Whether the Provider received the reimbursement Congress intended under the Medicare Act for treating certain cases that incurred extraordinarily high costs? Was the cost outlier threshold set improperly?

1. **Facts**
2. *The Medicare Prospective Payment System*

Since 1983, Medicare has generally reimbursed hospitals via the Prospective Payment System (“PPS”). The PPS reimburses qualifying hospitals at prospectively fixed rates. *See* Pub. L. No. 98-21, §601, 97 Stat. 65, 149; 42 U.S.C. §1395ww(d). In calculating prospective payment rates, the Secretary begins with the “standardized amount,” a figure that prospectively approximates the average cost incurred by hospitals nationwide for each treated patient. *See* 42 U.S.C. §1395ww(d)(2). To account for regional variations in labor costs, the Secretary then determines the proportion of the standardized amount attributable to wages and wage-related costs and then multiplies the labor-related portion by a wage index that reflects the relation between the local average of hospital wages and the national average of hospital wages. *See Cape Cod Hosp. v. Sebelius*, 630 F.3d 203, 205 (D.C. Cir. 2011); 42 U.S.C. §§1395ww(d)(2)(H), (d)(3)(E). The standardized amount is also weighted to reflect the disparate hospital resources required to treat major and minor illnesses. *Cnty of Los Angeles v. Shalala*, 192 F.3d 1005, 1008 (D.C. Cir. 1999); 42 U.S.C. §1395ww(d)(4).

The weighting occurs by classifying Medicare patients into different groups based on their diagnoses, and each diagnosis-related group (“DRG”) is assigned a particular weight representing the relationship between the cost of treating patients within that group and the average cost of treating all Medicare patients. *Cape Cod*, 630 F.3d at 205-206; 42 U.S.C. §1395ww(d)(4). The Secretary takes the standardized amount, adjusts it according to the wage index, and multiplies it by the weight assigned to the patient’s DRG; the result is known as the DRG prospective payment rate. *Cnty of Los Angeles*, 192 F.3d at 1009.

1. *Medicare Outlier Payments*

“Congress recognized that health-care providers would inevitably care for some patients whose hospitalization would be extraordinarily costly or lengthy,” and therefore, enacted methods to “insulate hospitals from bearing a disproportionate share of these atypical costs.” *Cnty of Los Angeles*, 192 F.3d at 1009 (**Exhibit C-2**). For this reason, Section 1886(d)(5)(A) of the Medicare Act provides for supplemental “outlier” payments to providers that qualify. This Section states (in pertinent part) that:

(ii)…[A] hospital [paid under the PPS] may request additional payments in any case where charges, adjusted to cost…for discharges in fiscal years beginning on or after October 1, 1994, exceed the sum of the applicable DRG prospective payment rate plus any amounts payable under subparagraphs (B) and (F) plus a fixed dollar amount determined by the Secretary.

(iii) The amount of such additional payment…shall be determined by the Secretary and shall…approximate the marginal cost of care beyond the cutoff point applicable under clause…(ii).

42 U.S.C. §1395ww(d)(5)(A) (**Exhibit C-3**)

This Section was implemented by the regulations at 42 C.F.R. §§412.80-412.86.

Each fiscal year, the Secretary determines a fixed dollar amount that, when added to the DRG prospective payment, serves as the eligibility trigger for outlier payments. *See* 42 U.S.C. §1395ww(d)(5)(A)(ii), (iv); 42 C.F.R. §412.80(a)(2)-(3). This amount is known as the “fixed loss threshold.” If a hospital’s estimated costs in treating a patient exceed the sum of the DRG prospective payment rate and the fixed loss threshold, the hospital is eligible for an outlier payment. *See* 42 U.S.C. §1395ww(d)(5)(A)(ii)-(iii); 42 C.F.R. §412.80(a)(2)-(3). The hospital thus incurs the full cost of treating a patient above the DRG prospective payment rate up to the fixed loss threshold. The higher the fixed loss threshold, the lower the number of cases that qualify for outlier payments.

The Medicare Act states that the total amount of outlier payments 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.” 42 U.S.C. §1395ww(d)(5)(A)(iv) (**Exhibit C-3**). The Secretary reads this section of the Act together with the requirement of prospectively fixed rates to mean that the fixed loss thresholds must be established at the start of each fiscal year. *See* *Cnty of Los Angeles*, 192 F.3d at 1009.

In order to implement her interpretation, the Secretary first makes a predictive judgment about the total amount of payments that can be expected to be paid based on DRG prospective payment rates. *Cnty of Los Angeles*, 192 F.3d at 1009.

Next, she examines historical data to determine the threshold that “would probably yield total outlier payments falling within the five-to-six percent range.” *Id.*  (**Exhibit C-2**) Because the fixed loss threshold is set prospectively based on historical data, the accuracy of the threshold depends primarily on how well historical data predicts future payments. During the fiscal year at issue, the Secretary set the fixed loss threshold at a level that would make the anticipated total outlier payments equal to 5.1% of the anticipated total DRG prospective payment rate totals.

Providers that incur costs treating patients that exceed the fixed loss threshold are eligible for outlier payments in amounts that “approximate the marginal cost of care” beyond the fixed loss threshold. 42 U.S.C. §1395ww(d)(5)(A)(iii) (**Exhibit C-3**). The implementing regulation provided for outlier payments of 80 percent of the difference between the hospital’s operating costs and the fixed loss threshold. *See* 42 C.F.R. §412.84(k). This method means “[t]he amount of the outlier payment is proportional to the amount by which the hospital’s loss exceeds the outlier [fixed loss] threshold.” *Dist. Hosp. Partners v. Sebelius*, 2011 WL 2621000, \*2 (D.D.C. 2011) (**Exhibit C-4**).

The Secretary established a fixed loss threshold of $22,185 for federal fiscal year 2008 via notice published in the November 27, 2007, Federal Register. See 72 FR 66887 (November 27, 2007) (**Exhibit C-5**). The Providers have challenged the Secretary’s method for establishing the fixed loss thresholds as “arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law within the meaning of 5 U.S.C. 706(2)(A)...[[1]](#footnote-1)” The Providers request that the Board request that the Secretary recalibrate the fixed loss threshold for the fiscal years at issue and direct the MAC to recalculate Inpatient PPS payments for the Providers and for the fiscal year at issue in accordance with the recalibrated FLT.[[2]](#footnote-2)

1. **Argument**
2. *The Secretary Properly Determined the Fixed Loss Threshold*

The Providers argue that the Secretary failed to set a fixed loss threshold that complied with the Medicare Act. The Providers allege a litany of deficiencies in the fixed loss threshold that it claims harmed the Providers. Specifically, the Providers claim that (1) the fixed loss threshold was artificially inflated due to “turbo charging” by certain Providers that charged far more than their costs for hospital supplies and services; (2) actual payments were well below the 5.1% anticipated outlier payment percentage set by the Secretary; (3) the Secretary’s use of a “cost methodology” rather than a “charge methodology” was flawed; and (4) the Secretary failed to consider relevant data relating to changes in costs that resulted in the fixed loss threshold being inaccurate.

The District Court for the District of Columbia considered – and rejected – substantially identical claims in *District Hosp. Partners, L.P. v. Sebelius*, CA No. 11-0116 (D.D.C. January 6, 2014). In *District Hospital Partners, L.P.*, the Providers similarly claimed that the Secretary’s methodology for setting fixed loss thresholds for outlier payments for fiscal years 2004-2006 was arbitrary and capricious.

The Providers similarly claimed that the threshold was inflated by “turbo charging” by certain Providers in the years from which the Secretary took the data used to construct the fixed loss threshold. The Court found, however, that there was no evidence in the administrative record that there was better, more recent data available to the Secretary at the time the Secretary established the fixed loss threshold.

The Providers also argued that the Secretary’s cost methodology was flawed and used outdated data that failed to take into account changes in costs. The Court found, however, that the Secretary was justified in using historical data and had adopted an “Outlier Correction Rule” and a reconciliation process that were “reasonable and adequately responsive” to concerns about the process. *Id.*, at 22 (**Exhibit C-4**).

The Court proceeded to grant the Secretary’s Motion for Summary Judgment and deny the Providers’ Motion for Summary Judgment, upholding the fixed loss threshold for fiscal years 2004-2006. The Providers here challenge the fixed loss thresholds at issue for substantially identical grounds as those challenged by the Providers in *District Hospital Partners, L.P.* The District Court thoroughly addressed all of the Providers’ challenges in a 30-page opinion and found them all lacking. The Board should adopt the District Court’s reasoning and affirm the MAC’s adjustment for the same reasons.

1. *The Board Does Not Have the Authority to Grant Relief to the Providers*

The Secretary properly determined the fixed loss threshold for outlier payments under the Medicare Act and the Regulations. Moreover, the Board does not have the authority to award the relief the Providers seeks. 42 C.F.R. §405.1867 requires the Board to comply with all of the provisions of the Medicare Act and regulations issued thereunder.

The Secretary has issued regulations relating to outlier payments at 42 C.F.R. §§412.80-412.86. In particular, 42 C.F.R. §412.80(c) provides that “CMS will issue threshold criteria for determining outlier payment in the annual notice of the prospective payment rates published in accordance with §412.8(b).” (**Exhibit C-6**)

CMS proceeded to issue these threshold criteria in the Federal Register for the fiscal years at issue. The Board may not disregard the Final Rule published under this regulation. *See Lima Mem. Hosp. v. BlueCross BlueShield Assoc./CGS Administrators, LLC*, PRRB Dec. No. 2013-D8 (March 13, 2013), p. 18 (Board was obligated to follow interim final rule changing cost reporting period as authorized by regulation). The Providers have not alleged that the MAC failed to abide by the Regulations, or the threshold criteria issued by CMS in making its adjustments. Rather, the Providers are challenging the fixed loss threshold itself. The Board does not have the authority to modify regulations and final rules issued by CMS under the Regulations. Accordingly, the Board must allow the Provider to seek expedited judicial review of the fixed loss threshold pursuant to 42 C.F.R. §405.1842.

1. **Conclusion**

For the foregoing reasons, the Board should allow the Providers to seek expedited judicial review in accordance with 42 C.F.R. §405.1842.

1. **LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS**

**United States Statutes**

42 U.S.C. §1395ww(d);42 U.S.C. §1395ww(d)(2);42 U.S.C. §1395ww(d)(2)(H);42 U.S.C. §1395ww(d)(3)(E);42 U.S.C. §1395ww(d)(4);42 U.S.C. §1395ww(d)(5)(A);42 U.S.C. §1395ww(d)(5)(A)(ii);42 U.S.C. §1395ww(d)(5)(A)(iii);42 U.S.C. §1395ww(d)(5)(A)(iv)

**Regulations:**

42 C.F.R. §405.1842;42 C.F.R. §405.1867;42 C.F.R. §412.8(b);42 C.F.R. §412.80(a)(2);42 C.F.R. §412.80(a)(3);42 C.F.R. §412.80(c);42 C.F.R. §412.84(k);42 C.F.R. §412.80-412.86

**Federal Register Notices**

72 FR 66887 (November 27, 2007)

**Federal Court Cases**

*Cape Cod Hosp. v. Sebelius*, 630 F.3d 203 (D.C. Cir. 2011);*Cnty of Los Angeles v. Shalala*, 192 F.3d 1005, 1008,1009 (D.C. Cir. 1999);*District Hosp. Partners v. Sebelius*, 2011 WL 2621000 (D.D.C. 2011);*District Hosp. Partners, L.P. v. Sebelius*, CA No. 11-0116 (D.D.C. January 6, 2014)

**Administrative Decisions**

*Lima Mem. Hosp. v. BlueCross BlueShield Assoc./CGS Administrators, LLC*, PRRB Dec. No. 2013-D8 (March 13, 2013)

**V. EXHIBITS**

**C-1** Schedule of Providers

**C-2** *Cnty of Los Angeles v. Shalala*, 192 F.3d 1005, 1008,1009 (D.C. Cir. 1999)

**C-3** 42 U.S.C. §1395ww(d)(5)(A)

**C-4** *Dist. Hosp. Partners v. Sebelius*, 2011 WL 2621000, \*2 (D.D.C. 2011)

**C-5** 72 FR 66887 (November 27, 2007)

**C-6** 42 C.F.R. §412.80(c)

1. See the Providers’ PPP, pg. 16. [↑](#footnote-ref-1)
2. See the Providers’ PPP, pg. 18. [↑](#footnote-ref-2)