.

The bottom line is that Temple University Health System showed an operating loss of \$50 million for the fiscal year ending June 30, 2002.

TUHS AND MEDICARE OUTLIER PAYMENTS

In the face of this severe financial challenge, the health system has a responsibility to explore every means possible to ensure that we continue to provide quality healthcare to our communities. In recent years, Medicare outlier payments, which help offset the costs of treating high-cost patients, have become an increasingly important component in Temple's ability to meet that obligation.

¹ Temple University Health System consists of: Temple University Hospital, Temple University Children's Medical Center, Temple University Hospital—Episcopal Campus, Jeanes Hospital, Northeastern Hospital, TUHS Physicians primary care network.

It is important to note that the increased payments to Temple for outliers were the result of accepted practices that were completely within the rules of the Medicare program at the time. The funding Temple receives from Medicare outlier payments has become critical to our ability to carry out our mission in Philadelphia.

Last fall, the Centers for Medicare and Medicaid Services (CMS) announced its intention to drastically alter the current outlier reimbursement formula. Recently, a proposed rule appeared in the Federal Register announcing the proposed changes and providing for a 30-day period during which affected parties may comment on the rule. Temple is grateful that CMS and the Administration have decided to consider input from the hospital community in developing this policy and will be submitting its concerns in writing regarding the rule shortly.

Temple respects the decision of CMS to take these actions and will work with CMS and our local Fiscal Intermediary to successfully implement the new system. However, Temple believes that there are two areas where the rules must be improved.

—First, we urge CMS to reconsider its decision not to lower the fixed-loss threshold amount from its current level of \$33,560. Lowering the outlier threshold would allow more hospitals to receive payments to help offset the costs of treating high-cost patients and would help mitigate the effects on many hospitals, like Temple University Hospital, that will otherwise see outlier payments drop dramatically. Further, by maintaining the fixed-loss threshold at this historically high level, the effect of the rule is that CMS is not merely redistributing the existing funding set aside for outlier payments, but actually removing funding from the system.

—Second, and most important, Temple strongly disagrees with provisions in the proposed rule calling for an immediate implementation of the new system with no transition period.

To repeat, we do not argue the Administrator's right to change the rules, nor the general tenor of the proposed changes. However, we strongly urge the inclusion of a transition period to the new system to preserve the continuity of services at those hospitals that would be most affected by the new rules.

Temple, like other providers, has budgeted for, and is operating, under the current rules of the Medicare program. A steep drop in expected payment for outlier cases could be financially devastating, resulting in an immediate, unplanned loss of millions of dollars for TUHS in fiscal year 2003, and losses of a similar magnitude in subsequent years.

We believe that this funding is essential to the ability of our hospital, which is already pushed financially, to deliver high-quality care. The immediate loss of Medicare dollars on top of substantial cuts in IME, physician reimbursement, and Medicaid and General Assistance, coupled with spiraling costs such as malpractice insurance, nursing salaries, and drugs would require a dramatic rethinking of our mission.

TUHS cannot sustain the immediate loss of Medicare reimbursement of this magnitude. TUHS strives to provide the highest quality of care, physician training, and research, in the most difficult financial environment we have ever faced. The impact of these additional pressures could be severe. Potentially, TUHS could be forced to cut staff, and curtail services, particularly in the regional trauma center and the emergency room setting where TUHS provides the greatest amount of free care.

Additional cutbacks could create access problems in clinics supported by TUHS physicians and lead to the elimination of various community outreach efforts. Finally, budget shortfalls could curb the delivery of care within TUHS hospitals by delaying necessary technology enhancements.

Phasing in these changes, preferably over the course of several fiscal years, would ameliorate the effect on those hospitals that would be most severely affected by the new rules and prevent possible disruptions in service.

CMS has a long history of utilizing phase-in periods to implement changes in payment policy for this very reason; perhaps the most notable example being the transition from cost-based payment for inpatient hospital services to the current DRG-based prospective payment system.

We believe that a similar approach is warranted in this instance. If a revised outlier policy is implemented without a transition period, it will have a punitive effect on our system, and ultimately our patients. Further, because outlier payments are made from a fixed pot of funds, we would urge that any transition scheme be implemented in a non-budget neutral manner with an infusion of new Medicare funds to ensure that the burden for insuring continuity of services does not fall disproportionately on individual facilities. If CMS is not prepared to provide for a transition period, we would urge that the Congress take steps to pass legislation requiring that CMS do so.

CONCLUSION

Temple University Health System is committed to working with CMS to ensure the successful implementation of a new outlier policy. However, we believe that an immediate transition to these rules would excessively harm many hospitals, hospitals that have not violated the law and provide indispensable services to key communities around the country. We ask only for the time to adjust to a new system. Mr. Chairman, thank you for the opportunity to testify on this important matter and for your leadership on this issue.

Senator SPECTER. Thank you very much, Mr. Marshall.

STATEMENT OF GAIL WOLF, SENIOR VICE PRESIDENT AND CHIEF NURSING OFFICER, UNIVERSITY OF PITTSBURGH MEDICAL CENTER

Senator SPECTER. We now turn to Dr. Gail Wolf, senior vice president and chief nursing officer for the University of Pittsburgh Medical Center. She also serves as executive director of the Beckwith Institute for Innovation of Patient Care, which she founded in 1989. Dr. Wolf has her baccalaureate in nursing from West Virginia University, her master's from University of Kentucky, and her doctorate in nursing administration and organizational psychology from Indiana University.

Thank you for coming today, Dr. Wolf, and we look forward to your testimony.

Dr. WOLF. Thank you, Senator. Thank you for the invitation to testify. As you said, I am the senior vice president and chief nursing officer for the University of Pittsburgh Health System. The UPMC Health System, located in Pittsburgh, is an integrated health delivery system comprised of 19 acute care hospitals. We care for approximately 165,000 hospitalized patients annually, and are the largest employer in Western Pennsylvania. My job is to oversee patient care and nursing practice throughout the entire system. I have been a nurse for more than 30 years, and it is from that perspective that I would like to speak with you today on the issue of patient outliers.

We all know that patients in our hospitals today are sicker, largely due to advances in medical technology that is available today. At UPMC Presbyterian, which is our flagship academic health center, we see patients that are the sickest of the sick. People come to us from all over the world because they have medical conditions that cannot be treated elsewhere. We have currently patients in our intensive care units that would not have been alive 5 or 10 years ago, many of whom recover to lead productive lives. Because they are so ill, however, it often takes them longer to recover than the DRG time allowed for average cases and, thus, they become outliers, as we have heard today.

To illustrate the gravity of the problem, however, I would like to share two examples of patients who are sitting in our ICUs as we speak. The first is Mr. B, who is a 57-year-old retired farmer from West Virginia. He came to us for treatment of advanced heart failure. This is a condition that can be caused by a heart attack, high blood pressure, or just weakening of the heart muscle. Heart failure affects over 6 million Americans, and it is the most frequent discharge diagnosis for Americans aged 65 and older.

In this case, Mr. B's heart failure was so advanced that he was totally unable to function due to his illness. While he was hospital-

ized with us, Mr. B developed ventricular tachycardia, which is a lethal heart rhythm that is pretty common in heart failure. He went into cardiac arrest. We successfully resuscitated him and implanted a permanent internal cardiac defibrillator and pacemaker so that if his heart failed again he would not suffer the dire consequences.

The average length of hospitalization for heart failure is 4.2 days, and in many cases that is adequate. However, in this extreme case, Mr. B had been hospitalized 9 days to undergo treatment for his condition.

Now, this gentleman was a great patient, in that he learned and did everything he could possibly do himself to help manage his disease. He followed all of his instructions, he took all of his medications, but despite all of his and our efforts, he continued to deteriorate, and ultimately he needed an artificial heart device and subsequent heart transplant to stay alive. He was a fortunate one, in that he received a new heart after just a few months. Today, he is a new man, full of energy, up and about, cannot wait to get back to West Virginia for the snow to melt and get back to his garden.

The second example I want to share with you is Mrs. B, who is a 32-year-old mother of two young daughters. She is a college graduate who works with the deaf. At age 13, she had been diagnosed with cancer of the kidney. Over the years, complications of her disease left her with liver damage and only about 30 inches of intestine. She went on disability, and eventually came to UPMC for a multivisceral transplant, which includes the stomach, duodenum, pancreas, and small bowel.

While waiting for organ donation, Mrs. B developed acute liver failure and actually was the sickest patient I have ever seen. Fortunately, suitable organs were found in time, and she underwent a successful transplant of multiple organs. The allowed length of stay for this type of patient is 41½ days. However, in this extreme situation she was hospitalized for 60 days, due to the critical nature of her illness. Today, she is doing well, and ready to return to her children and her active life.

I use these examples to illustrate how difficult it is for us to manage diseases by numbers. The proposed outlier policy penalizes hospitals like UPMC Presbyterian and others, that take on the toughest cases. Academic medical centers like ours have high outlier numbers because we are the only true academic center in western Pennsylvania and see the sickest patients. These are not average patients, and an arbitrary threshold is difficult to quantify the cost of their care in advance.

In addition to patient intensity, geographic location will also determine the percentage of outliers an organization sees. In some areas such as Boston, or even here in Washington, there are multiple trauma and transplant centers to share the burden of outliers, but where there is a sole provider of those services, one would expect higher outlier percentages.

Both of the patients I have described became outliers. Their care was not inexpensive, but it was necessary, and it saved their lives.

Mr. Chairman, in conclusion, I hope that the committee will work with CMS to take into account these special patients when commenting on the new CMS outlier rule. Thank you.

[The statement follows:]

PREPARED STATEMENT OF GAIL WOLF

Good morning. My name is Gail Wolf, and I am the Senior Vice President and Chief Nursing Officer for the University of Pittsburgh Health System. The UPMC Health System is an integrated health care delivery system comprised of 19 acute care hospitals. We care for approximately 165,000 patients annually, and are the largest employer in Western Pennsylvania.

My job is to oversee patient care and nursing practice throughout the system. I have been a nurse for more than 30 years, and it is from that perspective that I would like to speak to you today on the issue of patient outliers.

At UPMC Presbyterian, which is our flagship academic health center, we see patients that are the sickest of the sick. People come to us from all over the world because they have medical conditions that could not be treated elsewhere. We currently have patients in our intensive care units that would not have been alive 5 or 10 years ago—many of whom recover to lead productive lives. Because they are so ill, however, it often takes them longer to recover than the DRG time allowed for average cases, and thus they become outliers.

To illustrate, I would like to share two examples of patients sitting in our ICU today. The first is Mr. B, a 57-year-old retired farmer from West Virginia. He first came to us for treatment of his advanced heart failure, a condition caused by heart attacks, high blood pressure, or just weakening of the heart muscle. Heart Failure affects over six million Americans and is currently the most frequent discharge diagnosis for Americans age 65 or older. Mr. B's heart failure was so advanced that he was unable to function.

While hospitalized, Mr. B developed ventricular tachycardia, which is a lethal heart rhythm common in heart failure. He went into cardiac arrest. We successfully resuscitated him and inserted a permanent internal cardiac defibrillator/pacemaker to prevent it from happening again. The average length of hospitalization for heart failure is 4.2 days. However, in this extreme case Mr. B had been hospitalized 9 days to undergo treatment for his condition.

Mr. B was a great patient in that he learned and did everything he could possibly do to manage his disease. But despite all his and our efforts, he continued to deteriorate and ultimately needed an artificial heart device and subsequent heart transplant to stay alive. Mr. B was fortunate in that he received a new heart after just a few months. Today he is a new man—full of energy, up and about, and anxiously waiting for the snow to melt so he can get back to his garden.

The second example is Mrs. B, a 32-year-old mother of two young daughters. She is a college graduate who works with the deaf. At age 13 she had been diagnosed with cancer of the kidney. Over the years, complications of her disease left her with liver damage and only about 30 inches of intestine. She came to UPMC for a multi-visceral transplant, which includes the stomach, duodenum, pancreas and small bowel.

While waiting for organ donation, Mrs. B developed acute liver failure and was sicker than any patient I have ever seen. Fortunately suitable organs were found in time and she underwent a successful transplant of multiple organs. The allowed length of stay for this type of patient is 41.5 days; however in this extreme situation Mrs. B. was hospitalized for 60 days due to the critical nature of her illness. Today, however, she is doing well and is ready to return to her children and resume her active life.

I used these examples to illustrate how difficult it is to manage diseases by numbers. The proposed outlier policy penalizes hospitals, like UPMC Presbyterian, that take on the toughest cases. Academic medical centers like UPMC Presbyterian have high outlier numbers because they see the sickest patients. These are not average patients, and an arbitrary threshold cannot quantify the cost of their care in advance.

Both these patients I described became outliers. Their care was not inexpensive, but it was necessary—and it saved their lives. Mr. Chairman, I hope that the committee will work with CMS to take into account these special patients when commenting on the new CMS outlier rule.

Senator SPECTER. Thank you very much, Dr. Wolf.

STATEMENT OF ANDREW WIGGLESWORTH, PRESIDENT, DELAWARE VALLEY HOSPITAL ASSOCIATION

Senator SPECTER. Our next and final witness is Andrew Wigglesworth, president of the Delaware Valley Healthcare Council, which represents and advocates for more than 150 hospitals, health systems, and health-related organizations in southeastern Pennsylvania, southern New Jersey, and Delaware. He is also president and CEO of the Philadelphia International Medicine, received his B.A. in international relations from American University. Thank you for joining us, Mr. Wigglesworth. The floor is yours.

Mr. WIGGLESWORTH. Mr. Chairman, members of the subcommittee, I want to commend you for holding this hearing and appreciate the opportunity to present our views on the proposed changes to the outlier payment policies. I have submitted fairly lengthy testimony which I will try to summarize in the interest of time.

Senator SPECTER. That will be made a part of the record, Mr. Wigglesworth. I have been advised since this hearing began that there is going to be a vote at 10:30. We are moving ahead on the nomination of Mr. Miguel Estrada, and the majority leader is summoning all Senators to the floor for that proceeding, but we have ample time, so proceed.

Mr. WIGGLESWORTH. Okay. I will be especially fast, Mr. Chairman.

I think while we all agree on the need to reexamine and address any unintended consequences of the current outlier policy, the council and its member organizations are deeply concerned with respect to the method, timing, and overall impact of the proposed rule published on March 5, last week, by the Centers for Medicare and Medicaid Services. In its rush to judgment, CMS has made serious allegations about the conduct of community institutions, as well as appeared to initiate it and then did not wait for the results of its own audit process for determining whether inappropriate activity has even taken place, or what specific policies should be developed.

More important, CMS is seeking to implement a remedy that (1) represents a fundamental shift in payment policies that Congress ought to be involved in and could, in fact, exceed its statutory authority, and (2) creates an administratively burdensome and potentially unworkable process for retrospectively reconciling payments and (3) will create immediate and, in some cases, unsustainable financial harm to certain hospitals that could jeopardize the access to needed services for Medicare beneficiaries as well as all other payments. We believe that the policy changes embodied in the proposed rule should be fully evaluated and any changes that have adverse financial implications should be phased in over a reasonable transition period.

In short, Mr. Chairman, the rule as proposed will not only hurt institutions, it really does not help all others, as Mr. Harkin was suggesting in his concerns, because of the way it is constructed in not reducing the outlier threshold level.

As was discussed by Mr. Scully, outlier payments are a critical component of any payment system based on averages. This system

was established over 20 years ago, as the Medicare program moved from cost-based reimbursement to prospective reimbursement. The Congress intended that these additional payments limit financial risk to hospitals and diminish any financial incentive for hospitals to avoid treating elderly patients with serious illness. The outlier payments partially reimburse hospitals for the losses that they incur in treating high-cost patients and, as was suggested, are funded by reducing total PPS payments by 5 to 6 percent.

As Mr. Scully pointed out, over the years, CMS has not been able to hit the outlier target consistently and, in fact, mentioned from 1997 onward the payments were over. Well, prior to 1997, all the payments were generally under, so there is a consistent track record of not being able to hit the outlier target, and it is due in part, obviously, to the complexity of this whole process, which is contributing to some of the problems that have been discussed here today.

CMS has taken actions over the past several months. One, as you mentioned earlier, Mr. Chairman, they increased the threshold to \$33,560. That was a 59 percent increase over the previous year. They also issued several program memoranda and initiated, as I referenced to earlier, a series of audits that all the fieldwork will be completed no later than July 1, 2003. They hope to have the whole process completed by July 31, 2004, and I guess as such, the principal point we would want to make here is, in terms of their whole audit process, none of the results are available that would either support or refute the allegations of abuse in terms of this program.

I think in terms of moving to the regional impact, as you know, Mr. Chairman, Philadelphia is home to one of the largest concentrations of medical and health care expertise in the world. Life sciences is really the future of the economy of southeastern Pennsylvania. Hospitals and health systems in that region, there are over 100, 5 medical schools that train nearly a quarter of the Nation's physicians. The outlier proposal as before you, or as before, in the proposed rule, would reduce payments to hospitals in the Greater Philadelphia area by an amount in excess of \$100 million, and this is coming in the context of an environment that you mentioned before, where medical professional liability costs are skyrocketing, the State budget has just been reduced in a significant way for Medicaid payments, which will reduce payments to hospitals in that region by another \$120 million.

In short, the institutions in southeastern Pennsylvania are in no position at this time to absorb a sudden and immediate reduction in outlier payments. In effect, the agency is, through the proposal—while there is a 30-day comment period would, in effect, be like switching a light switch in terms of cutting off a significant flow of dollars to this region.

In terms of the recommendations, Mr. Chairman, I think, again, we understand that CMS has legitimate policy concerns about the unintended consequences. However, the concerns that CMS was trying to address were identified actually over a decade ago, and there were comments, and CMS actually—and included in my testimony is the response to those comments, and CMS has been fol-

lowing, by increasing the outlier threshold, the response that they identified as far back as 1989.

Now, the proposed solution that they are proposing I think may have some equally significant unintended consequences. As I mentioned, just the manner and timing of the proposed policy will impact on the ability of hospitals to serve Medicare beneficiaries and their communities. No one wants this outcome. We urge the subcommittee to encourage CMS to consider the following recommendations:

Provide for a transition period. As has been mentioned before, and as you mentioned, Mr. Chairman, in every other major policy change, CMS and/or the Congress has provided a transition period, and as Mr. Scully mentioned before, AHA has weighed in on this matter. AHA strongly supports, on behalf of all hospitals across the country, a reasonable transition period with respect to this proposed change.

Second, we would like to see the proposed rule include a reduced threshold level. By remaining at \$33,560, in effect, it is unclear as to whether or not the agency will actually spend the minimum amount, or 5.1 percent, that it is supposed to spend on outlier payments.

Third, we would also like to see the elimination of the retrospective, really, reconciliation of cost-to-charge ratios that is included in the rule, and this is where there is a major policy change. In effect, they are turning the outlier payment as part of a prospective payment system in effect into a retrospective payment system, because hospitals and the fiscal intermediaries would have to engage in a process where they would have to reconcile and reprocess claims several times as the cost reports are finally settled. We believe that this is an unworkable process that will lead to a very burdensome administrative process and, again, may, in fact, exceed their fundamental authority.

PREPARED STATEMENT

Mr. Chairman, in conclusion, again we want to thank you for the opportunity to testify on this important public policy. The proposed rule will have a severe impact on the Greater Philadelphia area, as well as other parts of the Commonwealth and the Nation. We appreciate your help in trying to ensure the hospitals in our region are able to continue to provide services the public expects and deserves.

I would be happy to answer any questions you may have.
[The statement follows:]

PREPARED STATEMENT OF ANDREW B. WIGGLESWORTH

Mr. Chairman and members of the Subcommittee, my name is Andrew Wigglesworth and I am president of the Delaware Valley Healthcare Council (DVHC). The DVHC is located in Philadelphia and has 150 member hospitals, health systems, and other health related organizations in Southeastern Pennsylvania, Southern New Jersey, and Delaware. The mission of the Council is to help member organizations improve the health status of their community and to exercise leadership in reforming our health care system. Mr. Chairman we commend you for holding this hearing and appreciate the opportunity to present our views on the proposed changes to the Medicare outlier payment policies.

While we all agree with the need to re-examine and address any unintended consequences of the current outlier policy, the Council and its member organizations

are deeply concerned with respect to the method, timing and overall impact of the Proposed Rule published on March 5, 2003 by the Center for Medicare and Medicaid Services (CMS). In its rush to judgment, the CMS has made serious and unsupported allegations about the conduct of many community institutions as well as appears to have initiated and then did not want for the results of its own audit process for determining whether any inappropriate or illegal activity even has taken place and what specific policies should be developed.

More important, CMS is seeking to implement a remedy that: (1) represents a fundamental shift in payment policies that may exceed its statutory authority; (2) creates an administratively burdensome and potentially unworkable process for retrospectively reconciling payments; and (3) will create immediate and in some cases unsustainable financial harm to certain hospitals that could jeopardize access to needed services for Medicare beneficiaries as well as all other patients. We believe the policy changes embodied in the proposed rule should be fully evaluated and that any changes that have adverse financial implications should be phased in over a reasonable transition period.

Outlined below is a detailed discussion of the Medicare Outlier program, the Proposed Rule and our concerns.

BACKGROUND

The Medicare program provides for payments in addition to the basic prospective payments for cases involving extraordinarily high costs, referred to as "outlier" cases. Outlier payments are a critical component of any payment system based on averages. Twenty years ago, when the Medicare program moved from cost based reimbursement to a prospective payment system (PPS), Congress created these additional payments to limit hospitals' financial risk and to diminish any financial incentive for a hospital to avoid treating elderly patients with especially serious illness. The outlier payments partially reimburse hospitals for losses they incur in treating high cost patients and are funded by reducing total inpatient PPS payments by 5 to 6 percent.

Although the statute requires an outlier pool of between 5.0 percent and 6.0 percent of total estimated DRG payments, it does not establish any criteria for deciding the pool size within those limits, and CMS presumably has the authority to adopt any non-arbitrary policy.¹ The size of the pool within the permitted range affects the distribution of payments among hospitals, since some hospitals tend to have larger numbers of outlier cases than others, larger outlier pools and their related payments distribute more money to those hospitals with more complex and costly caseloads, while a smaller outlier pool, and the resulting larger regular PPS payments, favors those hospitals with caseloads of average complexity and cost.

Initially, the outlier pool was established at 6.0 percent, the statutory maximum, in order to provide hospitals the greatest possible insurance against costly cases. For the second year of PPS, however, the policy was reversed, and the pool was established at the statutory minimum of 5.0 percent in order to provide greater payments for typical cases. That pool size was continued until 1988, when the pool was increased to 5.1 percent to accommodate the statutory amendment that increased payments for burn case outliers without changing the thresholds for the other types of cases.² The pool has remained at 5.1 percent since then.

Any case for which costs exceed the PPS payment amount plus an additional fixed dollar amount, called a "threshold," qualifies as a cost outlier entitled to extra payment. CMS computes the threshold based on past experience, seeking to make the outlier payments exactly equal to the size of the outlier pool that has been set aside. Each year the PPS Rule states the dollar amount of costs that must be exceeded to qualify for cost outlier payments. Once the threshold is set for the year, all cases meeting the criteria receive outlier payments, with the result that the total amount of the outlier payments actually made may be greater or less than the size of the pool depending on the accuracy of the original estimates.

To identify outlier cases, the Medicare Fiscal Intermediary compares the estimated cost for a case to the DRG specific fixed loss threshold. Because hospitals cannot calculate costs on a case-by-case basis, the fiscal intermediary uses Medicare charges the hospital reported on its claim to estimate the cost of a case. The intermediary arrives at the cost estimate by multiplying the covered charges by the hospitals cost-to-charge ratio (CCR) from the most recently settled cost report, which is often several years old. Under current CMS policy, if the hospital CCR is more

¹*American National Health Lawyers Association, Medicare Law*, First Edition (March 2001), at pg. 62.

²SSA § 1886(d)(3)(B), 42 U.S.C. § 1395ww(d)(3)(B), 42 C.F.R § _____.

than 3 standard deviations above or below the statewide average CCR then the statewide average is used. The policy of substituting the statewide average CCR was adopted in 1989 to address CMS's concern that ". . . ratios falling outside this range are unreasonable . . . probably due to faulty data reporting or entry. Therefore, they should not be used to identify or pay cost outliers."

From an overall perspective, CMS has not estimated the outlier thresholds correctly since the initial implementation of PPS, and repeatedly has paid more or less than that which was contemplated. This outcome has led to requests that the funds not spent from the outlier pool be distributed in the form of higher payments in following years. CMS rejected this approach, stating that the statute requires estimates that are binding whether subsequent events lead to greater or lesser outlier payments than originally predicted. CMS's position was upheld in a court challenge.³

RECENT CMS OUTLIER RELATED ACTIVITIES.

CMS, through the authority granted it in accordance with Section 1886(d)(3)(B) of the Social Security Act, made revisions to the methodologies used in establishing outlier thresholds for Federal fiscal year 2003.⁴ This change increased the fixed cost outlier eligibility threshold from \$21,025 to \$33,560, an increase of 59.6 percent. These revisions were expected to address the issue created by the increases hospital charges and the effect on Medicare outlier reimbursement.

In November 2002, CMS officials made a number public statements about "fraud and abuse" in connection with the existing cost outlier reimbursement mechanism, and that CMS would be launching a review of hospitals nationwide.

On December 3, 2002, CMS issued Program Memorandum A-02-122 to Medicare fiscal intermediaries, which stated CMS' belief that some hospitals may be attempting to "game" the current outlier payment systems for the purposes of maximizing payment. This Program Memorandum launched a nationwide review of hospitals to determine whether and to what extent hospitals have sought to increase Medicare reimbursement for cost outliers by increasing aggregate charges.

On December 20, 2002, CMS issued Program Memorandum A-02-126 to Medicare fiscal intermediaries, which provided instructions to perform data analyses to identify those hospitals that "appear to present the greatest risk to the program". This Program Memorandum sets forth the scope of claims audit(s) to be performed for those hospitals that meet or exceed the thresholds established in the data analysis. Engagement letters for all providers subject to audit were to be issued by January 13, 2003. The audits were required to be scheduled so that fieldwork for some audits could start by February 1, 2003. Fieldwork for all audits must be scheduled to start no later than July 31, 2003. The Program Memorandum further states that CMS anticipates that this work will be completed on a flow basis with the entire sample being completed by July 31, 2004.

As such, no results are available at this time that would either support or refute CMS' allegations of fraud and abuse of the outlier program.

PROPOSED RULE

On March 5, 2003, CMS issued the Proposed Rule that would change the methodology for determining Medicare cost outlier reimbursement. Under the Proposed Rule, the outlier policy would change in the following key ways:

- The cost-to-charge ratios (CCR) from the latest tentative settled cost reports at the time the claim is processed would be used instead of the CCR from the most recently settled cost report. The proposal would also provide for an adjustment to the CCR for hospitals with high charge increases.
- The statewide average CCR would no longer be used in place of the hospital's actual CCR when the hospital's actual CCR is more than three standard deviations below the geometric mean. However, the statewide average CCRs would still apply in those cases where a hospital's operating or capital CCR exceeds the upper threshold or where a hospital has not yet filed its first Medicare cost report.
- Outlier payments would be subject to retrospective reconciliation when the cost report corresponding with the outlier cases is settled, by using the actual CCR calculated from the final settled cost report rather than the one from the latest tentative settled cost report at the time the claim is processed. Importantly, the details of the process required to implement this retrospective settlement are

³ See *County of Los Angeles v. Shalala*, 192 F.3d. 1005 (D.C. Cir. 1999).

⁴ 67 Fed. Reg. 49981 (Aug. 1, 2002).

not specified. At the time of settlement, any overpayment or underpayment would be adjusted for the time value of money during the intervening period. The proposed rule does not provide a transition for outlier payments and does not lower the outlier threshold, which remains at \$33,560. In spite of decreased outlier payments to providers, CMS and the Office of Management and Budget decided not to decrease the outlier thresholds until data is available to assess actual payments. CMS indicates that a change might be possible after first quarter 2003 data is available.

DVHC COMMENTS

As you know Mr. Chairman, CMS has asserted that the use of the statewide average cost-to-charge ratio to calculate outlier payments for hospitals with cost-to-charge ratios below the statewide average is the primary concern. Despite the fact that the potential problem with this methodology was brought to the agency's attention over a decade ago, CMS has now decided that an abrupt, mid year change in policy is warranted regardless of the consequences for hospitals.

Mr. Chairman, we believe this is the wrong way to change public policy and represents a significant departure from the process both Congress and CMS have used in the past to make major Medicare payment policy changes that have adverse financial implications for participating providers or health plans. As the members of the Subcommittee know, the federal government has very significant enforcement powers and legal remedies to take immediate action in cases involving allegations of fraud or other illegal activities. In fact, according to press accounts the federal government already has filed suit and entered into a voluntary agreement to suspend certain outlier payments with a California based organization.

However there is no current evidence to suggest that all hospitals that benefited from the current outlier methodology engaged in fraud or other illegal activities. Quite the contrary as the audits conducted by the agency at a number of hospitals in New England did not result in any allegations of inappropriate, much less illegal, actions related to outlier payments. It raises a question as to why the agency has now decided to proceed with immediate changes over a year before its nationwide outlier audit process is scheduled to be completed.

It is clear that CMS officials don't like the current outlier policy and believe it has had unintended consequences. But it is possible that even greater unintended consequences will occur by making radical changes to a decade old public policy with little external input or analysis on an immediate basis—like flipping a light switch—in the middle of a fiscal year.

As we all know too well, the Medicare program and its payment methodologies have become incredibly complex. In the past, both Congress and/or CMS have provided for transition periods to implement major policy changes. For example, the Medicare program originally included provisions for "length-of-stay" or "day" outliers. In 1995, length-of-stay or day outliers were phased out over a three year period. Similar transitions have been provided for policy changes in many other areas including medical education payments, outpatient payments, and changes in the wage index formula.

In another area that perhaps more closely parallels the core issue today, many in the hospital community have long felt that Medicare Plus Choice plans are "overpaid" when institution specific payments such as capital, outliers, medical education, and disproportionate share, are included in the calculation of per beneficiary payments to those plans. Why should these plans receive Medicare funds intended to help cover institution specific expenditures for services to the uninsured, medical education or physical plant improvement? The plans don't serve the uninsured or train doctors. After a number of years of debate, Congress changed the policy to exclude medical education payments from the calculation of the payments to plans. But the change did not occur overnight in the middle of the fiscal year in a manner that undermined the fiscal integrity of the plans. While the policy that gives any of these institution specific payments to the plans results in "over payments," but it is not fraud . . . it is not illegal . . . rather it is bad public policy.

To the extent that a hospital has uniformly applied its published charges to all payors and a decade old Medicare outlier policy results in what CMS argues are "overpayments" to that hospital, it is a flawed public policy, not fraud or illegal activity. Under Medicare law, an acute care hospital is not prohibited or otherwise restricted from increasing its published charges for patient services (as set forth in the hospital's "chargemaster"). The Medicare program cannot dictate to a provider what its charges or charge structure may be, though the program may determine whether or not the charges are allowable for use in apportioning costs under the

program.⁵ Medicare law requires hospital charges to be reasonably related to the costs of the services rendered, and uniformly applied to all patients.⁶ Subject to these conditions being met, there is nothing inherently unlawful in a hospital's choice to raise its rates/charges.

Moreover, CMS has known that there are potential unintended effects of the outlier formula for years. In comments to the 1989 Medicare PPS Final Rule, HCFA acknowledged that outlier payments could be affected by charge increases:

"Although concern . . . is appropriate, we believe that there are several factors that will mitigate its effects. First, increases in hospitals' charges relative to costs will be reflected in the cost-to-charge ratio assigned to the hospital in the future . . . Second, many hospitals are restricted in their ability to arbitrarily increase their charges by the fact that they must deal with other third party payers, some of which based their payments on charges . . . Third, a general acceleration in hospital charge increases can be incorporated into the setting of thresholds in future years, which would limit the potential benefits to hospitals . . ."—(53 Fed.Reg. at 38509 Sept. 30, 1988).

Consistent with those comments from 1989, CMS, through the authority granted it in accordance with Section 1886(d)(3)(B) of the Social Security Act, made revisions to the outlier threshold for Federal fiscal year 2003. (67 Fed. Reg. 49981 (Aug. 1, 2002). This change increased the fixed cost outlier eligibility threshold from \$21,025 to \$33,560, an increase of 59.6 percent. This level is up from \$14,050 just three years ago. These revisions were expected to address the problem created by the hospital charges increasing at a rate greater than hospital costs, and the effect on Medicare outlier reimbursement. To date there has been little analysis of the impact of increasing the threshold and whether the threshold increase coupled with the Proposed Rule will result in aggregate outlier payments of the statutorily required 5.1 percent of program expenditures.

Mr. Chairman, given the history of the Medicare outlier program and the prior actions of HCFA/CMS, the federal government itself shares much of the responsibility for the problem that is the subject of today's hearing and that the Proposed Rule attempts to address. However, the proposed rule if adopted will have dramatic consequences for many of DVHC's members and the delivery of health care in the greater Philadelphia area.

REGIONAL IMPACT

The greater Philadelphia area is home to one of the largest concentrations of medical and health care resources in the world. In addition to being home to the nation's first hospital and first medical school, today the region is a global life sciences center.

—The life sciences sector is the largest single component of our regional economy and health services alone account for over 250,000 employees—one in seven jobs.

—Nearly 100 hospitals and 5 medical schools.

—Over 100 biotechnology companies

—Home to 80 percent of the nation's largest pharmaceutical companies.

—Nearly one in five physicians in the country receives some portion of their training in Philadelphia.

—One of the top areas in the country in terms of NIH research.

In short the Philadelphia metropolitan area is more dependent on health care as a percentage of its economy than any other major metropolitan area in the country.

Equally important, those impressive statistics do not tell the full story, particularly as it relates to the financial stress on our hospitals and health systems. Consider a few other statistics:

—Philadelphia is the largest city in America without a public hospital system and our hospitals provide nearly a half a billion dollars in uncompensated care.

—The average hospital operating margin is only 0.2 percent.

—The Philadelphia market is the most highly concentrated payor market in the country where Moody's Investor Service has said payors are dictating prices and driving down hospital revenues.

—The cost of medical liability coverage is skyrocketing out of control with hospitals spending nearly as much on liability coverage as uncompensated care. The increased cost of liability coverage has resulted in hospital layoffs, loss of

⁵ Medicare Provider Reimbursement Manual § 2203 (CMS-Pub.15-1).

⁶ Medicare Provider Reimbursement Manual § 2202.4 (CMS-Pub.15-1). 10

physicians, and closure of key services ranging from a trauma center and paramedic units to maternity units.

—In fact, recruitment of physicians in Southeastern Pennsylvania virtually has been halted due to the liability insurance crisis. In fact, last year out of all residency programs in the area in orthopedics, not one of the graduating students resided in Pennsylvania. Moreover, a recent survey of residents indicated that 82 percent of residents after they completed training would not stay in Pennsylvania due to the current liability environment.

—The state Medicaid program currently only pays 77 cents on the dollar of care, and in response to the state budget deficit the Governor just announced the elimination of Medicaid payments for outpatient disproportionate share, medical education, and community access funds resulting in the loss of \$120 million to hospitals in Southeastern Pennsylvania.

These are just a few of the stresses on our region's hospitals. And like hospitals all across the country we are struggling with workforce shortages, the increased costs of disaster preparedness and the prospect of further Medicare cuts. It is because of these challenges that we are here today. The region's hospitals are extremely fragile and in no position to absorb sudden and dramatic mid year cuts in Medicare outlier payments.

According to preliminary estimates, the combination of the increase in the outlier threshold adopted last year and the provisions of the proposed rule will reduce Medicare payments to our region by over \$100 million dollars. Further, we believe this number is conservative as it is very difficult to model the implications of the retrospective reconciliation of outlier payments based on cost-to-charge ratios in subsequently settled cost reports. At some institutions, the loss of these funds will result in layoffs, reduction in services, and impact on care for the entire community.

RECOMMENDATIONS

Mr. Chairman, we recognize that CMS has legitimate policy concerns about the unintended consequences of the current outlier policy. However, the concerns CMS is trying to address were identified over a decade ago. Now the proposed "solution" may have other equally significant unintended consequences. In fact, just the manner and timing of the proposed policy will impact on the ability of hospitals to serve Medicare beneficiaries and their communities. No one wants that outcome. We urge this Subcommittee to encourage CMS to consider the following recommendations:

1. *Provide for Transition Period.*—The CMS should not implement Medicare policy changes that have significant adverse financial implications for participating providers in the middle of a fiscal year with no provision for a reasonable transition period. At the very least the proposed changes, including the elimination of the statewide average CCR should be considered in the context of the annual PPS rule effective October 1, 2003 with provision for a phase out similar to other major Medicare policy changes.

2. *Reduce the Threshold Level.*—The proposed rule does not lower the current outlier threshold. As mentioned previously, the threshold has risen from \$14,050 to \$33,560 in just three years. The current threshold should be reduced in tandem with any orderly change that may be made to eliminate the use of the statewide average. As proposed, it is unclear whether combination of provisions will result in the statutory requirements for spending between 5.1 percent and 6 percent on outliers will be met.

3. *Eliminate the Retrospective Reconciliation of Cost-to-Charge Ratios.*—The proposed rule would require individual claims to be processed twice over several years as the Medicare cost reports are settled. This will be very burdensome, if not impossible from an administrative standpoint for Fiscal Intermediaries as well as hospitals. Equally important, this policy change will result in further unpredictability in payments for hospitals and hinder prudent financial management in an era of extremely constrained resources. In addition to potentially exceeding the CMS statutory authority, this proposal will change a significant part of the prospective payment system into a retrospective system. This is a fundamental policy change. Any change of this magnitude should be under Congress' purview.

Finally, in public comments and in the Proposed Rule, CMS officials have repeatedly implied that hospitals that benefited under the current policy have committed fraud or illegal activity. No one condones fraud. If there is evidence of illegal activity by individual organizations, the government should use the options available to it to address the issue. However, in this instance the vast majority of hospitals did not have any deliberate policy to take advantage of Medicare. The unintended consequences of bad public policy should not be equated with fraud or illegal activities.

Moreover this whole issue is indicative of how badly the Medicare payment system for hospitals is broken and how complex it has become.

Mr. Chairman, I want to thank you for the opportunity to comment on this important public policy issue. The Proposed Rule that will have a severe impact on the greater Philadelphia area as well as other parts of the Commonwealth and the nation. We appreciate your help in trying to ensure that hospitals in our region are able to continue to provide services the public expects and deserves. I would be happy to try to answer any questions you or the other members of the Subcommittee may have.

Senator SPECTER. Mr. Scully, thank you for staying to hear the testimony. You have heard an impassioned plea, summarized by Mr. Wigglesworth, on the impact on southeastern Pennsylvania. I think that the issues relate generally and nationally, but he makes a pretty strong case about the—focusing on southeastern Pennsylvania.

You may have a special interest in that area since, as you have already identified, Chester Crozier is your home area hospital, notwithstanding the fact that you are a national officer. I have a special interest in Pennsylvania and the Southeast, notwithstanding the fact that I am a United States Senator, and we are concerned about the national policy, but Mr. Wigglesworth talks about life sciences being key to the area. Life sciences are key to the whole country, and the \$100 billion in loss in revenue is only one facet. The most important facet is the quality of care, so how about the recommendations which have come from these three witnesses, perhaps starting first with the transition period.

I would urge you, this subcommittee would, and I think there would be a lot of support in the Congress, to establish a transition period which gives some time to acclimate.

Before you respond to that, we have not had any specificity from our other witnesses. Mr. Marshall, what would you think to be an adequate transition period? Let us get the debate started.

Mr. MARSHALL. About 30 months. That would take us into 3 fiscal years, that would allow us to readjust.

Senator SPECTER. What would you settle for?

Mr. MARSHALL. 29.

Senator SPECTER. Dr. Wolf.

Dr. WOLF. I do not have a specific period of time in mind, but I think a transition period of at least several years would be a good one.

Senator SPECTER. Mr. Wigglesworth.

Mr. WIGGLESWORTH. In terms of the time frame, I could go with either one, but at the very least, this whole process ought to be put into the regular rule that at least would extend it beyond, not have this policy go into effect in the middle of a fiscal year, and it should at least go to the next fiscal year, and there ought to be a period for an orderly phaseout over a number of months, as both the other witnesses say.

I would also add this one other point. I am here representing a large number of institutions, some of which benefit, some of which are hurt. One thing that everyone is in agreement with is that there ought to be, where there is severe financial implications, there ought to be a transition period. Today, it is outliers. Tomorrow it could be some other major policy change, and the agency

should not do it mid-fiscal year, in effect like switching a light bulb.

Senator SPECTER. Well, would each of you submit in writing what you would like to see by way of a transition period?

Mr. WIGGLESWORTH. Absolutely.

Mr. MARSHALL. Yes, Senator.

[The information follows:]

UPMC HEALTH SYSTEM,
200 LOTHROP STREET, PITTSBURGH, PA,
April 1, 2003.

RE CMS-1243-P / Medicare Program; Proposed Changes in Methodology for Determining Payment for Extraordinary High-Cost Cases (Cost Outliers) under the Acute Care Hospital Inpatient Prospective Payment System

Centers for Medicare and Medicaid Services,
Department of Health and Human Services,
ATTN: CMS-1243-P, Baltimore, MD 21244-1850

DEAR SIR OR MADAM: On behalf of the UPMC Health System (UPMC), we are submitting one original and three (3) copies of our comments regarding the Centers for Medicare and Medicaid Services (CMS) proposed rule, "Medicare Program; Proposed Changes in Methodology for Determining Payment for Extraordinary High-Cost Cases (Cost Outliers) under the Acute Care Hospital Inpatient Prospective Payment System" (FR Vol. 68, No. 43 Page 10420-10429, 3/5/03). We hope these comments/suggestions will be considered before any final guidelines are published.

GENERAL OBSERVATIONS

Even the most modest changes to Medicare payment systems have profound effects on providers and Fiscal Intermediaries (FIs). Though the proposed changes in methodology for cost outliers appear simple, the procedural changes, data requirements, and financial implications to making such changes are not. Therefore, we believe that before these rules are finalized, CMS should better define the terms, offer guidance for different scenarios, add clear explanations for how they should be addressed, and ensure consistency between these proposed new rules and those already in place.

Because these changes not only have a financial implication but also require process changes for compliance, there should be a phased-in implementation schedule. Reasonable processes should be set-up and tested among the providers, Fiscal Intermediaries (FIs), and CMS to make the accounting correct and expeditious. Considering the magnitude of both the processing implications, and financial implications, CMS should work together with health care providers nationwide to ensure that all aspects of Medicare outlier reimbursement are covered. It is only in this manner that CMS can ensure the integrity of the Medicare Trust Fund, and providers can be assured that they are being appropriately compensated for the expense incurred for high cost cases.

With the sweeping changes being proposed in this rule, the most crucial aspect to providers is the maintenance of the fixed-loss outlier threshold at the current \$33,560 level. Special consideration should be given to re-evaluating CMS' position to hold the threshold at that level before it is implemented in the final rule.

SPECIFIC COMMENTS—PHASE-IN OF THE PROPOSED CHANGES OVER A TRANSITION PERIOD

Eliminate Statewide Averages (Pg. 10424) and Gradually Reduce Fixed-Loss Outlier Threshold (for Inpatient PPS) from \$33,560 Level (Pg. 10426)

CMS has proposed sweeping changes to the calculation and process for the payment of Medicare outliers. The proposed changes include:

- Using more current cost-to-ratios (CCRs) to ensure that outlier payments are made for truly high cost cases.
- Eliminating the use of the statewide average for hospitals that fall below the range considered reasonable (effective October 1, 2002, the low end of the range was 0.194, per Federal Register, August 1, 2002, Vol. 67, No. 148, page 50125) under the current Medicare regulations, using instead the hospital's own specific cost-to-charge ratio.

- Shifting the Medicare outlier payment from a prospective Medicare payment to a retrospective or “settled” item on the Medicare cost report to ensure that the outliers paid are reflective of the high cost cases for that period.
- Maintaining the fixed-loss threshold at the current \$33,560 level to maintain the outlier payments at the estimated 5.1 percent of total payments.

Comments.—As a Health System, we are in agreement with many of the provisions outlined in the proposed rule, such as the use of more current cost-to-charge ratios and the elimination of the statewide average for hospitals below the range considered reasonable. We are also in agreement that hospitals that have worked to game the system should be prevented from continuing to receive outlier payments for cases that are not high cost cases. The dilemma for the Medicare Program is how to prevent excessive payments to those hospitals that aggressively set their charges to maximize their Medicare payments for outliers, without negatively impacting those hospitals that did not engage in such practices.

Under Program Memorandum A-02-122, CMS defined excessive charging practices as those hospitals that had an increase in average charges per Medicare case of 20 percent or more from fiscal year 2000 to fiscal year 2001 and fiscal year 2001 to fiscal year 2002. One of our major teaching facilities that treats a significant number of high intensity cases, which is also being paid under the statewide average provision, did not meet the criteria noted above. Their charge increases were not excessive as defined by CMS. This facility, as well as all other facilities in our Health System, will be significantly impacted by the immediate implementation of all of these provisions. In evaluating our Health System’s financial position, it is projected that our outlier payments will now approximate 2.68 percent of total payments (defined as the combination of the base DRG plus outlier payments) under the proposed provisions. Although we are not in a position to assess the impact to healthcare providers nationwide, based upon our own Healthcare System, these provisions will most certainly impact the financial position of many providers in a similar manner.

Recommendation.—We would propose to allow a transition period for those hospitals that did not engage in aggressive price setting. This transition period would entail the following:

- gradual phase-out of the statewide average for those hospitals below the range considered reasonable.
- gradual reduction of the fixed-loss threshold from the current \$33,560.
- gradual increase of the marginal cost factor from 80 percent to 100 percent as actual costs would be used for the calculations.

In addition to phasing in the revenue reductions certain to come from these proposed provisions, a transition period would afford CMS the opportunity to monitor the impacts these provisions would have on healthcare providers nationwide, as well as allow providers to adjust their operations accordingly. With the implementation of a transition period, CMS could then assess the impact these provisions were having on the Medicare outlier payments representing 5 percent–6 percent of total payments as mandated in Section 1886 (d)(5)(A)(iv) of the Social Security Act, giving CMS the opportunity to amend these provisions if the Medicare outlier payments drop below the 5 percent level.

SPECIFIC COMMENTS—INDIVIDUAL PROPOSE MEDICARE OUTLIER COMPONENT REVISIONS

Regardless of a transition period which we believe is essential, we believe that CMS should reconsider the following individual provisions outlined in the proposed rule.

Fixed-loss Outlier Threshold (for Inpatient PPS)—Maintain at \$33,560 Level (Pg. 10426)

CMS has indicated that they believe the fixed-loss outlier threshold should be based on projected payments using the latest available historical data without retroactive adjustment, either mid-year or at the end of the year, to ensure that actual outlier payments are equal to 5.1 percent of the total DRG payments.

Comments.—We are not in agreement with this position and believe the \$33,560 fixed-loss threshold is too high based on the fiscal year 2003 data currently available to providers. CMS indicates that outlier payments are intended to recognize the fact that hospitals occasionally treat cases that are extraordinarily costly and otherwise not adequately compensated under an average-based payment system. CMS needs to recognize that with the limitations established by the proposed rule, especially maintaining the fixed loss threshold at \$33,560, many high cost cases will not be recognized as outlier cases. In the treatment of patients, care can’t be stopped at a point in time so as not to exceed the threshold, and as such, providers will

incur the cost of the case and not receive the corresponding outlier payment compensating them for this cost.

UPMC Health System is comprised of a number of academic teaching, and community hospitals. Utilizing recent claims data and the proposed changes in outlier regulations, we estimated our outlier payments as a percentage of total payments (combination of the base DRG plus outlier payments). Under the provisions of the proposed regulations, outlier payments represent 2.68 percent of total payments, significantly below the legislative number of 5 percent. Section 1886 (d)(5)(A)(iv) of the Social Security Act states the following: “The total amount of the additional payments made under this subparagraph for discharges in a fiscal year may not be less than 5 percent nor more than 6 percent of the total payments projected or estimated to be made based on DRG prospective payment rates for discharges in that year.” While we recognize that our analysis may not be indicative of national data, we believe that since a large discrepancy exists within our specific system data, CMS should use more current data in assessing the impact of the proposed regulation.

Recommendation.—We believe that section 1886 (d)(5)(A)(iv) of the Social Security Act requires CMS to change its fixed loss outlier threshold when mid-year changes decrease the total projected outlier payments below the 5 percent minimum level. While we realize CMS cannot wait for all outlier settlements to be finalized to determine an actual 5 percent payment level, nor can they accurately project a provider’s possible charge increases, they should calculate estimated outlier recovery projections based upon available federal fiscal 2003 data. These estimated outlier recoveries should be factored into the development of a new outlier threshold level.

CMS indicated the data for the first quarter offiscal year 2003 inpatient claims will be available soon, and that this data may allow CMS to evaluate the current threshold and whether outlier payments to date appear to be approximately 5.1 percent of the total DRG payment. Our recommendation would be for CMS to evaluate that data prior to finalizing the proposed rule so as to adjust the fixedloss threshold based on current data.

Recalculation of Outlier (Inpatient) Payments at Time of Settlement (Page 10425)

CMS has proposed a new section §412.84 (i)(2) which would require that outlier payments be subject to adjustment when a hospital’s cost report is settled. As part of the proposed settlement process, the Fiscal Intermediary (FI) would be required to detennine the actual operating and capital cost-to-charge ratios (CCRs) based on the ratio of costs and settlement charges used on that fiscal year’s finalized cost report. These audited CCRs would then be applied against each Medicare discharge claim to re-compute the final outlier reimbursement amount.

Comments.—While we recognize that this methodology would result in a cost outlier payment that is more reflective of the time period for which the cost outlier is being paid, we believe that this process presents a multitude of issues which need to be addressed. Specifically, there are five (5) aspects of this proposed provision that we would like to address.

(1) Historically, since September 1, 1983, the outlier payment policy applied by CMS has been prospective, with payments made for outliers considered final payments. CMS has indicated that they believe that prospective outlier payments are more vulnerable to potential overpayments, thus necessitating the need for actual cost outlier settlements. This proposed outlier rule would make the outlier payment a “settled” item on the Medicare cost report. In this regard, we refer to the Social Security Act, Section 1886(d)(2)(B) and Section 1886(d)(5)(A)(iv) which respectively state:

“Reducing for Value of Outlier Payments.—The Secretary shall reduce each of the average standardized amounts determined under subparagraph (A) for hospitals located in an urban area and for hospitals located in a rural area by a proportion equal to the proportion of payments under this subsection (as estimated by the Secretary) based on DRG prospective payment amounts which are additional payments described in paragraph (5)(A) (relating to outlier payments) for hospitals located in such respective area” and “The total amount of the additional payments made under this subparagraph for discharges in a fiscal year may not be less than 5 percent nor more than 6 percent of the total payments projected or estimated to be made based on DRG prospective payment rates for discharges in the year”.

Section 1886(d)(2)(B) of the Social Security Act points to the fact that there is a reduction of the base DRG, via the standardized amounts, for providers based upon the estimate of outlier payments to providers. By making the outlier a “settled” item, the proposed rule is silent on how the over or under payments of the outlier recouped/paid at year-end be translated into the base DRG payment, since the base

DRG would continue under the current policy to be handled prospectively, with the outlier under the proposed policy being handled retrospectively.

Recommendation.—CMS needs to address how the over or under payments of the outlier recouped/paid at year-end be handled in relationship to the base DRG in the final rule. In addition, with the transition of the outlier from a prospective payment basis to a retrospective payment basis, we believe CMS should obtain Congressional approval to make that switch since it departs from what Congress intended in Section 1886(d)(2)(B) of the Social Security Act.

(2) The proposed rules are silent as to what point in time the outlier settlement for a given fiscal year becomes final. The Medicare appeal process and/or re-opening process, available to providers and Fiscal Intermediaries (FIs), can include issues which affect the outlier calculation. These issues include indirect Medicare Education (IME) and Disproportionate Share (DSH) payments. Both IME and DSH impact not only the outlier threshold, but also the actual outlier payment itself. If teaching or disproportionate share providers are underpaid for either IME or DSH, the outlier payments and the number of cases that qualify for an outlier are overstated. Conversely, if IME or DSH is overstated, the outlier payments and the number of cases that qualify for an outlier are understated. The proposed regulation does not provide guidance related to this complicated issue.

Recommendation.—In the final rule, CMS needs to address at what point in time the outlier settlement for a given fiscal year becomes final.

(3) CMS has indicated in this proposed rule that they are still evaluating the procedural changes necessary to implement this process but admitted that this process would have to be done on a claim-by-claim basis to obtain new and accurate outlier settlement amounts.

Recommendation.—Prior to implementation, CMS should assess the procedural changes that will be necessary to re-process and validate 100 percent of all claims for all providers nationwide. That assessment should not only include the necessary procedural changes that need to be implemented by both the Healthcare providers and the Fiscal Intermediaries (FI), but it should include the estimated manpower and cost to the Medicare Program to re-process 100 percent of all Medicare claims.

(4) CMS indicates that by targeting the outlier to be a “settled” item, outlier payments would now be based on the relationship between the hospital’s costs and charges at the time a discharge occurred, ensuring that when the final outlier payments are made, they would reflect an accurate assessment of the actual costs the hospital incurred. However, under the current Medicare outlier payment formula, that is not the case. The actual Medicare outlier payment represents only 80 percent of the difference between the actual cost of the case and the established threshold for that case.

Recommendation.—For Medicare outlier payments to represent actual cost, we would recommend that the marginal cost factor of 80 percent be eliminated and valued at 100 percent. The 80 percent marginal cost factor is reducing the cost outlier payment to 80 percent of the actual calculated cost.

(5) The adoption of this proposed provision to make the inpatient acute Medicare outlier payment a retrospective or “settled” item as opposed to a prospective item creates an inconsistency between the Inpatient Prospective Payment System (IPPS), and both the Outpatient Prospective Payment System (OPPS) and the Long-Term Acute Care Payment System. Currently, the outpatient outlier provisions under both the Social Security Act 1833(t)(5) and OPPS regulation 419.43(d) do not recognize any further or final settlement of the outpatient outlier payments. In addition, the Final Rule in Federal Register 67, No. 69, August 30, 2002, establishing a prospective payment system for Medicare payment of inpatient hospital services furnished by long-term care hospitals, does not recognize any further or final settlement for the outlier payments.

Recommendation.—The inconsistency in the treatment of Medicare outlier payments for prospective payment systems should be addressed by CMS prior to being implemented in the final rule under IPPS.

The Proposed Rule Requests Comments Regarding “Substantial Evidence” Requirements by a Provider to Request a Change in the Cost-to-Charge Ratios. (Proposed §412.84(i)(1))

The preamble of the proposed rule indicates that CMS would have the authority (page 10424) to direct the Fiscal Intermediary (FI) to change the hospital’s cost-to-charge ratio (CCR) if a hospital’s charges have been increasing at an excessive rate compared to that of other hospitals. Provider(s) would be permitted to contact their FI to request that its CCR be changed if it presents “substantial evidence” that the ratios are inaccurate. The CMS regional office, however, would have to approve these requests.

Comments.—We believe the terms “substantial evidence” and “excessive charges” are subjective and are open to varying interpretations. Before the regulations are issued, better definitions along with clear examples should be provided.

Recommendation.—CMS should provide clear examples of what is defined as “substantial evidence” including guidance on how the implementation of high cost programs (such as a new heart program) and the related charging structure should be handled. Another example may be linking the overall charge increase to the related cost due to the implementation of better cost accounting methods.

With respect to “excessive charging practices” of a provider, although we agree that no provider should engage in behavior that jeopardizes the integrity of the Medicare Trust Fund, the current Medicare regulations are silent with respect to the charge structure that a provider implements as long as the charge structure is consistent among payrols. To propose a process that could dissuade a provider from raising their charge structure could potentially impact the reimbursement from other payors. Therefore, CMS should define what type of charge increase is “excessive”.

The Proposed Rule is Silent on How to Calculate the Interim (Operating & Capital) Cost-to-Charge Ratios in a Merger Situation

Recommendation.—CMS should add a provision explaining how the cost-to-charge ratio (CCR) will be calculated for the situation where two (2) providers merge under one (1) provider number. The current regulations as well as the proposed rule are silent with respect to this issue.

Special Recordkeeping Requirements in Conjunction with the Recalculation of Outlier Payments at Time of Settlement (Page 10425)

The proposed outlier recalculation settlement process (as proposed in section §412.84(i)(2)) includes special record keeping requirements which would be necessary to implement this procedural change. Currently CMS has indicated that they are still evaluating procedural changes necessary to implement this process but admitted that this process would have to be done on a claim-by-claim basis to obtain new and accurate outlier settlement amounts.

Comments.—Because the procedural changes have not yet been defined, and the implementation will undoubtedly place additional burden on both providers and Fiscal Intermediaries (FIs), consideration must be given to the information that must be made available to providers to validate the Medicare outlier payments received.

Recommendation.—We believe that CMS should instruct each FI to supply each provider with an electronic file listing by claim, showing the original interim outlier payment and the re-calculated outlier amount, detailing the specific data elements used in the calculation. We believe CMS and the FI must incorporate this detailed outlier data file into their standard routine settlement process so no special request is required by the provider from the FI.

Without these detailed files from the FI, the provider will be unable to confirm the accuracy of the FI's outlier re-calculation. As CMS indicated, this re-calculation cannot be done accurately except on a claim-by-claim basis, supporting documentation should be available for the provider's review.

The Establishment of a Time Value Adjustment for Over and Under Payments of Outliers

CMS has proposed to incorporate a time value adjustment for possible overpayment or underpayments of outlier payments as determined using updated cost-to-charge ratios (CCRs) from the applicable cost report settlement year. For discharges occurring on or after the effective date of the final rule, the time value adjustment would be made for the period the outlier payments were inappropriately held by the provider. A similar adjustment would be made for underpayments to the hospital.

Comment.—We are not in agreement with this approach as the initiation of a time value adjustment on selected line items on the cost report is not consistent with other “settled” items such as Indirect Medical Education (IME) and Disproportionate Share (DSH). CMS supports its argument by noting that providers have the opportunity to manipulate their outlier payments by dramatically increasing charges during the year in which the discharge occurs. In this situation, the provider would receive excessive outlier payments, which although the provider would incur an overpayment and have to pay the money back when the cost report is settled, would allow the provider to obtain excess payments from the Medicare Trust Fund on a short-term basis. Other areas of the cost report that involve “settled” items are not subjected to the assessment of interest.

Recommendation.—CMS should address the consistency of assessing interest on overpayments of “settled” items on the cost report prior to this provision being implemented in the final rule.

If you have any questions regarding our comments please telephone me at (412) 647-4820.

Sincerely,

JOHN W. PAUL.

DELAWARE VALLEY HEALTHCARE COUNCIL,
March 27, 2003.

Hon. ARLEN SPECTER,
Chairman, Subcommittee on Labor, Health and Human Services and Education,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: On behalf of the members of the Delaware Valley Healthcare Council, I am writing, to follow up on the March 11 hearing before your Subcommittee on Medicare outlier payment policies: In particular, we would like to respond to your request for a specific recommendation on the appropriate timeframe for a transition period as well as to clarify the record related to certain statements made at the hearing by CMS Administrator Thomas Scully. The Council, along with many other hospital associations including the AHA, is urging CMS to amend the proposed regulations to provide at least a 30 month transition period, reduce in the outlier threshold, and to eliminate the proposed retrospective reconciliation of outlier payments. Our position is described in greater detail below.

At the outset, we also want to take this opportunity to thank you again for holding the March 11 hearing. Your continued commitment to developing an equitable resolution to this policy matter is of critical importance to all hospitals in the Delaware Valley and across the Commonwealth.

While we all agree with the need to re-examine and address any unintended consequences of the current outlier policy, the Council and its member organizations are deeply concerned with respect to the method, timing, and overall impact of the Proposed Rule published on March 5, 2003 by the Center for Medicare and Medicaid Services (CMS). The CMS has made serious and unsupported allegations about the conduct of many community institutions. Further, CMS appears to have initiated an audit process and then failed to even wait for its outcome in determining either whether any inappropriate activity has taken place or what specific policies should be developed.

As drafted, the Proposed Rule will adversely affect virtually all hospitals across the United States. CMS is seeking to implement a "remedy" that: (1) represents a fundamental shift in payment policies with no transition; (2) does not lower the current outlier threshold; (3) creates an administratively burdensome and potentially unworkable process for retrospectively reconciling payments; and (4) creates immediate and, in some cases, unsustainable financial harm to certain hospitals that could jeopardize access to needed services for Medicare beneficiaries and all other patients. In our region, no hospital would benefit from the Proposed Rule. In short, the combination of changes proposed by CMS represents the "worst of all worlds" for hospitals.

30 MONTH TRANSITION PERIOD

After discussions with our members, the American Hospital Association and other interested parties, we are urging the CMS to provide a thirty-month transition period (i.e. the remainder of this fiscal year plus at least two years beginning on October 1). There is no justification for a policy of this magnitude to be implemented in the middle of a fiscal year. As noted at the hearing there is ample precedent for such transition periods. For example, the Medicare outlier program originally included provisions for "length-of-stay" or "day" outliers. In 1995, length-of-stay or day outliers were phased out over a three-year period. We urge the Subcommittee to support a thirty-month transition period in this case as well.

The CMS suggested that there is a need to act immediately, and without any transition, based on concern of fraudulent or other illegal activity. However, there is no current evidence to suggest that hospitals that benefited from the current outlier methodology actually engaged in fraud or other illegal activities. In fact, at institutions where the CMS actually has completed audits, there have been no allegations of inappropriate, much less illegal, actions related to outlier payments.

As you know, the federal government has very significant enforcement powers and legal remedies to take immediate action in cases involving allegations of fraud or other illegal activities. According to press accounts, the federal government has already filed suit and entered into a voluntary agreement to suspend certain outlier payments with a California based organization. As a practical matter, it would appear that a substantial portion of the fiscal impact of the proposed policy already

has been achieved through this voluntary agreement. If the CMS believes that some institutions have engaged in illegal conduct, then it can and should take appropriate enforcement action.

However, CMS should not penalize the entire hospital field by not providing a reasonable transition for implementation of this policy. In fact, CMS officials now have conceded in various forums that the primary issue appears to be the result of a flawed public policy, not illegal actions by hospitals. It is unfortunate that the debate over this important policy in a sense has been distorted and undermined by these allegations. The unintended consequences of bad public policy should not be equated with fraud or illegal activities. Moreover, this whole issue is indicative of how badly the Medicare payment system for hospitals is broken and, how complex it has become.

FISCAL IMPACT ON DELAWARE VALLEY HOSPITALS

At the hearing there may have been some confusion concerning the fiscal impact of the Proposed Rule on institutions in the Greater Philadelphia area. Unfortunately, due to the time constraints it was not possible to respond to certain points made for the record. First, as part of his verbal testimony, Mr. Scully suggest that our estimate of the fiscal implications of the Proposed Rule included Tenet institutions in Philadelphia. As Tenet has voluntarily given up outlier payments, our fiscal estimated did not include those institutions.

Second, also as part of his verbal testimony, Mr. Scully suggested that Thomas Jefferson University Hospital (TJUH) would benefit under the March 5 Proposed Rule and gain approximately \$2 million in Medicare payments. Based on our review of the rule and discussions with the administration of TJUH, the hospital lost approximately \$2 million when the outlier threshold was raised from \$14,050 to \$21,025 several years ago. TJUH now is losing millions more in Medicare payments as a result of increasing the outlier threshold to \$33,560 in 2002. Perhaps Mr. Scully was referring to impact of his original hope to reduce the outlier threshold. As the outlier threshold under the March 5 Proposed Rule remains unchanged at \$33,560, it is unclear how TJUH could benefit under the CMS proposal. Unfortunately, the material accompanying proposed rule does not include any financial impact analysis or data to help further clarify the effect of this rule on TJUH or all other hospitals.

According to our estimates, the combination of the increase in the outlier threshold adopted last year and the provisions of the proposed rule will reduce Medicare payment to hospital in our region by over \$100 million. Further, we believe this number is conservative as it is very difficult to model the implications of the retrospective reconciliation of outlier payments based on cost-to-charge ratios in subsequently settled cost reports. Given the enormous financial stress and other challenges facing our hospitals, the loss of these outlier funds will result in layoffs, reduction in services, and impact on care for the entire community.

Despite the fact that the potential problems with current methodology were brought to the agency's attention over a decade ago, CMS is proposing an abrupt, mid year change in policy without regard to the significant financial consequences for hospitals. We believe this is the wrong way to change public policy and represents a significant departure from the process both Congress and CMS have used in the past to make major Medicare payment policy changes that have adverse financial implications for participating providers or health plans.

As we testified on March 11, we recognize that CMS has legitimate policy concerns about the unintended consequences of the current outlier policy. However, the proposed "solution" may have other equally significant unintended consequences. We urge CMS to: (1) provide at least a 30 month transition period (i.e. remainder of this fiscal year and 24 months beginning on October 1); (2) reduce the outlier threshold; and (3) eliminate the retrospective reconciliation of outlier payments.

Again, thank you for your continuing leadership to help shape an appropriate Medicare outlier payment policy. The Proposed Rule will have a sever impact on the greater Philadelphia area as well as other parts of the Commonwealth and the nation. We appreciate your help in try to ensure that hospital in our region are able to continue to provide health care services that the public expects and deserves.

Sincerely,

ANDREW WIGGLESWORTH,
President.

DELAWARE VALLEY HEALTHCARE COUNCIL,
May 12, 2003.

Hon. Arlen Specter,
*Chairman, Subcommittee on Labor, Health and Human Services and Education,
 U.S. Senate, Washington, DC.*

DEAR MR. CHAIRMAN: On behalf of the members of the Delaware Valley Healthcare Council (DVHC), I am writing in further follow up to your Appropriations Subcommittee's March 11 hearing on Proposed Regulations changing Medicare outlier payment policies. As you know, in the proposed regulations the Centers for Medicare and Medicaid Services (CMS) provided for a 30-day comment period. As the comments received by CMS demonstrate overwhelming support for core elements of DVHC's position, we wanted to share a brief summary of those comments for the Subcommittee's hearing record.

At the March 11 hearing and in a March 27 letter to you, we outlined DVHC's strong opposition to the Medicare outlier payment changes proposed by CMS. In our view CMS is seeking to implement a "remedy" that (1) represents a fundamental shift in payment policies with no transition; (2) does not lower the current outlier threshold; (3) creates an administratively burdensome and potentially unworkable process for retrospectively reconciling payments; and (4) will create immediate, and in some cases unsustainable, financial harm to certain hospitals that could jeopardize access to needed services for Medicare beneficiaries as well as all other patients. We continue to believe the combination of changes contained in the CMS Proposed Rule represents the "worst of all worlds" for hospitals in Southeastern Pennsylvania and across the nation.

My colleagues and I have since examined all of the public comments submitted to CMS and the results show virtually unanimous support for a transition period to enable hospitals to adjust in an orderly way to proposed policy changes. Of the hundreds of letters received by CMS, nearly 300 specifically ask CMS to include a transition period and only four expressed outright opposition to a transition period. Importantly, all the major national hospital associations—the American Hospital Association, the Association of American Medical Colleges, the National Association of Public Hospitals, and the Federation of American Hospitals—supported a reasonable transition period. Attached for your review is a list of all hospitals and associations that wrote to CMS in support of a transition period.

As we indicated at the hearing, CMS has a long-standing practice of providing a transition period for major changes in Medicare payment policies including previous changes to outlier payment policies. For example, CMS has provided transition periods ranging from ten years for modifications to capital payments to three years for phasing out length of stay outliers. In fact, we are unaware of any major payment policy change with a negative impact on hospitals for which CMS has provided less than a full year transition. Hospitals in Southeastern Pennsylvania, as well as many other parts of the country, are simply in no financial position to absorb abrupt mid-year changes in payment policies of the nature proposed by CMS. If the changes proposed by CMS are adopted immediately, it will adversely affect the delivery of care not only for Medicare beneficiaries, but for the entire community in many parts of this country.

Mr. Chairman, we continue to be grateful for your efforts on behalf of hospitals to secure a reasonable transition period for this major change in Medicare outlier payment policy. If you or your staff have any questions or need further clarification of the issues related to the outlier policy changes or our analysis of the public comments on the March 5 Proposed Rule, please do not hesitate to call. I can be reached at 215.735.3295.

Sincerely,

ANDREW B. WIGGLESWORTH,
President.

IN SUPPORT OF TRANSITION PERIOD

National

American Hospital Association; Federation of American Hospitals; National Association of Public Hospitals and Health Systems; and Associations of American Medical Colleges.

Alabama

Northwest Medical Center (Winfield); Jefferson Health System, Cooper Green Hospital, Jefferson Outpatient Care (Birmingham); Jackson Hospital (Montgomery); Alabama Hospital Association; DCH Health System (West Central Alabama);

Wedowee Hospital (Wedowee); Alabama Hospital Association (Montgomery); and Gasden Regional Medical Center.

Arizona

Arizona Hospital and Healthcare Association (Phoenix); Sierra Vista Regional Health Center (Sierra Vista); Sun Health (Sun City).

ARKANSAS

Arkansas Hospital Association; Baptist Memorial Hospital Forrest City (East Arkansas); Delta Memorial Hospital (Dumas); Ouachita County Medical Center (Camden); Ouachita Valley Health System (Camden); St. Vincent Health System (Little Rock); Baptist Health (Little Rock); Sparks Health System (Fort Smith); Baptist Memorial Hospital (Blytheville).

California

Mark Twain St. Joseph's Hospital (San Andreas); Sequoia Hospital (Redwood City); Dominican Hospital (Santa Cruz); Chino Valley Medical Center (Chino); Oak Valley Hospital (Oakdale); Coalinga Regional Medical Center (Coalinga); Torrance Memorial Medical Center (Torrance); Hoag Hospital (Newport Beach); Healthcare Association of Sand Diego and Imperial Counties (San Diego); Sutter Auburn Faith Hospital (Auburn); Adventist Health, Feather River Hospital (Paradise); San Clemente Hospital and Medical Center (San Clemente); University of California (Oakland); and Catholic Healthcare West (San Francisco).

Colorado

Porter Adventist Hospital (Denver); Parkview Medical Center (Pueblo); Colorado Health and Hospital Association; and Memorial Hospital (Colorado Springs).

Connecticut

St. Vincent's Medical Center (Bridgeport); Johnson Memorial Hospital (Stafford Springs); Saint Mary's Hospital (Waterbury); and Bristol Hospital (Bristol).

Delaware

St. Francis Hospital (Wilmington) and Delaware Healthcare Association (Dover).

Florida

Kendall Regional Medical Center (Miami); Shands HealthCare (Gainesville) (2 letters); Munroe Regional Medical Center (Ocala); West Florida Healthcare (Pensacola); Tampa General Hospital (Tampa); Memorial Healthcare System (Hollywood); and Bethesda Memorial Hospital (Boynton Beach).

Georgia

Union General Hospital, Inc. (Blairsville); Central Georgia Health System (Macon); Southern Regional Health System (Riverdale); Piedmont Medical Center (Atlanta); Gwinnett Health System (Lawrenceville); Georgia Hospital Association (Marietta); Memorial Health (Savannah); and Saint Joseph's Hospital of Atlanta (Atlanta).

Idaho

Portneuf Medical Center (Pocatello); Idaho Hospital Association; St. Luke's Regional Medical Center (Boise); and Saint Alphonsus Regional Medical Center (Boise).

Illinois

Louis A. Weiss Memorial Hospital (Chicago); Resurrection Health Care (Chicago) (2 letters); Adventist Health System (Hinsdale); Freeport Health Network (Freeport); Katherine Shaw Bethea Hospital (Dixon); St. Mary's Hospital (East St. Louis); Morris Hospital (Morris); Proctor Hospital (Peoria); Loyola University Health System (Maywood); and Illinois Hospital Association (Naperville).

Indiana

Kosciusko Community Hospital (Warsaw); Good Samaritan Hospital (Vincennes); St. Vincent Health (Indianapolis); St. Vincent Health St. Joseph Hospital (Kokomo); and Greater Lafayette Health Services (Lafayette).

Iowa

Trinity Regional Medical Center (Fort Dodge); Mercy Medical Center (Des Moines); and Spencer Hospital (Spencer).

Kansas

Hospital District No. 5 (Harper); Cushing Memorial Hospital (Leavenworth); Saint Luke's South Hospital (Overland Park); Kansas Hospital Association; Salina Regional Health Center (Salina) (2 letters); Anderson County Hospital, Saint Luke's Health System (Garnett) (6 letters); and Wesley Medical Center (Wichita).

Kentucky

Kentucky Hospital Association; Jewish Hospital HealthCare Services (Louisville); and Caritas Health Services (Louisville).

Louisiana

North Oaks Health System (Hammond); Tulane University Hospital and Clinic (New Orleans) (2 letters); Pendleton Memorial Methodist Hospital (New Orleans); and West Jefferson Medical Center (Marrero).

Massachusetts

Lahey Clinic (Burlington) (2 letters).

Michigan

Henry Ford Health System (Detroit); Botsford General Hospital (Farmington Hills); Detroit Medical Center (Detroit); and University of Michigan Health System (Ann Arbor).

Minnesota

St. Francis Regional Medical Center (Shakopee); Minnesota Hospital Association (St. Paul); and United Hospital (St. Paul).

Mississippi

Grenada Lake Medical Center (Grenada); Baptist Mernorial Hospital Golden Triangle (Columbus) (11 letters); Baptist Memorial Hospital Booneville (Booneville) (4 letters); Baptist Memorial Hospital North Mississippi (Oxford); Baptist Memorial Hospital Union County (New Albany); Natchez Regional Medical Center (Natchez); St. Dominic/Jackson Memorial Hospital (Jackson); Mississippi Baptist Health Systems (Jackson); Baptist Memorial Hospital DeSoto (Southaven); and Gilmore Memorial Hospital (Amory).

Missouri

Wright Memorial Hospital (Trenton); St. Francis Hospital and Health Services (Maryville); Bates County Memorial Hospital (Butler); SSM Health Care (St. Louis) (2 letters); Cass Medical Center (Harrisonville); Saint Luke's Northland Hospital (Kansas City); St. Luke's Health System (Smithville); Freeman Health System (Joplin) (42 letters); and St. John's Mercy Health Care (St. Louis).

Montana

An Association of Montana Health Care Providers (Helena).

Nebraska

BryanLGH Medical Center (Lincoln); Good Samaritan Health Systems (Kearney); and Nebraska Hospital Association.

Nevada

Nevada Hospital Association.

New Hampshire

The Cardiovascular Center at St. Joseph Hospital (Nashua) (2 letters).

New Jersey

Trinitas Hospital (Elizabeth); St. Joseph's Wayne Hospital (Wayne) (2 letters); and St. Mary's Hospital (Passaic); New Jersey Council of Teaching Hospitals (Trenton); New Jersey Hospital Association; Saint Clare's Health System; St. Joseph's Regional Medical Center (Paterson); Atlantic Health System (Florham Park); The University Hospital, University of Medicine and Dentistry of New Jersey (Newark); Atlantic City Medical Center (Atlantic City); and The Cooper Health System.

New Mexico

Memorial Medical Center (Las Cruces) and Sandia Health System Albuquerque Regional Medical Center and Rehabilitation Hospital of New Mexico (Albuquerque).

New York

NYU Hospitals Center (New York); Nyack Hospital (Nyack); Lenox Hill Hospital (Upper East Side); John T. Mather Memorial Hospital (Port Jefferson); Oswego Hos-

pital (Oswego); Catholic Health System Mercy Hospital of Buffalo (Buffalo); Catholic Health System Kenmore Mercy Hospital (Buffalo); Catholic Health System Sisters of Charity Hospital (Buffalo); Catholic Health System St. Joseph Hospital (Cheektowaga); Soldiers and Sailors Memorial Hospital (Penn Yan); Saratoga Care (Saratoga Springs); Hospital for Joint Diseases Orthopaedic Institute (New York); Long Beach Medical Center (Long Beach); Montefiore Medical Center (Bronx); Greater New York Hospital Association (New York); New York-Presbyterian Hospital, New York-Presbyterian Healthcare System (New York); University of Rochester Medical Center, Strong Memorial Hospital and Highland Hospital (Rochester); Lenox Hill Hospital (New York); St. Elizabeth Medical Center (Utica); North Shore—Long Island Jewish Health System (Westbury); and Nicholas H. Noyes Memorial Hospital (Dansville).

North Carolina

Wilkes Regional Medical Center (North Wilkesboro); Person Memorial Hospital (Roxboro); Alleghany Memorial Hospital (Sparta) (5 letters); Southeastern Regional Medical Center (Lumberton); Carolinas HealthCare System (Charlotte); Novant Health (Winston-Salem); and Moses Cone Health System (Greensboro).

North Dakota

Medcenter One (Bismarck) and North Dakota Healthcare Association (Bismarck).

Ohio

The Center for Health Affairs (Cleveland).

Oklahoma

St. John Medical Center (Tulsa).

Oregon

Asante Health System (Medford) (9 letters); Columbia Memorial Hospital (Northwest Oregon); Oregon Association of Hospitals and Health Systems; Rogue Valley Medical Center (Medford) (3 letters); Three Rivers Community Hospital (Grants Pass); Genesis Recovery Center (Central Point); Silverton Hospital (Silverton); and Mid-Columbia Medical Center, (The Dalles).

Pennsylvania

Temple University Health System (Philadelphia); Delaware Valley Healthcare Council; Phoenixville Hospital, University of Pennsylvania Health System (Phoenixville); Central Montgomery Medical Center (Lansdale); Memorial Hospital (York); Chestnut Hill Healthcare (Philadelphia); St. Joseph Medical Center (Reading); Holy Redeemer Health System; Catholic Health East (Newtown Square); The Hospital and Healthsystem Association of Pennsylvania (Harrisburg); Geisinger Health System (Danville); Abington Memorial Hospital (128 letters); Crozer-Keystone Health System, Delaware County Memorial Hospital (Drexel Hill) (2 letters); Crozer-Keystone Health System, Crozer-Chester Medical Center (Upland); UPMC Health System (Pittsburgh); Crozer-Keystone Health System, Taylor Hospital (Ridley Park); Crozer-Keystone Health System (Springfield); Holy Redeemer Health System (Huntingdon Valley) (6 letters); Temple University Health System (Philadelphia); Mercy Health System (Havertown) (3 letters); and Thomas Jefferson University Hospital (Philadelphia).

South Carolina

Trident Health System (Charleston); Summerville Medical Center (Summerville); and Bamberg County Hospital and Nursing Center (Bamberg).

South Dakota

Avera McKennan Hospital and University Health Center (Sioux Falls).

Tennessee

Baptist Memorial Hospital Collierville (Collierville); Tennessee Christian (Madison); West Tennessee Healthcare (Jackson); Williamson Medical Center (Franklin); Gateway Health System (Clarksville); Baptist Memorial Hospital Union City (Union City); Baptist Memorial Hospital for Women (Memphis); Baptist Memorial Hospital Tipton (Covington); Baptist Memorial Hospital Memphis (Memphis); Baptist Memorial Hospital Lauderdale (Ripley); Baptist Memorial Hospital Huntingdon (Carroll County); Baptist Rehabilitation Germantown (Germantown); Tennessee Hospital Association (Nashville); and Maury Regional Hospital (Columbia).

Texas

East Texas Medical Center Regional Healthcare System (Carthage); Memorial Hermann Healthcare System (Houston); Christus St. Joseph's Health System (Northeast Texas) (2 letters); Christus Health Gulf Coast (Houston); St. Joseph Health System (Bryan); Seton Healthcare Network (Austin) (2 letters); Dallas Southwest Medical Center (Dallas); Vinson and Elkins (Houston); Baylor Health Care System (Dallas); St. Luke's Episcopal Hospital (Houston); Hillcrest Health System (Waco); and St. Joseph Regional Health Center (Bryan).

Utah

Utah Hospitals and Health Systems Association.

Virginia

Southside Regional Medical Center (Petersburg); Prince William Health System (Manassas); Tazewell Community Hospital (Tazewell); Carilion Giles Memorial Hospital (Pearisburg); and Mary Washington Hospital (Fredericksburg).

Washington

Tri-State Memorial Hospital (Clarkston); Sacred Heart Medical Center (Spokane); and Empire Health Services (Spokane).

West Virginia

Charleston Area Medical Center Health System (Charleston); Jefferson Memorial Hospital (Ranson) (2 letters); West Virginia University Hospitals (Morgantown); and Monongalia Health System (Morgantown).

Wisconsin

Columbia St. Mary's (Milwaukee) (2 letters) and Aurora Health Care (Milwaukee).

Wyoming

Wyoming Hospital Association (Cheyenne).

Senator SPECTER. If you want to be successful in influencing CMS, you are going to have to be realistic. This subcommittee urges a realistic transition period, but let us come to grips with the realities. When you are talking about the end of the fiscal year, I think that is something that CMS may well accommodate to, and something beyond that, but put it in writing, and make it specific.

On the threshold issue, there again I would like to see something specific. It seems to me that the increase from \$20,000 to \$33,000 is a big increase, calculated, according to the testimony, at some 59 percent, but let us come forward, aside from the comment and the objection, with something very specific that you would like to see them undertake.

Mr. Wigglesworth, would you explain a little more of this concept of the retrospective payment system?

Mr. WIGGLESWORTH. Mr. Chairman, what is being proposed in the rule is to use the most current cost-to-charge ratio which is part of the process of calculating outlier payments, and using it from not, as is the current process, where you use the final, settled cost report, but using the tentatively settled cost report, but it would be the most recent one that is submitted.

Then, 2 to 3 years later, as is in current practice, the final cost report would be settled, and what the agency is proposing is that they would pay initially on the basis of the tentative cost report, and then have a reconciliation process, where they would reconcile the claims several years later, based on the final settled cost report.

So what it means is, the FIs would process them once, then 2 years later, when there is a final cost report, they would have to process it again, rerun it, and there would be a reconciliation, either with the agency paying potentially more to the hospital, or the

hospital reimbursing the agency. This creates a whole other level of uncertainty. From a financial standpoint, while we are still evaluating, I assume they would have to create reserves on their books in terms of the hospital. It is an unworkable addition to an already complex claims processing environment.

Senator SPECTER. Mr. Scully, would you care to comment these issues?

Mr. SCULLY. Yes, I would like to comment on a couple, one is of the \$100 million rough impact on southeast Pennsylvania. About \$60 million of that is on Tenet, and they have already voluntarily said they are not going to bill us for those any longer, largely as a result—I have all the detailed numbers hospital-by-hospital, for every hospital in the country, if you would like them for the committee, and I do think there is a problem, obviously with Tenet, with Temple, and we have talked about that, and Crozier Chester and UPMC probably are three of the biggest hospitals in Pennsylvania.

But I think when you look at lowering the threshold, which Andy and I have talked about a lot, back down from \$33,560, which I have personally advocated to the administration, OMB understandably is skeptical, since we have been \$1.6 billion to \$1.9 billion over each of the last 5 years, and their attitude is, your estimators are never right, and so I think unless we do something to limit, at least a very, a limited transition in order to take away the people that have been overbilling for this, I am going to have a very hard time making the argument to bring down the threshold, which will affect all of the other hospitals.

As of right now, OMB's position, which I think is understandable is, since you have missed by \$1.8 billion last year, maybe we should just leave it where it is until we figure out whether we are close, and Andy is correct that in several years in the 1980s and the mid-1990s, we spent less than the 5.1 percent on the outliers, but in the last few years, we have been way, way off on the high side.

The other argument I would make on the 5-year, on the retrospective fix, which I came up with because it was the only way I could think of fixing it, if I could just take 1 minute to explain how this works. If you have a \$10,000 hip replacement in a hospital, hospitals, even though it is not relevant for anything but Medicare generally, have charges that are generally much higher than the costs, so if you have a \$10,000 DRG for hip replacement—it is not what it costs. I am just making that number up for simplicity—a hospital might have a \$50,000 charge.

We monitor those charges on their cost reports, and if they had a history 3 or 4 years back where their last cost report was a \$50,000 charge, we give them what is called a cost-to-charge ratio. In that case it would be .20, or they are charging five times their true cost. We discount that, so when their charges came in we would say, you said your charge was \$50,000, but history shows you that it is really not, it is \$10,000, so you do not get an outlier payment.

What the hospitals have done is, they have basically jacked up their charges from, say, \$50,000 to \$200,000, and in some cases much higher, so our cost report data is 3 years old, so we go back and look at the most recent cost reports we have, which is 1999,

and if a hospital had a cost-to-charge ratio of .20, we take their \$200,000 charge, discount it by one-fifth, and come up with a \$40,000 charge and say, that is your real true costs, and they get an outlier payment for that. In many cases, they have jacked it up much more than that.

But essentially we are working on 3-year-old data, so there is no way for us to really reconcile their true costs, so what Andrew is concerned about, and there is no other way I can find to fix this, is that we would say, look, you can charge us for outliers as much as you want, but at some point when we catch up on our true cost reports, we are going to come back and see if you actually charged us true costs.

The two ways people have gamed this is by massively ratcheting up their cost-to-charge ratio, in some cases 15, 20 times true costs, and the other way is, if you come in below .20, which means you are charging five times your true charges, your true costs, we kick automatically through—God knows why we came up with this—what is called the State-wide average, so if you came out that you actually charged seven times your costs, we say that must be a mistake and we are going to bring you up to the State-wide average, so if your cost-to-charge ratio is .15 in Philadelphia, which some of the Tenet hospitals were, we would say that must be a mistake, so we will bring you up to the State-wide average, which is .35. It is very confusing.

Senator SPECTER. Mr. Scully, another Senator has arrived.

Mr. SCULLY. Yes, sir.

Senator SPECTER. Let us give her a chance.

OPENING STATEMENT OF SENATOR MARY L. LANDRIEU

Senator LANDRIEU. Thank you, Mr. Chairman. I wish I could have been here when you all started, but I had two speeches this morning and a meeting earlier. I wanted to thank you for calling this hearing, and say that I am aware of the problem that exists within Medicare outliers and hope that we can find a solution that gives the proper kind of guidance to hospitals as they seek proper reimbursements.

So I thank you for focusing on this. If there are ways that we can save the system dollars we want to, but we can begin by giving clear guidance to the hospitals that are using these very complicated. If anybody can come up with a solution, Mr. Scully, you with your experience probably can.

So I have a statement to submit to the record. I am just going to sit and listen for a few minutes.

Senator SPECTER. It will be made a part of the record, without objection.

Senator LANDRIEU. Thank you, Mr. Chairman.

[The statement follows:]

PREPARED STATEMENT OF SENATOR MARY L. LANDRIEU

Thank you, Mr. Chairman. For 38 years, Medicare has provided health care security to millions of America's seniors and people with disabilities. This year alone, 38 million people will receive the medical treatment they need because of Medicare. As successful as it has been, the Medicare program functions as one would expect a 1965 program to perform in the year 2003. Its rules and regulations are cum-

bersome, its reimbursements are too often inadequate, and it has not always kept pace with decades of dramatic improvements in health care.

In addition, Medicare faces serious financial challenges. Its current form will not sustain the 77 million baby boomers that will begin to retire in 2010. Without substantial changes to the program, the federal government will not have the resources necessary to fulfill its promise of health care security for all seniors. Congress has attempted to reform Medicare in the past, but has succeeded only in making incremental changes to a program in need of overall reform. The time has come for us to meet this challenge head on.

The main function of the Center for Medicare and Medicaid Services is to maximize the benefits for current and future participants by preserving the integrity of the provider payment system. One of the single most effective ways for them to fulfill this role is to be cognizant of payment structures that may be open to fraud and abuse and regulate them in such a way as to ensure fraud and abuse is limited. That is exactly what CMS has done in the case of Medicare outlier payments. I commend them for their efforts to increase the level of scrutiny of these payments and encourage them to continue in this endeavor.

At the same time, I would recommend to you, Mr. Scully, that CMS further study the underlying payment formula to assess whether or not any of its components or assumptions are inherently flawed and as a result are giving rise to inflated payments. For instance, your own reports indicate that the lag in time that results from basing the cost-to-charge ration on the most recently settled cost instead of the current cost report may increase outlier payments. There may, in fact, be ways to improve this formula so that it better reflects the actual cost a hospital incurs in caring for a complicated patient.

In addition, Medicare should also strive to provide detailed and ongoing guidance to providers on ways to avoid compliance risks. If one studies the suggested ways that hospitals could manipulate their costs to generate higher reimbursement, it is clear that many, if not all, of these situations may be occurring unintentionally or because of billing errors and outdated accounting procedures. Advising providers of ways that they may avoid these risks will eliminate the negligent wrongdoers and allow CMS and OIG to focus only on those engaged in intentional fraud.

I am looking forward to the opportunity to engage in a discussion on this issue with our panel here today. I hope that this will be the first of many opportunities this committee has to engage in the debate of Medicare reform. The 38 million seniors who depend on this program need for us to do what is necessary to meet our obligation to fulfill Medicare's promise of health care security.

I thank the Chair.

Senator SPECTER. Thank you, Senator Landrieu. Thank you very much.

Mr. Scully, we hope you can find some way to make an accommodation on an adjustment period, and that rise from the 20s to \$33,000 does seem, at least to me, to be very, very tough, but to give some accommodation period so that it can be assimilated.

I think we have made some significant progress, because there had been an attempt, as you outline it, to put the rule into effect immediately. It was released on February 28, published on 5 March, a comment period until April 4, so there will be a period of time after that, and then there will be some additional time before a rule is promulgated taking into account what those comments were, so at least that is some assistance, but I hope you will work with the hospitals, which are having these very difficult transition times.

ADDITIONAL PREPARED STATEMENTS

We have received additional prepared statements that will be made part of the hearing record.

[The statements follow:]

PREPARED STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION

On behalf of our nearly 5,000 member hospitals, health care systems, networks and other providers of care, the American Hospital Association (AHA) appreciates the opportunity to submit this statement on changes to the outlier payment policy proposed by the Centers for Medicare & Medicaid Services (CMS) and published March 5, 2003 in the Federal Register.

We have very serious concerns about this proposal's dramatic revisions to Medicare outlier payment policy. While we agree that changes need to be made to ensure the accuracy of outlier payments, the mid-year amendments proposed by CMS are unreasonable. The revisions will not just affect a small number of hospitals with significant outlier experience, but rather almost every hospital in the country. Yet CMS did not publish any data on the financial impact of its proposed changes or offer a full 60-day comment period so that hospitals could better analyze, understand, and comment on the dramatic mid-year changes in the proposed rule. Moreover, cost settlement of outlier payments for all hospitals is unnecessary and unjustified, the outlier threshold must be lowered to reflect savings achieved by its proposed policy changes, and a transition period is necessary for those hospitals harmed.

BACKGROUND

Twenty years ago, when the Medicare program moved from cost-based reimbursement to an inpatient prospective payment system (PPS), Congress mandated that additional payments be provided to limit hospitals' financial risk when treating elderly patients with especially serious illnesses. These so-called "outlier" payments are critical for hospitals because they are designed to alleviate the financial burden of unusually costly cases that otherwise would be significantly under-reimbursed in a PPS that pays on the basis of averages. The system is budget neutral—meaning that the PPS standardized amount is reduced to fund outlier payments.

The outlier system and its payment formula are very complex. In general, a hospital's costs must exceed a specified dollar amount, or threshold, in order to qualify for the additional payments. But CMS cannot determine actual hospital costs for each and every patient seen in a hospital, so the agency uses hospital charges and converts them to estimated costs, using a hospital's cost-to-charge ratio. Even when compensated for outlier payments, however, hospitals are not reimbursed the full cost of care for these patients.

COST SETTLEMENT

Currently, CMS uses the cost-to-charge ratio from a hospital's most current final settled cost report to estimate hospital costs in the current year. Because there is a significant time lag in settling Medicare cost reports, this cost-to-charge ratio may be three to five years old. During this time, it is likely that a hospital's charges as well as its costs will have changed, making that cost-to-charge ratio outdated, and no longer reflective of hospitals' costs.

Under the proposed rule, CMS would use more up-to-date data when determining the cost-to-charge ratio for each hospital. Rather than relying on the most recent final settled cost report, CMS proposes to use the most recent tentatively settled cost report. The AHA supports this initiative, which would decrease the lag time in cost-to-charge ratios from the three-to-five-year period to potentially eight months after the close of a hospital's cost reporting period. In addition, CMS has proposed to allow hospitals to request changes to their cost-to-charge ratio if they present data that the current ratio used by fiscal intermediaries is inaccurate. And, CMS would be able to change a hospital's cost-to-charge ratio if, within the past two years, its data show dramatic hospital charge increases. These changes will ensure that outlier costs are calculated using accurate and timely data, and this will dramatically improve outlier payments in the inpatient prospective payment system. The AHA strongly believes that these measures are sufficient to ensure both accountability of the system, and appropriate outlier payments. Proceeding further with cost-settlement is not necessary.

In addition to changing the calculation of a hospital's cost-to-charge ratios, CMS would require that outlier payments be adjusted and reconciled upon final settlement of a hospital's Medicare cost report. This would be implemented by using hospitals' final settled cost-to-charge ratio to re-calculate outlier payments. This incredibly burdensome proposal is duplicative and inefficient, as it would require the re-processing of hundreds of thousands of claims to determine both if a claim qualifies for an outlier payment given a hospital's final-settled cost-to-charge ratio, and if so, how much the payment should be. This would create more volatility in Medicare

payment and hospitals' planning, budgeting and operations. Under such a scenario, cost settlement would result in outlier payments that are no longer part of a prospective payment system, but rather they would be cost-based—the direct opposite of the intent of Medicare legislation.

This complex process is unwarranted and unnecessary. The use of tentatively settled cost reports should be more than adequate to determine appropriate outlier payments in a prospective payment system. We urge you to strongly encourage CMS not to move forward with cost settlement. The agency's other proposed changes will achieve the desired improvements in the system to protect access to care for the most costly and ill Medicare patients, protect the integrity of outlier payments, and protect Medicare Part A Trust Fund payments to hospitals.

STATEWIDE AVERAGE

In addition to using more recent cost-to-charge ratios, the rule proposes to eliminate use of the statewide average cost-to-charge ratio. Currently, hospitals with cost-to-charge ratios that fall outside of an acceptable range have their hospital-specific cost-to-charge ratio changed to the average urban or rural cost-to-charge ratio for their state. This policy, adopted in 1989, resulted in significant changes in the cost-to-charge ratios for certain hospitals. The American Hospital Association agrees that use of the statewide average should be eliminated.

THRESHOLD

Given the significant policy changes in the rule, the outlier threshold needs to be recalculated. Using more updated cost-to-charge ratios and eliminating the use of statewide average cost-to-charge ratio would substantially lower overall outlier payments to hospitals in 2003. And thus, the outlier threshold must be lowered to allow more hospitals and more high-cost cases to qualify for these payments. If these two changes were adopted it is our belief that the threshold should decline in order to ensure hospitals are reimbursed at the targeted amount of 5.1 percent of total inpatient PPS payments. These funds have already been carved out of base Medicare payments for 2003, necessitating that the threshold be recalculated to ensure that Medicare outlier payments in aggregate are received in full by the nation's hospitals. We're extremely disappointed that CMS has ignored the premise that elimination of the statewide average should, by definition, result in a lowering of the outlier threshold. We ask the subcommittee to insist that CMS adapt this policy change. In addition, AHA is conducting an analysis to determine how much the outlier threshold should be lowered and we will include the findings of this analysis in our comment letter to CMS.

TRANSITION

In the proposed rule, CMS indicated that it was "unable to quantify the likely impacts of these proposed changes." AHA's initial data analysis indicates that the adoption of these policies would have a significant impact on many providers. Three out of four hospitals receive outlier payments. These providers have budgeted for and are operating under the current rules of the Medicare program. A steep drop in expected payments for outlier cases could be financially devastating, especially given the increased financial pressures of workforce shortages and skyrocketing labor costs, rising pharmaceutical and technology costs, and soaring medical liability premiums.

CMS frequently provides transition periods to help ameliorate the impact of major policy changes that reduce Medicare payments to hospitals and other providers. For example, CMS recently completed a 10-year phase-in of capital PPS payments, and a four-year phase-in of the removal of salaries related to graduate medical education and certified registered nurse anesthetists in the calculation of the area wage index. Hospitals were also provided transitional corridor payments and hold harmless payments when the outpatient hospital prospective payment system was implemented. We urge the subcommittee to ensure that a transition period is made available for those hospitals significantly harmed by any change in the outlier regulation.

CONCLUSION

Mr. Chairman, America's hospitals are experiencing total margins that are at their lowest level in 10 years, and the majority of hospitals continue to be reimbursed less than what it costs them to provide the services that Medicare patients need. Still, even as they face dwindling federal resources, hospitals are committed to continue providing top-notch care . . . including the care needed by those most extremely ill of America's seniors.

But the proposed outlier rule, as it currently is written, stands to jeopardize our ability to deliver on that commitment. While we support CMS' proposal to use the most current cost-to-charge ratio in calculating outlier payments, we ask you to urge CMS to abandon the additional requirement that outlier payments be reconciled upon cost settlement. In addition, CMS must reexamine and lower the outlier threshold, and ensure that protections are put in place that allow a transition period for those hospitals affected by this mid-year change in policy.

PREPARED STATEMENT OF THE NEW JERSEY HOSPITAL ASSOCIATION

The New Jersey Hospital Association has reviewed the proposed rule, published by the Centers for Medicare and Medicaid Services on March 5, 2003 related to Medicare cost outliers. We are currently in the process of formulating our comments associated with this proposed rule for submission to CMS. Prior to the completion of those comments we would like to take the opportunity to outline our initial thoughts in the form of this statement.

While CMS has provided a general outline for how Medicare cost outlier payments to hospitals will be calculated in the future, there are a number of ambiguities in the proposed rule. Further, we are currently reviewing several aspects of the proposal. The following is a list of those issues:

THE OUTLIER THRESHOLD

The proposed rule calls for a change to use of a more recent ratio of cost to charges (RCC), and ultimate settlement to a hospital's actual RCC. Making these changes without a significant downward adjustment to the cost outlier threshold will cause CMS to make cost outlier payments at a level significantly below the required 5 percent and therefore over-correct for any excess payments in this payment pool. We are concerned that the proposed rule as presented will not adequately reimburse hospitals their cost, as prescribed, for outlier cases.

TRANSITION PERIOD

With the strong likelihood that outlier payments to many hospitals will be significantly reduced, it would be appropriate for CMS to include a transition period that would allow hospitals to adjust to these changes over a multi-year period.

IMPLEMENTATION

A mid-year change to an issue of this magnitude will be problematic for hospitals. CMS should consider implementing this rule for hospital cost reporting periods beginning on or after the effective date of the rule.

THE SETTLEMENT PROCESS

In the proposed rule, CMS indicates its intent to reconcile outliers retrospectively to hospital's actual RCC from their final settled cost report. CMS has not clearly described whether this reconciliation will occur in all cases. Further, CMS has not explained how it will account for IME and DSH components of outlier payments and the outcome of hospital appeals that occur post settlement. Since post-payment reconciliation based on audited costs undermines the prospectivity of PPS, CMS should limit the cases to which this is applied.

INTERMEDIARY ADJUSTMENTS TO TENTATIVE RCCS

The proposed rule allows intermediaries to adjust hospital specific RCCs from the tentative settled cost report subsequent to a review relative to other hospitals. CMS should provide the intermediaries with corridors or other guidelines to minimize the potential for uneven application of this component across intermediaries.

INTEREST ASSESSMENTS

Interest assessments under the Medicare program are statutory. CMS should not impose interest assessments on outliers without specific statutory to do so.

Again, NJHA will be providing more comprehensive comments to CMS on the proposed rule prior to the April 4, 2003 deadline. We appreciate this opportunity to inform the Subcommittee of our initial concerns related to this rule.

If the Subcommittee has any questions about these comments, please contact Sean Hopkins, Senior Vice President, Health Economics at 609 275-4022 or shopkins@njha.com.

ADDITIONAL COMMITTEE QUESTIONS

Senator SPECTER. There will be some additional questions which will be submitted for your response in the record.

[The following questions were not asked at the hearing, but were submitted to the Department for response subsequent to the hearing:]

QUESTIONS SUBMITTED BY SENATOR ARLEN SPECTER

Question. The new outlier payment policies, if implemented, will cause significant payment reductions for many hospitals. Consistent with prior Medicare practice when payment policies are changed abruptly, wouldn't it be fair to transition these payment reductions over a multi-year period?

Answer. Outlier payments are uniquely susceptible to manipulation because hospitals set their own level of charges and are able to change their charges without notification to, or review by, their fiscal intermediary. Such changes by a hospital directly affect its level of outlier payments, unlike IIME or DSH where the fiscal intermediary must agree to a change to the underlying data. Therefore, an extended transition period would allow the effects of inappropriate redistribution of outlier payments to continue into the future. We believe it is essential to ensuring that outlier payments are made for truly high-cost cases to eliminate those effects as soon as possible.

Question. Don't the current outlier thresholds take into account the projected 2003 charge increases that would be reversed by the reconciliation of outlier payments to the final, audited 2003 cost reports under the proposed rule? Shouldn't the outlier thresholds be reduced to reflect these new policies?

Answer. We are examining the appropriate level of the threshold in conjunction with preparing the final outlier rule, and will address the issue of whether the threshold should be reduced in that final rule that is expected to be published later this year.

Question. Isn't it true that CMS has never issued any clear guidance on hospital charging levels? Didn't CMS's historic outlier policies require hospitals to raise charges dramatically even to receive the appropriate level of outlier payments they were due (because of substantial annual increases in the outlier thresholds)?

Answer. It is true the Federal government has never directly regulated hospitals' charging practices. It is not true that CMS policies regarding the outlier threshold have required hospitals to increase charges dramatically. Outlier thresholds are determined based on hospitals' historical charge data, and the dramatic increase in the threshold is a reflection, not a cause, of some hospitals' rapidly rising charges.

Question. Isn't it true that the failure of the Medicare Program to timely settle cost reports often caused hospitals to receive excessive outlier payments?

Answer. It is true that extended delays in settling cost reports increases the time lag between the data used to process claims and the contemporaneous data. However, the excessive outlier payments we are addressing are primarily attributable to small groups of hospitals increasing their charges by 30 percent or more annually the last couple of years.

Question. Isn't it true that the failure of the Medicare Program to properly update cost-to-charge ratios also often caused hospitals to receive excessive outlier payments?

Answer. It is true that extended delays in settling cost reports increases the time lag between the data used to process claims and the contemporaneous data. However, the excessive outlier payments we are addressing are primarily attributable to small groups of hospitals increasing their charges by 30 percent or more annually the last couple of years.

Question. These new policies would impose interest charges on a hospital that receives outlier payments that are later reduced upon audit. Can the Medicare Program impose interest charges without explicit statutory authority?

Answer. We are imposing an adjustment to account for the time value of the excess outlier payments the hospitals have received. This adjustment is consistent with the statutory requirement at section 1886(d)(5)(A)(iii) that outlier payments approximate the marginal cost of care beyond the threshold. That is, because hospitals are uniquely able to manipulate outlier payments by increasing charges, it is necessary to establish a mechanism whereby an adjustment can be made to ensure payments appropriately reflect the marginal costs of care for outlier cases.

Question. Isn't it true that the cost-to-charge ratio of outlier cases differs from that of regular cases because outliers are the highest cost cases? If yes, how can

outlier payments be determined accurately using cost-to-charge ratios based principally on non-outlier cases?

Answer. Hospitals' charge structures are consistent across patients. Therefore, the cost-to-charge ratio should not vary based upon whether a case incurs high costs. The charges will be higher, but the ratio will be the same, and, thus, the costs will be correspondingly higher.

Question. When your proposal went to OMB the threshold was \$22,000 and you claimed it would affect a small number of hospitals and when it came out of OMB it was \$33,000 and affects nearly every hospital. If this fix is so urgent, how could you send a proposal to OMB that was completely rewritten?

Answer. It was revised as part of the necessary review and clearance process applicable for every Federal regulation, no matter how urgent.

Question. What was the result of your October 2002 adjustment in the threshold? What was the result of the national program review initiated December 3, 2002? If you believed a national review was necessary how can you move forward with a precise and accurate proposed reform when you don't have the results of your national program review?

Answer. In fiscal year 2002, we now project we will actually have paid 7.9 percent of total DRG payments in outliers. The adjustment we made October 2002 appears to have brought the fiscal year 2003 percentage down significantly below that level. The national review helped us to identify the scope of the problem, and the changes we are making reflect our findings from that review.

Question. Why are you opposed to a 60-day comment period, followed by a 180-day rulemaking period and working with all hospitals on a fair and seamless transition period to account for significant impacts and changes?

Answer. Outlier payments are uniquely susceptible to manipulation because hospitals set their own level of charges and are able to change their charges without notification to, or review by, their fiscal intermediary. Such changes by a hospital directly affect its level of outlier payments, unlike IME or DSH where the fiscal intermediary must agree to a change to the underlying data. Therefore, an extended transition period would allow the effects of inappropriate redistribution of outlier payments to continue into the future. We believe it is essential to ensuring that outlier payments are made for truly high-cost cases to eliminate those effects as soon as possible.

Question. Mr. Scully what would you do if you were a hospital administrator and CMS told you that in the middle of your fiscal year you were going to lose \$2 million per month? How can you say hospital administrators should not be in the position when CMS only now has figured out there is a "problem" and it's your system and administration under which they all operate?

Answer. In just fiscal year 2001 and fiscal year 2002 alone, Medicare has paid hospitals \$4.4 billion more than budgeted for outlier payments. We now know that much of that excess amount was directly attributable to hospitals deliberately taking advantage of a loophole in the system. For example, one hospital in Brownsville, Texas, had outlier payments in 2003 approximately 110 percent of its DRG payments, and, under current rules, is projected to receive outlier payments in fiscal year 2004 equal to 134 percent of its 2004 DRG payments. Furthermore, this hospital increased its charges by 40 percent from fiscal year 2001 to fiscal year 2002. Those are the hospital administrators this change is targeting.

CONCLUSION OF HEARING

Senator SPECTER. Thank you all very much for being here. That concludes our hearing.

[Whereupon, at 10:46 a.m., Tuesday, March 11, the hearing was concluded, and the subcommittee was recessed, to reconvene subject to the call of the Chair.]