

2005

# The Effect of Hospital Charges on Outlier Payments under Medicare's Inpatient Prospective Payment System: Prudent Financial Management or Illegal Conduct?

R. Brent Rawlings

*Hancock, Daniel, Johnson & Nagle, PC*

Hugh E. Aaron

*Healthcare Regulatory Advisors, Inc.*

Follow this and additional works at: <http://lawcommons.luc.edu/annals>



Part of the [Health Law and Policy Commons](#)

---

### Recommended Citation

R. B. Rawlings & Hugh E. Aaron *The Effect of Hospital Charges on Outlier Payments under Medicare's Inpatient Prospective Payment System: Prudent Financial Management or Illegal Conduct?*, 14 *Annals Health L.* 267 (2005).

Available at: <http://lawcommons.luc.edu/annals/vol14/iss2/4>

## The Effect of Hospital Charges on Outlier Payments Under Medicare's Inpatient Prospective Payment System: Prudent Financial Management or Illegal Conduct?

*R. Brent Rawlings, J.D., M.H.A.\**

&

*Hugh E. Aaron, J.D., M.H.A., CPC, CPC-H†*

“There’s obviously a hefty debate going on in the government right now about whether what Tenet did was legal or not. . .”<sup>1</sup>

Thomas A. Scully, Administrator, Centers for Medicare and Medicaid Services, January 7, 2003.

---

\* Mr. Rawlings is an Attorney in the Central Virginia office of Hancock, Daniel, Johnson & Nagle, P.C., a law firm that specializes in providing assistance and guidance to health care providers in virtually all legal matters affecting the health care industry. He received his Bachelor of Science in Health Policy and Administration from the Pennsylvania State University; his Juris Doctor from the T.C. Williams School of Law at the University of Richmond; and his Master of Health Administration from the Medical College of Virginia at Virginia Commonwealth University. Address all correspondence to Mr. Rawlings at [brawlings@hdjn.com](mailto:brawlings@hdjn.com) or you may reach him by telephone at (804) 967-9604.

† Mr. Aaron is President of Healthcare Regulatory Advisors, Inc. (a health law firm) and HRAI Coding Specialists, LLC (a national medical coding and billing training/consulting firm). His work focuses primarily on medical coding issues and Medicare coverage, billing, and payment matters. In addition to his health law practice, Mr. Aaron developed and teaches two weeklong courses – the Medicare Boot Camp<sup>®</sup> – Hospital Version and the Certified Coder Boot Camp<sup>®</sup>. Mr. Aaron is an Adjunct Assistant Professor of Law at the University of Richmond School of Law where he teaches Health Care Regulation. He is also an Affiliate Assistant Professor in the Department of Health Administration at Virginia Commonwealth University (Medical College of Virginia Campus). Mr. Aaron earned his Juris Doctor degree (cum laude) from the University of Richmond where he served as an editor of the Law Review and was a member of the McNeill Law Society (academic honor society). He also holds a Master of Health Administration degree from the Medical College of Virginia and a Bachelor of Business Administration degree from Christopher Newport University. Address all correspondence to Mr. Aaron at [hearon@hrai.com](mailto:hearon@hrai.com) or you may reach him by telephone at (804) 965-6387.

1. Caroline Said, *Tenet Whittles Billing; Medicare Receipts to Fall Nearly 90%*, SAN FRANCISCO CHRON., Jan. 7, 2003, at B1.

## I. INTRODUCTION

Under the Medicare Inpatient Prospective Payment System (IPPS)<sup>2</sup>, when the cost of providing services exceeds a specified threshold, hospitals receive additional payments.<sup>3</sup> These so called “outlier” payments recently became the source of significant controversy when the federal government discovered that certain hospitals had received unusually large outlier payments.<sup>4</sup> Shortly thereafter, the federal government suggested that individual hospitals, most notably numerous hospitals owned by Tenet Healthcare Corporation, may have manipulated their charges in an effort to achieve higher outlier payments.<sup>5</sup> In some instances, formal investigations into Medicare billing practices were initiated.<sup>6</sup>

---

2. For purposes of this paper, the term “Inpatient Prospective Payment System” is used to refer to Medicare’s prospective payment system for short-term, acute care, inpatient hospital services. In actuality, there are other hospital inpatient prospective payment systems utilized within the Medicare program. For example, inpatient prospective payment systems are used for rehabilitation hospitals, *see* 42 C.F.R. § 412.600 (2004), long-term care hospitals, *see* 42 C.F.R. § 412.500 (2004), and psychiatric hospitals, *see* 42 C.F.R. § 412.400 (2004). Also, for purposes of this paper, the term “hospital” refers to short-term, acute care, inpatient hospitals, unless otherwise stated.

3. *See* 42 U.S.C. § 1395ww(d)(5) (2000); 42 C.F.R. § 412.80 (2002).

4. *See* Department of Health and Human Services, Program Memorandum Intermediaries, Transmittal A-02-122, Dec. 3, 2002, *available at* [http://www.cms.hhs.gov/manuals/pm\\_trans/a02122.pdf](http://www.cms.hhs.gov/manuals/pm_trans/a02122.pdf) (last visited Apr. 21, 2005); *CMS Announces Steps to Stop Questionable Billing Practices*, HEALTH CARE DAILY REPORT, (Bureau of National Affairs, Inc.), Dec. 4, 2002; Medicare News Press Release, Centers for Medicare and Medicaid Services, CMS Takes Steps to Crack Down on Inappropriate Hospital Outlier Claims (Feb. 28, 2003), *at* <http://cms.hhs.gov/media/press/release.asp?Counter=715> (last visited Apr. 21, 2005).

5. *See Fraud and Abuse: Tenet Takes Close Look at Pricing Strategy in Response to HHS Probe of Hospital Chain*, HEALTH CARE DAILY REPORT, (Bureau of National Affairs, Inc.), Nov. 8, 2002; *CMS Announces Steps to Stop Questionable Hospital Billing Practices*, HEALTH CARE DAILY REPORT, (Bureau of National Affairs, Inc.), Dec. 4, 2002; *Hospital Finances Do Not Warrant Increased Medicare Funding, Scully Says*, HEALTH CARE DAILY REPORT, (Bureau of National Affairs, Inc.), Dec. 10, 2002; *Fraud and Abuse: CMS Issues Further Instructions For Investigating Medicare Outlier Claims*, HEALTH CARE DAILY REPORT, (Bureau of National Affairs, Inc.), Dec. 4, 2002. Hospital pricing strategies aimed at obtaining higher than average Medicare outlier payments have repeatedly been referred to as an attempt at “gaming” or to “game” the “system.” *See* Department of Health and Human Services, Program Memorandum Intermediaries, Transmittal A-02-122, Dec. 3, 2002, *available at* [http://www.cms.hhs.gov/manuals/pm\\_trans/a02122.pdf](http://www.cms.hhs.gov/manuals/pm_trans/a02122.pdf) (last visited Apr. 21, 2005) (stating that “CMS believes that some hospitals may be attempting to “game” the current payment systems”); Medicare News Press Release, Centers for Medicare and Medicaid Services, CMS Takes Steps to Crack Down on Inappropriate Hospital Outlier Claims, (Feb. 28, 2003), *at* <http://cms.hhs.gov/media/press/release.asp?Counter=715> (last visited Apr. 21 2005) (stating “proposed new regulations . . . will prevent further gaming of the outlier system” and that “CMS understands the gaming that led to this unintended spending. . .”).

6. *See Hospitals: Hospitals New Tenet Billing Policy to Cut Monthly Medicare Outlier Payments by \$57 Million*, HEALTH CARE DAILY REPORT, (Bureau of National Affairs, Inc.),

Ultimately, the Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Finance Administration (HCFA),<sup>7</sup> revised the existing outlier regulations in an effort to limit the potential for manipulation. However, the issue remains as to whether alleged abuses of the outlier payment calculation methodology were in fact violations of then current federal law.

This article begins by providing a general overview of the Medicare IPPS, followed by a more specific explanation of outlier payments and the outlier payment calculation methodology. Second, the article discusses recent revisions to the outlier payment calculation methodology and their resulting impact on outlier payments. Third, the article discusses the outlier controversy in the context of one of the nation's largest investor-owned hospital companies, Tenet Healthcare Corporation. Fourth, the article discusses the nuances of financial management in the hospital industry which may have contributed to the alleged outlier abuses. Lastly, the article concludes with an analysis of possible legal theories on which the federal government could base enforcement actions relating to outlier payments.

## II. OUTLIERS AND THE INPATIENT PROSPECTIVE PAYMENT SYSTEM: AN OVERVIEW

### A. Medicare's Inpatient Prospective Payment System

To understand outlier payments and the methodology by which they are calculated, it is first necessary to have a general understanding of how Medicare pays hospitals for inpatient services. Historically, Medicare "reimbursed" hospitals on a *retrospective* basis. This "cost-based" retrospective payment system reimbursed hospitals for the "reasonable cost" of covered services provided to Medicare beneficiaries.<sup>8</sup> Cost-based reimbursement included reimbursement for virtually all costs relating to covered patient services, including room and board, nursing care, depreciation expenses, interest or capital debt, lease expenses, and, in some cases, a reasonable return on equity.<sup>9</sup> Because the federal government reimbursed hospitals for their costs, hospitals were not required to assume

---

Jan. 7, 2003; Andrew Pollack, *Tenet Healthcare Says U.S. Inquiry is Intensifying*, N. Y. TIMES, July 10, 2003, at C1.

7. See Press Release, Department of Health and Human Services, The New Centers for Medicare & Medicaid Services (CMS) (Jan., 14, 2001), at <http://www.hhs.gov/news/press/2001pres/20010614a.html> (last visited Apr. 21, 2005).

8. See Steven Golub, Note and Comment, *The Role of Medicare Reimbursement in Contemporary Hospital Finance*, 11 AM. J. L. & MED. 501, 507 (1986) (providing a history of Medicare reimbursement).

9. See *id.* at 507-08.

any substantial financial risk relating to the provision of services to Medicare beneficiaries. Consequently, hospitals had very little incentive to efficiently manage resource consumption – a fact that ultimately contributed to the rising cost of health care and federal budget deficits.<sup>10</sup>

Beginning October 1, 1983, Medicare replaced the cost-based reimbursement system for short-term, acute care, inpatient hospital services with the Inpatient Prospective Payment System (IPPS).<sup>11</sup> The primary objective of this change was to create incentives for hospitals to operate efficiently and minimize unnecessary costs.<sup>12</sup>

Under IPPS, hospitals are reimbursed a predetermined amount; i.e., a *prospective* payment rate per-discharge (the “IPPS payment”) for most inpatient cases, regardless of the costs incurred by the hospital in rendering services to the patient.<sup>13</sup> This prospective payment approach represented a drastic departure from the previous cost-based reimbursement system. Unlike retrospective cost-based reimbursement, IPPS essentially places the hospital at risk for managing resource consumption. If a hospital’s actual costs exceed the IPPS payment, then the hospital must absorb the loss.<sup>14</sup> If a hospital’s actual costs are less than the IPPS payment, then the hospital realizes a gain.<sup>15</sup>

The per-discharge IPPS payment is comprised of multiple components.<sup>16</sup> First, there is the base payment rate for operating costs or the *operating* “Federal rate.”<sup>17</sup> Second, there is the base payment rate for capital-related costs or the *capital* “Federal rate.”<sup>18</sup> The operating Federal rate and the capital Federal rate are subject to certain adjustments and “add-on” payments that can result in a higher IPPS payment.<sup>19</sup>

10. *Cf. id.* at 502.

11. Social Security Amendments of 1983, Pub. L. No. 98-21, 97 Stat. 139 Section 601 (codified as amended (Apr. 20, 1983) at 42 U.S.C. ch. 7). *See also infra* note 13 and accompanying text.

12. 68 Fed. Reg. 45,659 (2004).

13. *See* 42 C.F.R. § 412.2 (2004); *See generally* INTRODUCTION TO HEALTH SERVICES 135-41 (STEPHEN J. WILLIAMS SC.D & PAUL R. TORRENS, M.D., M.P.H. eds., 5th ed. 1999) (providing a general discussion of hospital reimbursement under the Medicare program).

14. *See* 42 C.F.R. § 412.1(a)(1) (2004).

15. *See id.*

16. *See* 42 C.F.R. § 412.2(c)-(f) (2004); 68 Fed. Reg. 45,348 (2004).

17. *See generally* 42 C.F.R. § 412.2(c) (2004); *see generally* 68 Fed. Reg. 45,479 (2004). Operating costs include those costs related to hospital operations such as labor, supplies, utilities, cost of ancillary services, etc. 42 C.F.R. § 412.2(c)(1)-(5) (2004).

18. *See* 42 C.F.R. § 412.2(d) (2004); 68 Fed. Reg. 45,348 (2004). Capital costs include those costs related to the capital financing of hospital operations such as interest or capital debt, lease expenses, etc. 42 C.F.R. § 413.130 (2004).

19. *See* 68 Fed. Reg. 45,348 (2004). Potential adjustments and “add-on” payments include: Medicare Dependent Hospitals, 42 C.F.R. § 412.108 (2004); Sole Community

The IPPS payment – the combination of the operating Federal rate, the capital Federal rate, and any potential adjustments/add-on payments – constitutes “payment in full” for all covered services rendered in connection with the discharge.<sup>20</sup> For most inpatient cases, increased costs generally do not result in any additional payment to the hospital. Rather, under IPPS hospitals receive a prospectively determined fixed payment rate, subject only to specific adjustments where applicable.

In general, hospitals incur a loss for cases where the hospital’s costs exceed the payment rate and a gain for cases where the payment rate exceeds the hospital’s costs.<sup>21</sup> In theory, the gains and losses should balance out over time. However, there may be individual cases where a hospital’s costs are so far in excess of the IPPS payment that it would be difficult for the hospital to make up the loss on future cases. In such “extraordinarily”<sup>22</sup> high cost cases, the IPPS provides an additional “outlier payment” to the hospital to help offset the loss.<sup>23</sup>

### *B. Outlier Payment Calculation Methodology*

For inpatient cases where the cost of providing care is extraordinarily high in relation to the IPPS payment, the IPPS provides for an additional outlier payment to hospitals.<sup>24</sup> In general terms, if the hospital’s costs for a case (determined by applying a “cost-to-charge” ratio to the hospital’s charges for the case) exceed the IPPS payment for the case plus a “fixed-loss threshold” dollar amount, hospitals receive an outlier payment in addition to the IPPS payment for the case.<sup>25</sup>

The fixed-loss threshold is a set dollar amount determined annually by

---

Hospitals, 42 C.F.R. § 412.92 (2004); Large Urban Add-on, 42 C.F.R. § 412.316 (2004); Disproportionate Share Hospital, 42 C.F.R. § 412.106 (2004); Indirect Medical Education, 42 C.F.R. § 412.105 (2004); New Medical Technology, 42 C.F.R. §§ 412.87, 412.88 (2004); and Outlier Payments, 42 C.F.R. § 412.80 (2004).

20. See 42 C.F.R. § 412.2(b) (2004).

21. See 42 C.F.R. § 412.1(a)(1) (2004).

22. The adverb “extraordinarily” is used throughout the statutes and regulations related to cost outliers to indicate a level of costs that is unusually high and which exceeds the fixed-loss cost threshold amount. See generally 42 C.F.R. § 412.84 (2004) (using the term “extraordinarily” in describing costs associated with outlier payments).

23. See 42 U.S.C. § 1395ww(d)(5) (2004); 42 C.F.R. § 412.80-86 (2004). Please note that Medicare also provides an Outpatient Outlier Payment. See 42 C.F.R. § 419.43 (2004).

24. See generally Medicare Program; Change in Methodology for Determining Payment for Extraordinarily High-Cost Cases (Cost Outliers) Under the Acute Care Hospital Inpatient and Long-Term Care Hospital Prospective Payment Systems, 68 Fed. Reg. 34,494, 34,495-97 (June 9, 2003) [hereinafter *Outlier Final Rule*] (to be codified at 42 C.F.R. pt. 412) (providing a detailed explanation of payment for outlier cases).

25. See 42 U.S.C. § 1395ww(d)(5) (2004); 42 C.F.R. § 412.80(a) (2004).

CMS based on hospitals' historical charge data.<sup>26</sup> In making this annual determination, CMS sets the fixed-loss threshold at an amount it projects will result in total outlier payment to all IPPS hospitals equaling a target percentage of total IPPS payments to all hospitals for a given year.<sup>27</sup> By statute, the target percentage must be at least five percent, but not more than six percent.<sup>28</sup>

Historically, CMS has set the target percentage at 5.1 percent.<sup>29</sup> The fixed-loss threshold is \$25,800 for fiscal year 2005.<sup>30</sup>

Appendix I provides an example of the outlier payment calculation methodology.<sup>31</sup> Where, as in this example, a hospital's costs exceed the base IPPS payment plus the fixed-loss threshold (adjusted to reflect area differences in operating and capital costs), the hospital receives an outlier payment. The outlier payment calculation methodology involves four steps.<sup>32</sup>

As you read the following, it may be helpful to reference Appendix I:

*Step One – Determine the Base Operating and Capital IPPS Payment Amounts*

The base IPPS payment for a given discharge consists of an operating payment and a capital payment.<sup>33</sup> The *operating* payment of the IPPS payment is determined as follows:

- a) The applicable labor related portion of the National Adjusted Operating Standardized Amount<sup>34</sup> (the "Standardized Amount") is

---

26. See Outlier Final Rule, *supra* note 24, at 34,496.

27. See Outlier Final Rule, *supra* note 24, at 34,496.

28. 42 U.S.C. § 1395ww(d)(5)(a)(iv).

29. Outlier Final Rule, *supra* note 24, at 34,496.

30. Medicare Program, Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates, Final Rule, 68 Fed. Reg. 45,477 (Aug. 1, 2004). This amount represents a decrease both from the \$31,000 threshold used in FY 2004 and from the \$35,085 originally proposed for FY 2005. 69 Fed. Reg. 28,376 (May 18, 2004).

31. This example is an adaptation of the IPPS outlier payment simulation provided in 68 Fed. Reg. 34,494, 34, 495-96 (June 9, 2003).

32. See generally Outlier Final Rule, *supra* note 24.

33. See 42 C.F.R. § 412.112 (2002); 68 Fed. Reg. 45,346, 45,348 (Aug. 1, 2003).

34. The labor related National Adjusted Operating Standardized Amount is an amount determined by CMS annually. In general, the labor related standardized amount is the same for all hospitals nationally. This amount can be found in Table 1A, 1B, or 1C of the IPPS Final Rule for the applicable fiscal year as published in the Federal Register. See 69 Fed. Reg. 78,526, 78,532 (Dec. 30, 2004) (FY 2005).

multiplied by the applicable Wage Index<sup>35</sup> for the hospital to adjust the labor related portion of the Standardized Amount to reflect local wage-related costs.<sup>36</sup>

b) The non-labor-related portion of the Standardized Amount<sup>37</sup> is added to the result of the wage adjusted labor-related Standardized Amount to determine the total Standardized Amount for the hospital.<sup>38</sup>

c) The total Standardized Amount is then multiplied by the relative weight for the Diagnosis-Related Group (DRG) applicable to the case to determine the unadjusted operating portion of the IPPS payment.<sup>39</sup> DRGs provide a method of classifying inpatient cases into groups based on a combination of factors including the principal diagnosis, the existence of certain complications and comorbidities, surgical procedures performed, and the patient's age, sex, and discharge status.<sup>40</sup> The relative weight is a number assigned by CMS to each DRG (the "DRG relative weight"). The DRG relative weight reflects the "estimated relative cost of hospital resources" required to care for a patient with the associated

35. In general the wage index applicable to a given hospital is determined based on the hospital's geographic location. However, in some cases, hospitals can be "reclassified" for purposes of the wage index. See 42 § C.F.R. 412.230 (2002) (describing criteria for an individual hospital seeking redesignation to another rural area or an urban area). The wage index for the applicable area can be found in Table 4A, 4B, or 4C of the IPPS Final Rule for the applicable fiscal year as published in the Federal Register. See 69 Fed. Reg. 78,526 (FY 2005).

36. See 42 U.S.C. § 1395ww(d)(3)(E) (2000) (requiring adjustment to the labor-related portion to account for area differences in hospital wage levels); 68 Fed. Reg. at 45,348.

37. Nonlabor-related Standardized Amount can be found in Table 1A, 1B or 1C of the IPPS Final Rule for the applicable fiscal year as published in the Federal Register. See 69 Fed. Reg. at 78,532 (FY 2005). This amount is not subject to any adjustment except for hospitals located in Hawaii and Alaska where the nonlabor-related standard amount receives a cost-of-living adjustment. See 42 U.S.C. § 1395ww(d)(5)(H) (authorizing and adjustment to take into account the unique circumstances of hospitals in Alaska and Hawaii).

38. See 42 C.F.R. § 412.64(a) (2002).

39. 42 C.F.R. § 412.63(w).

40. For a general discussion of the history, development and relevance of DRGs, see STEPHEN J. WILLIAMS & PAUL R. TORRENS, INTRODUCTION TO HEALTH SERVICES 135-41 (5th ed. 1999). At least in theory, cases with similar service intensity and resource consumption are grouped into the same DRG. See 68 Fed. Reg. at 45,351. For fiscal year 2004 there were a total of 514 separate DRGs. 68 Fed. Reg. at 45,350-51, 45,353. Each discharge is assigned to only one DRG, 42 C.F.R. § 412.60(c)(2) (2002), based upon the "principal diagnosis," 68 Fed. Reg. 45351, i.e., "the diagnosis established after study to be chiefly responsible for causing the patient's admission to the hospital." 42 C.F.R. § 412.60(c)(1) (2002). Some cases with the same principal diagnosis or procedure are subdivided into different DRGs based on the presence or absence of a complication or comorbidity. 68 Fed. Reg. at 45,352. The coding system used to assign the appropriate diagnosis and procedure codes for inpatient hospital cases is the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). 68 Fed. Reg. at 45,351.



diagnoses.<sup>41</sup>

d) The operating portion of the IPPS payment amount is then subjected to a series of adjustments,<sup>42</sup> potentially including adjustments for disproportionate share hospitals (DSH),<sup>43</sup> rural referral centers,<sup>44</sup> indirect medical education (IME)<sup>45</sup>, Medicare dependent hospitals (MDH)<sup>46</sup> and sole community hospitals (SCH)<sup>47</sup>. In the example provided in Appendix I, there are no such adjustments applicable.

Once the operating payment of the IPPS payment is determined, the *capital* payment of the IPPS payment is then calculated as follows:

a) The Capital Standard Federal Payment Rate<sup>48</sup> is multiplied by the DRG relative weight to determine the capital portion of the IPPS payment prior to geographic adjustment.<sup>49</sup>

b) The unadjusted capital portion of the IPPS payment is then multiplied by the Capital Geographic Adjustment Factor<sup>50</sup> to arrive at the geographically adjusted capital portion of the IPPS payment.

c) For hospitals located in large urban areas<sup>51</sup>, the geographically adjusted capital payment of the IPPS payment is then subject to the large urban add-on adjustment.<sup>52</sup> This adjustment is not applicable to the

41. See 42 C.F.R. § 412.60(b) (2002).

42. See generally 42 C.F.R. § 412.90 (2002) (describing various adjustments to the prospective payment rate for inpatient operating costs).

43. See 42 C.F.R. § 412.106 (2002).

44. See 42 C.F.R. § 412.96 (2002).

45. See 42 C.F.R. § 412.105 (2002).

46. See 42 C.F.R. § 412.108 (2002).

47. See 42 C.F.R. § 412.92 (2002).

48. The Capital Standard Federal Payment Rate can be found in Table 1D of the IPPS Final Rule for the applicable fiscal year as published in the Federal Register. See 69 Fed. Reg. 78,532 (FY 2002).

49. See 42 C.F.R. § 412.312(a) (2002).

50. The Capital Geographic Adjustment Factor (GAF) is a geographic adjustment factor that is applied to take into account geographic variation in costs. 42 C.F.R. § 412.312(b)(2). Similar to the nonlabor-related portion of the Standardized Amount, the unadjusted capital payment of the IPPS payment for hospitals located in Hawaii and Alaska is subject to a cost-of-living adjustment. 42 C.F.R. § 412.312(b)(2)(iii). The Capital GAF for the applicable area can be found in Table 4A, 4B, or 4C of the IPPS Final Rule for the applicable fiscal year as published in the Federal Register. See 69 Fed. Reg. 78,526 (FY 2005).

51. See 42 C.F.R. § 412.63(c)(6) (defining "large urban area").

52. The large urban add-on is an adjustment made for hospital located in a large urban area to reflect the higher costs incurred by hospital located in those areas. 42 C.F.R. § 412.312(b)(2)(ii).

hospital in Appendix I because Appleton, Wisconsin is not considered a “large urban area.”

d) The geographically adjusted capital portion of the IPPS payment is then potentially subject to adjustments for DSH<sup>53</sup> and IME<sup>54</sup>. In the example provided in Appendix I, the hospital does not receive any DSH or IME adjustments.

Once the capital portion of the IPPS payment is calculated, it is added to the operating portion of the IPPS payment to determine the total base IPPS payment.

### Step Two – Adjust Charges to Costs

The hospital’s operating costs for the case are determined by multiplying total billed charges<sup>55</sup> by the hospital’s *operating* cost-to-charge ratio.<sup>56</sup> Likewise, the hospital’s capital costs are determined by multiplying total billed charges by the hospital’s *capital* cost-to-charge ratio.<sup>57</sup> In general terms, the use of cost-to-charge ratios provides a method of estimating costs for a given discharge based upon the historic difference between a hospital’s costs and its charges. Hospital-specific operating and capital cost-to-charge ratios are computed annually based upon the most recent settled (whether final settled or tentative settled) Medicare cost report for that hospital and hospital charge data for the same cost report period.<sup>58</sup>

This step results in separate operating and capital costs to be used throughout the remaining steps of the calculation.

### Step Three – Calculate Outlier Thresholds

In this step, separate operating and capital outlier thresholds are calculated. The resulting operating and capital outlier thresholds represent

53. 42 C.F.R. § 412.312(b)(3).

54. 42 C.F.R. § 412.312(b)(4).

55. Only covered charges are contemplated in determining outlier payments. *See* 42 C.F.R. § 412.84(j) (2002).

56. 42 C.F.R. § 412.84(g) (2002).

57. *Id.*

58. 42 U.S.C. § 412.84(h) (2002). Cost-to-charge ratios are determined using the most recent final or tentative settled cost report for each hospital. Outlier Final Rule, *supra* note 24, at 34,495. Total allowable inpatient Medicare costs in the cost report are determined by the hospital using the departmental method of cost apportionment. *See* Medicare Provider Reimbursement Manual §§ 2200.1, 2200.3 (stating that any hospital, regardless of size must use the departmental method of cost apportionment). Total allowable inpatient Medicare charges are accumulated through the Provider Statistical and Reimbursement Report (PS&R). *See* Outlier Final Rule, *supra* note 24, at 34,496.

the amounts that the hospital's cost must exceed in order for the case to qualify for an outlier payment.

The operating outlier threshold is calculated as follows:

a) The operating portion of the fixed loss threshold is determined by multiplying the fixed loss threshold<sup>59</sup> by the ratio of the operating cost-to-charge ratio to the sum of the operating and capital cost-to-charge ratios (i.e., operating costs as a percentage of total costs).<sup>60</sup>

b) The operating portion of the fixed loss threshold is then multiplied by the percentage of operating costs attributable to labor-related costs to arrive at the portion of the operating fixed loss threshold attributable to labor-related costs.<sup>61</sup>

c) The portion of the operating fixed loss threshold attributable to labor-related costs is then multiplied by the applicable Wage Index<sup>62</sup> for the hospital to adjust the labor related portion of the Standardized Amount to reflect local wage-related costs.<sup>63</sup>

d) The operating portion of the fixed loss threshold is then multiplied by the percentage of operating costs attributable to nonlabor-related costs to determine the nonlabor portion of the fixed loss threshold.<sup>64</sup>

e) The nonlabor portion of the fixed loss threshold is then added to the wage adjusted portion of the operating fixed loss threshold attributable to labor-related costs (as determined in Step Three, subpart (b) above) to

---

59. See *supra* notes 27-31 and accompanying text.

60. 68 Fed. Reg. 34,495.

61. *Id.* This step is necessary because, as you will recall, the nonlabor-related portion is not subject to any adjustment, unlike the labor-related portion which is subject to adjustments for differences in local wage-related costs. See *supra* notes 35-38 and accompanying text.

62. The wage index for the applicable area can be found in Table 4A, 4B, or 4C of the IPPS Final Rule for the applicable fiscal year as published in the Federal Register. For FY 2005 see 69 Fed. Reg. 78619. This is the same Wage Index figure used in Step One of the calculation.

63. See 68 Fed. Reg. 34,495. See also 42 U.S.C. § 1395ww(d)(3)(E) (requiring adjustment to the labor-related portion to account for area differences in hospital wage levels).

64. Similar to the determination of the operating payment of the IPPS payment, the determination of the operating portion of the fixed loss threshold is divided into a labor-related and non-labor related portion. See 68 Fed. Reg. 34,495. See also *supra* notes 35-40 and accompanying text.

arrive at the total adjusted operating fixed loss threshold.<sup>65</sup>

f) The total adjusted operating fixed loss threshold is then added to the operating portion of the IPPS payment (as determined in Step One) to determine the operating outlier threshold.<sup>66</sup>

The capital outlier threshold is calculated as follows:

a) The capital portion of the fixed loss threshold is determined by multiplying the fixed loss threshold<sup>67</sup> by the ratio of the capital cost-to-charge ratio to the sum of the operating and capital cost-to-charge ratios (i.e., capital costs as a percentage of total costs).<sup>68</sup>

b) The capital portion of the fixed loss threshold is then multiplied by the Capital Geographic Adjustment Factor<sup>69</sup> to arrive at the geographically adjusted capital portion of the fixed loss threshold.<sup>70</sup>

c) Similar to the geographically adjusted capital portion of the IPPS payment,<sup>71</sup> the geographically adjusted capital portion of the fixed loss threshold is subject to the large urban add-on adjustment, if applicable.<sup>72</sup>

d) The capital portion of the base IPPS payment (as determined in Step One) is added to the geographically adjusted capital portion of the fixed loss threshold IPPS payment to determine the capital outlier threshold.<sup>73</sup>

#### Step Four – Determine the Outlier Payment

The total outlier payment potentially consists of an operating outlier payment and a capital outlier payment.<sup>74</sup> Where operating costs exceed the operating outlier threshold, as in Appendix I, an outlier payment will result.<sup>75</sup> The excess of operating costs over the operating outlier threshold

---

65. See 68 Fed. Reg. 34,495.

66. *Id.*

67. See *supra* notes 27-31 and accompanying text.

68. 68 Fed. Reg. 34,495.

69. Similar to the determination of the capital payment of the IPPS payment, the Capital Geographic Adjustment Factor is applied. See *supra* note 51 and accompanying text.

70. 68 Fed. Reg. 34,495.

71. See *supra* notes 52-53 and accompanying text.

72. 68 Fed. Reg. 34,495.

73. *Id.*

74. See 42 C.F.R. § 412.84(k) (2002).

75. 68 Fed. Reg. 34,495.

is multiplied by the Marginal Cost Factor (90 percent for burn DRGs<sup>76</sup> and 80 percent<sup>77</sup> for all other DRGs) to arrive at the operating outlier payment.<sup>78</sup>

Similarly, where capital costs exceed the capital outlier threshold, the hospital will receive a capital outlier payment. The excess of capital costs over the capital outlier threshold is multiplied by the Marginal Cost Factor to arrive at the capital outlier payment. Ultimately, the operating outlier payment and the capital outlier payment are both added to the base IPPS payment to determine the total payment made to the hospital for the discharge.

In the Appendix II example, the outlier payment calculation methodology is performed in the same manner as in Appendix I; however, in Appendix II, the hospital's billed charges are only \$50,000 versus the \$105,000 billed charges in Appendix I. Consequently, the hospital's costs (determined by applying the hospital's cost-to-charge ratios to billed charges) do not exceed the outlier threshold IPPS payment and, as a result, the hospital would not receive an outlier payment. By comparing the result in Appendix I to that in Appendix II, one can see that the likelihood of outlier payment (i.e., the likelihood of exceeding the operating and capital outlier thresholds) is greatest where billed charges are high. Accordingly, by increasing its charges, a hospital can increase its likelihood of receiving outlier payments. It becomes clear that the ability of a hospital to "inflate" its charges can have a profound effect upon the resulting total payment made to the hospital for a given discharge under the IPPS.

By engaging in the practice of inflating charges for inpatient services in a systematic manner, a hospital could drastically improve Medicare revenues without necessarily incurring a corresponding increase in cost of the actual services provided. For example, based on the figures presented in Appendix I, Hospital A submits billed charges of \$105,000 in 2005 and receives an outlier payment of almost \$20,000. Comparatively, as in Appendix II, another hospital in the same town, having the same cost-to-charge ratios, submits billed charges of \$50,000 for the same services and receives no outlier payment.

An astute observer would pose the question: "wouldn't the practice of inflating charges have the effect of decreasing the cost-to-charge ratio so as to render the opportunity to realize an outlier payment less likely over time?" Stated differently, as charges increase at a rate much faster than costs over an extended period of time, the cost-to-charge ratio should decrease accordingly.

---

76. 42 C.F.R. § 412.84(l) (2002).

77. 42 C.F.R. § 412.84(k) (2002).

78. *Id.*

It is true that a pattern of submitting charges grossly in excess of costs over an extended period of time would have the effect of decreasing the cost-to-charge ratios over time. As shown in Appendix III, where a hospital's cost-to-charge ratios are significantly lower there is no outlier payment for the same case with the same billed charges as demonstrated in Appendix I.

This is a fair result when we consider the fact that outlier payments were intended to 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.<sup>79</sup> Thus, if charges do not truly reflect the cost of care, then outlier payment is not necessarily warranted. So, how is it, then, that hospitals were allegedly able to achieve higher outlier payments simply by increasing their charges?

As mentioned previously, cost-to-charge ratios are computed annually for each hospital based upon the most recent settled cost report for that hospital and charge data collected for the same period.<sup>80</sup> While the use of hospital-specific cost-to-charge ratios is considered "essential to ensure that outlier payments are made only for cases that have extraordinarily high costs, and not merely high charges,"<sup>81</sup> [emphasis added] it has become apparent that there were certain vulnerabilities in the outlier payment calculation methodology that may have allowed hospitals to take advantage of or "game" the system in an effort to maximize reimbursement for outlier cases.<sup>82</sup>

Historically, one key vulnerability in the outlier payment calculation methodology was reliance on the most recently final settled cost report in determining cost-to-charge ratios.<sup>83</sup> As a general matter, the cost report, which hospitals are required to submit to Medicare Fiscal Intermediaries ("Intermediaries") within 150 days of the end of the fiscal year, is a cost

79. See Outlier Final Rule, *supra* note 24, at 34,496.

80. 42 C.F.R. § 412.80(h) (2000). Prior to September 30, 1988, costs were determined using a nationwide cost-to-charge ratio of 60 percent rather than using hospital-specific cost-to-charge ratios. See Medicare Program; Changes to the Inpatient Hospital Prospective Payment System and Fiscal Year 1989 Rates, 53 Fed. Reg. 38,503 (Sept. 30, 1988) (to be codified at 42 C.F.R. pts. 405, 412, 413, and 489).

81. Medicare Program; Changes to the Inpatient Hospital Prospective Payment System and Fiscal Year 1989 Rates, 53 Fed. Reg. 38,503 (Sept. 30, 1988) (to be codified at 42 C.F.R. pts. 405, 412, 413, and 489).

82. See Outlier Final Rule, *supra* note 24, at 34,496; Department of Health and Human Services, Program Memorandum Intermediaries, Transmittal A-02-122, Dec. 3, 2002, available at [http://www.cms.hhs.gov/manuals/pm\\_trans/a02122.pdf](http://www.cms.hhs.gov/manuals/pm_trans/a02122.pdf) (last visited Apr. 21, 2005); CMS Announces Steps to Stop Questionable Billing Practices, HEALTH CARE DAILY REPORT, (Bureau of National Affairs, Inc.), Dec. 4, 2002.

83. See Outlier Final Rule, *supra* note 24, at 34,497-99.

allocation of total costs for revenue producing departments.<sup>84</sup> The resulting departmental costs are compared to total charges for each revenue producing department to create cost-to-charge ratios.<sup>85</sup> Historically, the cost-to-charge ratio from the most recent final settled cost report has been used to determine operating and capital costs for purposes of the outlier payment calculation methodology.<sup>86</sup>

The problem with basing the cost-to-charge ratios on final settled cost reports is that, in some cases, the most recent final settled cost report could be up to three years old (thirty-two months) or older at the time it is applied to current charges for the purpose of determining a current outlier payment.<sup>87</sup> This time lag in cost reporting has the effect of delaying the downward adjustment to the cost-to-charge ratio that would otherwise result where a hospital increases its charges at a rate faster than costs. Where using the hospital's *actual* cost-to-charge ratio would result in lower estimated costs, the time-lag in cost reporting allows the hospital to receive an outlier payment where it might not have otherwise.<sup>88</sup>

The time-lag in cost reporting allowed hospitals to reap the benefits of submitting excessive charges without experiencing the offset in outlier payments that would result from a significantly lower cost-to-charge ratio. But even if the time-lag in cost reporting did allow hospitals to achieve higher outlier payments, wouldn't cost-to-charge ratios decline over time as cost reports would eventually indicate a trend of charges rising at a rate faster than costs?

This brings us to the other key vulnerability in the outlier payment calculation methodology. In the past, where a hospital's operating or capital cost-to-charge ratios fell outside "reasonable" parameters, as set forth by CMS,<sup>89</sup> a statewide average cost-to-charge ratio could be substituted.<sup>90</sup> CMS equates reasonable parameters to three standard deviations higher or lower than the mean of cost-to-charge ratios for all hospitals nationwide.<sup>91</sup> Without question, the statewide cost-to-charge ratio

84. See STEPHEN H. BERGER, *FUNDAMENTALS OF HEALTH CARE FINANCIAL MANAGEMENT: A PRACTICAL GUIDE TO FISCAL ISSUES AND ACTIVITIES* 112-16 (2d ed. 2002).

85. *Id.* at 116-17.

86. See *supra* notes 64-67 and accompanying text.

87. See Outlier Final Rule, *supra* note 24, at 34,497.

88. See *id.*

89. For fiscal year 2003 the statewide average could apply where operating and capital cost-to-charge ratios fell below 0.194 and 0.012 respectively. Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2003 Rates, 67 Fed. Reg. 50,125 (Aug. 1, 2002) (to be codified at 42 C.F.R. pts. 405, 412, 413, and 485).

90. 42 C.F.R. § 412.84(h) (2002).

91. Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2003 Rates, 67 Fed. Reg. 50,263 (Aug. 1, 2002) (to be codified at 42 C.F.R.

would be much higher than any cost-to-charge ratio falling below these parameters.<sup>92</sup> Thus, where hospitals continued to increase charges at a rate faster than cost increases over an extended period of time, they could avoid the negative ramifications of declining cost-to-charge ratios by increasing charges at such an extreme rate as to fall below reasonable parameters, triggering substitution of the higher statewide average cost-to-charge ratio.<sup>93</sup>

To ascertain the extent of this phenomenon, CMS issued a Program Memorandum requesting Intermediaries to identify hospitals receiving the statewide average operating and capital cost-to-charge ratios.<sup>94</sup> In total, CMS identified forty-three hospitals assigned to use the statewide average operating cost-to-charge ratio and fourteen hospitals assigned to use the statewide average capital cost-to-charge ratio. The average actual operating cost-to-charge ratio for the forty-three hospitals was 0.164 compared to a 0.3425 statewide average. The average actual capital cost-to-charge ratio for the fourteen hospitals was 0.008 compared to a 0.035 statewide average. Interestingly, three hospitals were found on both lists.<sup>95</sup>

Similar to the outcome of the outlier payment calculation in Appendix I, the application of the statewide average cost-to-charge ratios allowed hospitals to realize a dual advantage from submitting high charges in that: (1) higher charges would be used as a basis for determining operating and capital costs; and (2) the hospital could avoid the cumulative effects of declining cost-to-charge ratios. As with the time-lag in cost reports, we are presented with another vulnerability which offers hospitals the opportunity to achieve higher outlier payments that are not supported by a real increase in the cost of care.

### C. Recent Changes to the Outlier Regulations

As the Centers for Medicare and Medicaid Services (CMS) observed in promulgating the revised final rule on the outlier payment calculation methodology: "if hospitals' charges are not sufficiently comparable in magnitude to their costs, the legislative purpose underlying the outlier regulations is thwarted."<sup>96</sup> In the years leading up to the March 5, 2003, proposed rule on outlier payments,<sup>97</sup> CMS began to notice evidence of just

---

pts. 405, 412, 413, and 485).

92. See *id.* (listing statewide cost-to-charge ratios).

93. Outlier Final Rule, *supra* note 24, at 34,499.

94. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Program Memorandum Transmittal A-02-122, Dec. 3, 2002, available at [http://www.cms.hhs.gov/manuals/pm\\_trans/a02122.pdf](http://www.cms.hhs.gov/manuals/pm_trans/a02122.pdf) (last visited Apr. 21, 2005).

95. Outlier Final Rule, *supra* note 24, at 34,499-500.

96. Outlier Final Rule, *supra* note 24, at 34,496.

97. See Medicare Program; Proposed Change in Methodology for Determining Payment



such an effect.<sup>98</sup> CMS increased the fixed-loss threshold by eighty percent between fiscal years 1997 and 2001.<sup>99</sup> This upward movement continued from fiscal year 2001 through fiscal year 2003 with an increase of another ninety-one percent.<sup>100</sup> Since determination of the fixed-loss threshold depends upon hospitals' historical charge data, the increases in the fixed-loss threshold provides some evidence that hospitals had significantly increased their charges during the same time period. But it is not clear that significant increases in the fixed-loss threshold were, as CMS phrased it, caused by hospitals "inappropriately maximizing their outlier payments."<sup>101</sup>

Regardless of whether or not hospitals had in fact "inappropriately" increased charges in an attempt to maximize their outlier payments, the increased fixed-loss threshold suggests that Congress's intent may have been thwarted somewhat in the sense that, where charges bear little or no relationship to costs, an outlier payment may result where the true costs of care are not, in fact, "extraordinarily high." Additionally, and perhaps more importantly, a significantly higher fixed-loss threshold could have the result of reducing outlier payments at hospitals where charges are not grossly inflated. In such a case, even though an outlier payment might otherwise have been warranted, hospital charges could potentially not be high enough to exceed the artificially inflated fixed-loss threshold, thus failing to trigger an outlier payment where, in fact, an outlier payment would have been appropriate. Indeed, as former CMS Administrator Thomas A. Scully ("Scully") stated in announcing the proposed regulations, CMS hoped to "provide relief to the many hospitals that have been denied legitimate payment for complex patients due to the inappropriate behavior of a small group of other hospitals."<sup>102</sup>

Another factor leading up to the revised final rule on the outlier payment calculation methodology was that outlier payments to hospitals had placed a

---

for Extraordinarily High-Cost Cases (Cost Outliers) Under the Acute Care Hospital Inpatient Prospective Payment System, 68 Fed. Reg. 10,420-21 (Mar. 5, 2003) (to be codified at 42 C.F.R. pt. 412).

98. Outlier Final Rule, *supra* note 24, at 34,496.

99. *Id.*

100. *Id.*

101. *See* Outlier Final Rule, *supra* note 24, at 34,496. In determining the outlier threshold, CMS is required to apply an offset to the average standardized amounts of payment equal to the projected outlier payments as a percentage of total DRG payments. *See generally* 42 U.S.C. § 1395ww(d)(2)(E) (2000). While this offset has historically been projected to be 5.1 percent of total DRG payment, the percentage has increased consistently from 1997 through 2002. Outlier Final Rule, *supra* note 24, at 34,496.

102. Medicare News Press Release, Centers for Medicare and Medicaid Services, CMS Takes Steps to Crack Down on Inappropriate Hospital Outlier Claims, Feb. 28, 2003, at <http://cms.hhs.gov/media/press/release.asp?Counter=715> (last visited Apr. 21, 2005).

significant drain on Medicare funds.<sup>103</sup> By 1998, outlier payments had exceeded CMS's target by approximately \$1 billion for the fiscal year. This figure approached \$2 billion by fiscal year 2001 and reached \$2.5 billion by fiscal year 2002.<sup>104</sup> Scully acknowledged the disconcerting nature of this upward trend in outlier payments by stating "[O]bviously this system is badly broken," but asserted that "CMS understands the gaming that led to this unintended spending."<sup>105</sup>

Accordingly, to prevent what it perceived as a thwarting of Congress's intent and to put an end to "inappropriate" payments to hospitals,<sup>106</sup> CMS issued a revised final rule on the outlier payment calculation methodology in 2003.<sup>107</sup> The rule sought to eliminate key vulnerabilities in the outlier payment calculation methodology by: (1) requiring the use of more timely cost-to-charge ratios for purposes of calculating outlier payments under the IPPS; (2) eliminating the use of higher statewide average cost-to-charge ratios for hospitals with specified characteristics; and (3) allowing reconciliation of outlier payments through the cost report settlement process.<sup>108</sup>

### 1. Use of More Timely Cost-to-Charge Ratios

Beginning October 1, 2003, the operating and capital cost-to-charge ratios used to calculate outlier payments are "based on either the most recent final settled cost report or the most recent tentative settled cost report, whichever is from the latest cost reporting period."<sup>109</sup> The tentative settlement is a more limited review that is not nearly as extensive as final settlement. Since it can take a period of twelve to twenty-four months, or

---

103. See Outlier Final Rule, *supra* note 24, at 34,496 (referencing a table showing the extent of outlier payments in excess of a target of 5.1% of total DRG payments).

104. *Id.*

105. Medicare News Press Release, Centers for Medicare and Medicaid Services, *CMS Takes Steps to Crack Down on Inappropriate Hospital Outlier Claims*, Feb. 28, 2003, at <http://cms.hhs.gov/media/press/release.asp?Counter=715> (last visited Apr. 21, 2005).

106. Medicare News Press Release, Centers for Medicare and Medicaid Services, *CMS Issues Final Rule for Outlier Payments to Hospitals*, June 5, 2003, at <http://cms.hhs.gov/media/press/release.asp?Counter=749> (last visited Apr. 21, 2005). CMS noted that outlier payments to hospitals were in some cases as high as "\$3 million per day," and "[costing] taxpayers one to two billion dollars per year in inappropriate overpayments for each of the last four years."

107. *Id.*

108. See Outlier Final Rule, *supra* note 24, at 34,497-505; see also Medicare News Press Release, Centers for Medicare and Medicaid Services, *CMS Takes Steps to Crack Down on Inappropriate Hospital Outlier Claims*, February 28, 2003, at <http://cms.hhs.gov/media/press/release.asp?Counter=715> (last visited Apr. 21, 2005).

109. 42 C.F.R. § 412.84(i)(2) (2003); See also Outlier Final Rule, *supra* note 24, at 34,497.

longer, after the tentative cost report is settled to produce a settled cost report, using the tentative settled cost report allows the Medicare Intermediaries to reduce the cost-to-charge ratio time-lag by, in some cases, two or more years.<sup>110</sup>

Even considering the effect of using the most recent tentative settled cost report in reducing the time-lag, there generally remains a period of one to two years between the time when a claim is processed and tentative settlement of the cost report. During this period, costs would continue to be overestimated where a hospital's rate of increase in charges is higher than its rate of increase in costs.<sup>111</sup> To further diminish the adverse effects of the reporting time-lag, the revised outlier regulations allow CMS to "specify an alternative to the ratios otherwise applicable."<sup>112</sup> Thus, in the event that data more recent than the most recent tentative settled cost report indicates that, relative to other hospitals, a hospital's charges have been increasing at an excessive rate, CMS could order the hospital to adjust its cost-to-charge ratios accordingly.<sup>113</sup>

## 2. Elimination of the Statewide Average Cost-to-Charge Ratio Floor

Beginning August 8, 2003, CMS eliminated the use of statewide average cost-to-charge ratios in instances where either a hospital's operating *or* capital cost-to-charge ratio falls below the "reasonable parameter," no matter how low it falls.<sup>114</sup> This provision effectively eliminates the opportunity to trigger use of the statewide average cost-to-charge ratio by increasing charges at a rate faster than costs. Hospital may no longer avoid the negative ramifications of declining cost-to-charge ratios by increasing charges at such an extreme rate as to fall outside of reasonable parameters.<sup>115</sup>

It should be noted that use of the statewide average cost-to-charge ratio remains available where a hospital's cost-to-charge ratio exceeds reasonable parameters; i.e. where cost-to charge ratios are higher than reasonable

---

110. Outlier Final Rule, *supra* note 24, at 34,497.

111. *Id.*

112. 42 C.F.R. § 412.84 (2003); *see also* Outlier Final Rule, *supra* note 24, at 34,498.

113. Outlier Final Rule, *supra* note 24, at 34,498. Additionally, to provide hospitals with some recourse should they find the ratios to be inaccurate, hospitals can contact fiscal intermediaries to request adjustment to the cost-to-charge ratio. 42 C.F.R. § 412.84 (i)(1)(2003).

114. *See* 42 C.F.R. § 412.84(h) (2003). Note that the statewide average would still apply to hospitals where the operating or capital cost-to-charge ratios exceed three standard deviations above the national mean. 42 C.F.R. § 412.84(i)(3)(ii) (2003). Such a situation could occur as a result of faulty data and thus the resulting ratios should not be used. Outlier Final Rule, *supra* note 24, at 34,500.

115. *See* Outlier Final Rule, *supra* note 24, at 34,496.

parameters.<sup>116</sup> One could argue that this provision may have the effect of unfairly penalizing a hospital with an accurate, but high cost-to-charge ratio (such as a hospital that strives to keep its charges low relative to its costs).

### 3. Reconciliation of Outlier Payments Through Settled Cost Reports

In promulgating the final rule, CMS recognized that reducing the time-lag in cost reporting and eliminating the use of statewide average cost-to-charge ratios would not be sufficient to prevent all possible opportunities to manipulate the system in an effort to maximize outlier payments.<sup>117</sup> It would still be entirely possible that the cost-to-charge ratio from the tentative settled cost report, for example, could still overestimate costs in instances where a hospital consistently increases its charges at a higher rate than the increase in the hospital's costs.

To address this possibility, the revised outlier regulations provide for a "reconciliation of outlier payments . . . based on operating and capital cost-to-charge ratios calculated based on a ratio of costs to charges computed from the [final settled cost report] coinciding with the discharge."<sup>118</sup> Thus, where the cost-to-charge ratios from the final settled cost report for a year turn out to be lower than those used in calculating the outlier payments initially (e.g. the cost-to-charge ratios from the tentatively settled cost report), CMS now has the authority to recalculate individual claims to recoup excess outlier payments.<sup>119</sup>

While this provision ensures that, upon reconciliation, the *actual* cost-to-charge ratio is applied to outlier payment calculation for the time period in which the discharge occurred, it does not account for the fact that the hospital would have the use of the overstated outlier payments during the time period between the original outlier payment and the time of reconciliation. To eliminate the possibility of obtaining any "time value of money" benefit from overstated outlier payments, the revised regulations provide that at the time of reconciliation outlier payments "may be adjusted to account for the time value of any underpayments or overpayments."<sup>120</sup>

While CMS asserted that the revised outlier payment calculation methodology would "benefit a great majority of hospitals that bill Medicare fairly," there remained the issue of allegedly "unbelievably abusive billing

---

116. See Outlier Final Rule, *supra* note 24, at 34,501.

117. *Id.* at 34,501.

118. 42 C.F.R. § 412.84(i)(4) (2002); see also Outlier Final Rule, *supra* note 24, at 34,501.

119. See Outlier Final Rule, *supra* note 24, at 34,500.

120. Payment for Outlier Cases, 42 C.F.R. § 412.84(m) (2002); Outlier Final Rule, *supra* note 24, at 34,501.

by a few hospitals.”<sup>121</sup> As early as December 2002, CMS had indicated its intent to scrutinize the billing practices of hospitals receiving questionable outlier payments.<sup>122</sup>

CMS had announced specific auditing standards for Intermediaries to identify hospitals that: (1) had outlier payments of eighty percent or more of their operating and capital DRG payments for discharges in the months of October and November 2002; or (2) had both estimated outlier payment greater than twenty percent of their operating and capital DRG payments for discharges in the months of October and November 2002, and had an increase in average charges per case of greater than or equal to twenty percent between 2000 and 2001 and 2001 and 2002.<sup>123</sup>

By the time the heightened auditing standards were announced, CMS had already identified a number of hospitals that had received higher than usual outlier payment in previous years – most recognizably twenty-four Tenet Healthcare Corporation facilities.<sup>124</sup> Tenet, which received \$763 million in outlier payments in fiscal year 2002 and an estimated \$750 million in fiscal year 2003,<sup>125</sup> would end up serving as a focal point in the mounting debate over whether such hospitals were simply practicing prudent financial management, or were actually engaged in unethical, or even illegal, conduct.

### III. TENET: AN OUTLIER EXPERIENCE

In a September 5, 2003, letter to Trevor Fetter, Acting Chief Executive Officer and President of Tenet Healthcare Corporation (“Tenet”), Senator Charles “Chuck” Grassley proclaimed that “[i]n the annals of corporate fraud, Tenet . . . more than holds its own among the worst corporate wrongdoers” and concluded that “Tenet appears to be . . . ethically and morally bankrupt.”<sup>126</sup> The letter announced a U.S. Senate Committee on

---

121. Medicare News Press Release, Centers for Medicare and Medicaid Services, CMS issues Final Rule for Outlier Payments to Hospitals (June 5, 2003), at <http://cms.hhs.gov/media/press/release.asp?Counter=749> (last visited Apr. 21, 2005).

122. Program Memorandum from Department of Health and Human Services Transmittal A-02-126, Centers for Medicare & Medicaid Services, *Instructions Regarding Outlier Payment*, (Dec. 20, 2002), available at [http://www.cms.hhs.gov/manuals/pm\\_trans/A02126.pdf](http://www.cms.hhs.gov/manuals/pm_trans/A02126.pdf) (last visited Apr. 21, 2005).

123. *Id.*

124. *CMS Announces Steps to Stop Questionable Hospital Billing Practices*, HEALTH CARE DAILY REPORT, (Bureau of National Affairs, Inc.), Dec. 4, 2002.

125. *Id.*

126. Letter from Senator Charles E. Grassley, Chairman, United States Senate Committee on Finance, to Trevor Fetter, Acting Chief Executive Officer and President, Tenet Healthcare Corporation, (Sept. 5, 2003), available at <http://www.finance.senate.gov/press/Gpress/2003/prg090803.pdf> (last visited Apr. 21, 2005). Senator Grassley’s comments

Finance investigation into Tenet's use of federal tax dollars. Senator Grassley noted in his letter an ongoing investigation by federal prosecutors seeking to determine whether Tenet should be excluded from participation in government health care programs. He also mentioned multiple parallel investigations into a number of Tenet corporate practices specifically identifying Department of Justice (DOJ) and Securities and Exchange Commission (SEC) investigations to determine whether Tenet may have improperly manipulated outlier payments to achieve additional reimbursement from Medicare.

Although investigations into the outlier payment issue developed in the wake of other headline-grabbing inquiries into Tenet fraud and abuse allegations,<sup>127</sup> as well as a massive \$54 million settlement over alleged Medicare billing fraud for cardiac patients,<sup>128</sup> the alleged manipulation of outlier payments is of particular interest because there is a significant question as to whether Tenet really violated any federal law.<sup>129</sup> Even former CMS Administrator Scully acknowledged the ambiguous nature of the outlier controversy, stating that "[t]here's obviously a hefty debate going on in the government right now about whether what Tenet did was legal or not."<sup>130</sup>

Concerns over excessive outlier payments at Tenet became public on October 28, 2002, when the investment bank UBS Warburg issued a report downgrading Tenet from "hold" to "reduce" in response to reports that the ratio of Tenet's outlier payments to its base inpatient payments was

---

relate to number of events in Tenet's past dating back to its predecessor, National Medical Enterprises (NME). He notes that the company was plagued with scandal in the early nineties leading up to a record \$379 million dollar settlement with the government.

127. See Caroline Said, *U.S. Sues Tenet Over Medicare Filings; Hospital Firm Accused of Overbilling in '90s*, S. F. CHRON., Jan. 10, 2003, at A1 (discussing suit alleging submission of fraudulent Medicare claims); *Hospitals & Health Systems-Tenet: U.S. Attorney Subpoenas Records from Seven Hospitals*, American Health Line, Jul. 16, 2003 (discussing U.S. Attorney investigation into allegedly illegal physician relocation agreements in violation of the federal antikickback statute).

128. See Kurt Eichenwald, *Operating Profits: Mining Medicare; How One Hospital Benefited from Questionable Surgery*, N.Y. TIMES, Aug. 12, 2003, at A1 (discussing Tenet's settlement related to allegations that physicians at one of Tenet's facilities, Redding Medical Center, in Redding, California, performed medically unnecessary procedures and then falsely billed Medicare and other government health programs for the procedures). See also Vince Galloro, *Not Quite Over Yet; Tenet Agrees to \$54 Million Fine, But Lawsuits Still Linger*, MODERN HEALTHCARE, Aug. 11, 2003.

129. See generally *Hospitals Outlier Payment Probe Seen Questionable, But Still Likely to Create New Audit Exposure*, HEALTH CARE DAILY REPORT, (Bureau of National Affairs, Inc.), Jan. 24, 2003; Mark R. Fitzgerald, *Hospital Outlier Payment Issues and Current Investigations* (American Health Lawyers Association), Mar. 19, 2003, available at <http://www.ppsv.com/issues/outlier.htm> (last visited Apr. 21, 2005).

130. Said, *supra* note 1.

expected to rise from 7.71% in fiscal year 2000 to a projected 23.5% in fiscal year 2003.<sup>131</sup> These figures are particularly alarming when compared to a less than 5% outlier ratio for all hospitals in the same period.<sup>132</sup> Apparently, Tenet's dependence upon outlier payments raised questions as to the financial position of Tenet in the minds of analysts at UBS Warburg.<sup>133</sup>

On the same day, Tenet issued a press release regarding Medicare outliers.<sup>134</sup> Tenet's earnings estimate for fiscal year 2003 included a projection that its Medicare outlier payments would comprise approximately 5% of its total projected net patient revenues.<sup>135</sup> Most likely already aware of the implications of its statement and the UBS Warburg report, Tenet began defending itself in the press release by citing the "extremely complex" nature of the Medicare outlier payment calculation and how it is impacted by "not only charge structures, but also acuity levels, the timing of cost report settlements, specific circumstances at individual hospitals, and the many other factors."<sup>136</sup>

Tenet further defended itself by stating that "its level of outlier reimbursement is impacted by its emphasis on large urban hospitals, the large number of teaching hospitals in its portfolio, and its strategy to develop high-acuity services at many of its facilities."<sup>137</sup> Essentially, Tenet implied that its unique demographic circumstances result in a sicker, more costly patient base for which outlier payment is appropriate and more likely. Ultimately, Tenet concluded by stating that it was "confident that its hospitals are fully compliant with Medicare rules and regulations, including

131. KENNETH WEAKLEY, UBS WARBURG, GLOBAL EQUITY RESEARCH, TENET HEALTHCARE (Oct. 28, 2002); Fitzgerald, *supra* note 129.

132. *Id.*

133. See generally *Fraud and Abuse: Tenet Takes Close Look at Pricing Strategy in Response to HHS Probe of Hospital Chain*, HEALTH CARE DAILY REPORT, (Bureau of National Affairs, Inc.), Nov. 8, 2002 (noting that according to then Chairman and CEO, Jeffrey Barbakow, Tenet received \$763 million in outlier payment in fiscal year 2002 and expected to receive \$750 million in 2003 representing 46 and 50 cents per share earnings in 2002 and 2003 respectively) [hereinafter REPORT 1].

134. Press Release, Tenet Healthcare Corporation, Tenet Conforms Existing Earnings Guidance; Issues Statement on Medicare Outliers (Oct. 28, 2002), at <http://www.tenethealth.com/TenetHealth/PressCenter/PressReleases> (last visited Apr. 21, 2005). The press release also confirmed that Tenet expected diluted earning per share from operations growth, but it is not clear whether this projection was connected with concerns over a potential reduction in outlier payments.

135. *Id.*

136. *Id.*

137. *Id.* See also REPORT 1, *supra* note 133 (noting that Barbakow stated that 56% of 2002 outlier payments were made to eleven of the system's 113 hospitals, in part because they were urban areas with an emphasis on teaching that brings in more acute or high-risk patients).

those governing outlier payments.”<sup>138</sup>

Despite Tenet’s reassurances that it was in full compliance with Medicare rules and regulations, little more than a week later, HHS announced that it had ordered the Office of the Inspector General (OIG) to audit Tenet’s outlier payments in accordance with Medicare regulations to assess their legality.<sup>139</sup> Clearly, in the minds of HHS officials, Tenet’s compliance was not so apparent.

Just one day after the announcement of the OIG audit, Tenet’s confidence seemed shaken. Interestingly, the Chairman and Chief Executive Officer at the time, Jeffrey C. Barbakow, stated that “as [he] carefully studied [Tenet’s] Medicare outlier situation . . . it became clear . . . that formulas [that drive outlier payments] were affected by [Tenet’s] overall pricing.”<sup>140</sup> More specifically, Barbakow admitted that, “in some cases, particularly aggressive pricing strategies created increasing outlier payments,” but he qualified that admission stating that “[Tenet’s] pricing approach was entirely consistent with the Medicare regulations.”<sup>141</sup>

Barbakow also announced the departure of the company’s Chief Operating Officer Thomas B. Mackey and Chief Corporate Officer and Chief Financial Officer David L. Dennis.<sup>142</sup> Barbakow later admitted that this dismissal was directly related to Tenet’s “aggressive pricing strategy” that led to high outlier payments for some of its hospitals.<sup>143</sup>

While the details of Tenet’s pricing strategy prior to the HHS OIG investigation are not clear, it appears that prices may have been set above the market rate in some markets.<sup>144</sup> For example, an analysis of discharge data for the year 2000 by the California Nurses Association (CNA), one of Tenet’s most ardent critics, revealed that the median gross charge for Tenet’s Medicare patients was about \$30,000 compared to a statewide median of \$15,000 and that median charges for one DRG were twice the statewide median.<sup>145</sup>

In December of 2002, Tenet released the details of a new pricing strategy designed to proactively address concerns over excessive outlier

---

138. *Id.*

139. REPORT 1, *supra* note 133.

140. *Id.*

141. *Id.*

142. *Id.*

143. *Fraud and Abuse: HHS Audit of Tenet Hospitals Focusing on Those That Charged Most, CEO Says*, HEALTH CARE DAILY REPORT, (Bureau of National Affairs, Inc.), Nov. 19, 2002.

144. *See id.* (suggesting that prices were set particularly high in some California hospitals).

145. *See* Press Release, California Nurses Association, Tenet’s Practices Could Endanger Public Health Funding, (Nov. 13, 2002), (on file with author).



payments.<sup>146</sup> The details of this new approach help to illuminate some of the problems associated with Tenet's previous strategy. The new pricing strategy was intended to "de-emphasize the role of gross charges and refocus on actual pricing."<sup>147</sup> One element of the strategy was to freeze hospital gross charges for a time, which seems to suggest the possibility that prior to the change, gross charges were increased on a regular or systematic basis. Another element of the strategy was the pursuit of a contract structure with managed care companies that reduced the relative importance of "stop-loss" payments tied to gross charges.<sup>148</sup> This element suggests that, as in the Medicare program, submitting high gross charges to commercial insurers may have produced higher payments to Tenet facilities.<sup>149</sup>

Approximately one month later, Tenet announced that it would change its method of calculating outlier payments.<sup>150</sup> At the time, it was estimated that the policy change would result in a \$57 million monthly reduction in Medicare outlier payments. More specifically, Tenet agreed to use the most recent cost reports available to set cost-to-charge ratios and to end the use of statewide averages to calculate outlier payments.<sup>151</sup> The proactive nature of this decision is noteworthy as these changes were adopted before the proposed rulemaking laying out the terms of the new outlier payment calculation methodology had been issued on March 5, 2003.<sup>152</sup> Scully expressed his surprise stating that "[I told Tenet that] '[I]f you want to do the honorable thing, you should turn the spigot off now.' To my amazement, they did so."<sup>153</sup>

---

146. See Press Release, Tenet Healthcare, Tenet Discusses New Pricing Philosophy (Dec., 3, 2002), at <http://www.tenethealth.com/TenetHealth/PressCenter/PressReleases> (last visited Apr. 21, 2005).

147. *Id.*

148. *Id.* Stop-loss payment is the commercial insurance industry's equivalent to outlier payments.

149. See Robert Salladay, *Hospital Billing Under Fire; Legislative Hearings on Tenet Focus on Market Power of Some Medical Facilities*, S.F. CHRON., Feb. 7, 2003, at B1 (discussing evidence that Tenet used aggressive pricing strategies with commercial payors to benefit from higher stop-loss payments).

150. *Hospitals: Tenet Healthcare Corp. Said Jan 6 that a New Company Billing Policy Will Reduce Medicare Outlier Payments by as Much as \$57 Million Each Month*, HEALTH CARE DAILY REPORT, (Bureau of National Affairs, Inc.), Jan. 7, 2003 [hereinafter REPORT 2]. It is not clear how Tenet went about implementing this new approach as outlier payments are ultimately calculated by the Medicare Fiscal Intermediary, not the hospital itself.

151. *Id.*

152. Medicare Program; Proposed Change in Methodology for Determining Payment for Extraordinarily High-Cost Cases (Cost Outliers) Under the Acute Care Hospital Inpatient Prospective Payment System, 68 Fed. Reg. 10,420 (March 5, 2003) (to be codified at 42 C.F.R. pt. 412).

153. *Said, supra* note 1.

Though Tenet maintained that the changes were made “as a show of good faith” and that it “continue[d] to believe that its hospitals properly followed existing rules regarding outlier payments,” it is noteworthy that the Department of Justice (DOJ) announced an investigation into potentially abusive outlier billing practices just days earlier.<sup>154</sup> As part of that investigation, the U.S. Attorney’s Office for the Central District of California subpoenaed documents related to outlier payments from nineteen Tenet hospitals.<sup>155</sup>

Scrutiny of Tenet’s past practices related to outlier payment calculation increased on July 8, 2003, when the SEC subpoenaed documents dating back to May 31, 1997, signaling a formal investigation by the agency.<sup>156</sup> While the focus of the investigation was not clear at the time, it appeared that the SEC was looking at whether Tenet executives misled investors by not sufficiently informing them that the company’s earnings growth was closely tied to outlier payments.<sup>157</sup> Tenet had been previously cooperating with the SEC in an informal investigation into the outlier controversy, but the subpoenas indicated a heightened level of concern by the SEC.<sup>158</sup>

As of December of 2004, neither the DOJ nor the SEC had concluded their investigation and the question as to whether charges would be brought remained unanswered. Nevertheless, fallout from the outlier controversy and Tenet’s other legal issues continued. Barbakow resigned as CEO in May of 2003, and acting CEO, President Trevor Fetter, was chosen to replace him in September of 2003.<sup>159</sup> A number of other top executives in the company resigned as well.<sup>160</sup>

It should be noted that scrutiny of Tenet’s billing practices was not limited to the federal government. Tenet Shareholder Committee, LLC<sup>161</sup> released the results of an investigation and legal analysis of Tenet’s “unlawful scheme to defraud Medicare” as well, concluding that Tenet

154. REPORT 2, *supra* note 150.

155. *Id.*

156. Andrew Pollack, *Tenet Healthcare Says U.S. Inquiry is Intensifying*, N.Y. TIMES, Jul. 10, 2003, at C1.

157. *Id.*

158. *Id.*; see also PAUL R. DEMURO, HEALTH CARE FRAUD & ABUSE: HOW TO NAVIGATE THE COMPLIANCE PROCESS 226 (1999) (explaining that it is possible to determine the type of inquiry underway based upon the entity issuing the subpoena and the type of subpoena issued).

159. *Tenet Names Fetter as CEO*, MODERN HEALTH CARE DAILY DOSE, Sept. 26, 2003.

160. *Outside Pressure Prompts Tenet Counsel to Resign*, MODERN HEALTH CARE DAILY DOSE, Sept. 26, 2003.

161. Tenet Shareholder Committee, LLC, at <http://www.tenetshareholdercommittee.org/index.htm> (last visited Apr. 21, 2005) (“The Tenet Shareholder Committee was formed to bring corporate governance reform and improved performance to Tenet Healthcare.”)

could face up to \$6 billion in legal liability as a result of its actions.<sup>162</sup>

Furthermore, scrutiny of billing practices was not limited to Tenet's hospitals.<sup>163</sup> A privately conducted analysis of Medicare payment data showed that less than one-third of hospitals with over twenty percent of inpatient Medicare revenue from outliers were owned by Tenet.<sup>164</sup> Furthermore, the analysis showed that an overwhelming majority of hospitals with the largest outlier percentages were locally operated tax exempt hospitals, more than a quarter of which were located in New Jersey.<sup>165</sup>

Much like Tenet in the early days of the investigations into the outlier payment issue, executives at these facilities defended hospital billing practices, took the position that their practices were consistent with Medicare rules and regulations, and attributed higher payments to a sicker, more costly patient base.<sup>166</sup> The Chief Financial Officer of Saint Barnabas Health Care System in West Orange, New Jersey, stated that higher outlier payments are "a byproduct of [hospital] charges and of [hospital] billing procedures. All of those are consistent with Medicare guidelines."<sup>167</sup> The Chief Operating Officer of Abington Memorial Hospital in Abingdon, Pennsylvania, commented that "pretty standard charge increases" allow the hospital to collect more from commercial health plans and that it is necessary to raise charges "to keep up with the costs."<sup>168</sup>

In response to these findings, Sean Hopkins, the Senior Vice President of Health Economics at the New Jersey Hospital Association, acknowledged that some hospitals may have tried to find "some mechanism to effectuate an increase" in their bottom lines and that hospitals may have been forced to find new ways to increase revenue because they were disproportionately hurt by Medicare cutbacks in the federal Balanced Budget Act of 1997.<sup>169</sup>

---

162. See *Fraud and Abuse Group Says Tenet faces \$6 Billion Liability As Result of Inflated Medicare Outlier Bills*, HEALTH CARE DAILY REPORT, (Bureau of National Affairs, Inc.), Apr. 9, 2003.

163. Mary Chris Jaklevic, *It's More Than Just Tenet; Analysis Shows Not-for-profit Hospital, Including a Cluster in New Jersey, Also Heavily Rely on Outlier Payments*, MODERN HEALTHCARE, Jul. 14, 2003, at 4.

164. *Id.* The analysis was conducted by Modern Healthcare using 2001 Medicare payment data provided by HSS, a health care reimbursement consulting firm.

165. *Id.* Kimball Medical Center in Lakewood, N.J., received 63% of its Medicare revenues from outlier payments. Saint Barnabas Health Care System, West Orange, N.J., received 41% of its Medicare revenues from outlier payments. Examples outside of New Jersey included Methodist Hospital, Houston, Tex., at 23.8% and Crozer-Keystone Health System, Springfield, Pa., at 32.1%.

166. *Id.*

167. *Id.*

168. *Id.*

169. *Id.*

Similarly, Kay McVay (“McVay”), President of the CNA suggested that “using outlier reimbursement [is] an end run around the cuts imposed by the Balanced Budget Act and stringent contractual HMO allowances.”<sup>170</sup>

Are arguments that hospitals were somehow driven to manipulate charges and pursue opportunities presented by the outlier payment calculation methodology and other “loopholes” in reimbursement methodologies in order to remain financially viable worthy of credence? Even the CNA’s McVay places some blame on the “inherent flaws of a market-driven health care industry” calling for “not just modifications in Medicare payment policies, . . . but [an] overhaul of our market-driven health care system.”<sup>171</sup>

Should the federal government be surprised by efforts to maximize Medicare reimbursement through higher outlier payments given the harsh realities of the hospital industry? Renowned health care economist Uwe Reinhardt commented on the federal investigation into Medicare billing fraud at Tenet’s Redding Medical Center in Redding, California stating: “[I] sometimes just shake my head at the American system, where the financial intent is almost cleverly designed to create mischief.”<sup>172</sup>

Were hospitals practicing prudent financial management or engaged in illegal conduct? The response of Tenet and others to investigations into the outlier payment controversy indicate that hospitals perceive the act of increasing charges in an effort to optimize Medicare reimbursement for inpatient services through higher outlier payments as prudent financial management. Testing that assertion requires a better understanding of the nuances of financial management in the hospital industry.

#### IV. PRUDENT FINANCIAL MANAGEMENT?

The Centers for Medicare and Medicaid Services (CMS) determined that Tenet and others, whether intentionally or not, effectively increased their outlier payments by aggressively increasing their charges in relation to their costs.<sup>173</sup> This practice, which led to “inappropriate” outlier payments in the years leading up to the release of the revised regulations, was commonly referred to by CMS as “gaming.”<sup>174</sup> How is it that hundreds of hospitals,

170. See Press Release, *supra* note 145.

171. *Id.*

172. Eichenwald, *supra* note 128.

173. Medicare News Press Release, Centers for Medicaid & Medicare Services, CMS Issues Final Rule for Outlier Payments to Hospitals, (June 5, 2003), at <http://www.cms.hhs.gov/media/press/release.asp?Counter=749> (last visited Apr. 21, 2005).

174. Medical News Press Release, Centers for Medicaid & Medicare Services, CMS Takes Steps to Crack Down on Inappropriate Hospital Outlier Claims (Feb. 28, 2003), at <http://www.cms.hhs.gov/media/press/release.asp?Counter=715> (last visited Apr. 21, 2005).

independent of one another, were able to take advantage of an apparent loophole in the outlier payment calculation methodology so effectively? The answer to that question lies in the unique realm of hospital financial management.

The primary role of the hospital financial manager is to plan for, acquire, and utilize capital to maximize the efficiency and value of the enterprise.<sup>175</sup> The competing interests of various stakeholders and the hostile business environment in which hospitals operate greatly complicate this already difficult role.<sup>176</sup> Failure to maximize efficiency and value presents the risk of financial deterioration, which could ultimately lead to a hospital's demise, thus having a profound impact on communities and, in the case of privately owned hospitals, investors.<sup>177</sup> Accordingly, hospitals must recognize an increasing need for financial resources and place a greater emphasis on prudent financial management.<sup>178</sup>

The hospital financial manager's ability to maximize efficiency and value is limited by rather substantial *revenue* pressures. Forty-three percent of hospital services are purchased by private payors.<sup>179</sup> Thirty-six percent of hospital services are purchased by Medicare.<sup>180</sup> While private payors purchase the greatest *portion* of hospital services, Medicare is the largest single purchaser of hospital services.<sup>181</sup>

These numbers are significant because both Medicare and private payors have become increasingly stringent with regard to benefit and coverage limitations.<sup>182</sup> Furthermore, both Medicare and private payors have been successful in decreasing reimbursement for individual services provided to

175. LOUIS C. GAPENSKI, UNDERSTANDING HEALTHCARE FINANCIAL MANAGEMENT 5 (3d ed. 2001).

176. See *Hospitals Face a Challenging Operating Environment*, Statement of the American Hospital Association before the Federal Trade Commission, Health Care Competition Law and Policy Workshop, (Sept. 9-10, 2002), at <http://www.aha.org/aha/advocacy-grassroots/advocacy/testimony/test020909ftc.html> (last visited Apr. 21, 2005) (discussing rising costs and other challenges facing hospitals).

177. *Id.*

178. See, e.g., BRUCE R. NEUMANN ET AL., FINANCIAL MANAGEMENT: CONCEPTS AND APPLICATIONS FOR HEALTH CARE ORGANIZATIONS 311-15 (1984).

179. Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, at 62 (Mar. 2002) [hereinafter *Policy*].

180. *Id.*

181. *Id.*

182. See Statement of the American Hospital Association before the Federal Trade Commission, Health Care Competition Law and Policy Workshop, *Hospitals Face a Challenging Operating Environment* (Sept. 9-10, 2002), at <http://www.hospitalconnect.com/aha/advocacy-grassroots/advocacy/testimony/test020909ftc.html> (last visited Apr. 21, 2005) (discussing reduced reimbursement from public payors and increasingly demanding and sophisticated practices among private payors) [hereinafter *Statement*].

beneficiaries and insureds.<sup>183</sup> Consequently, some services may not be reimbursed at all and, if they are, reimbursement may be at or below cost. In such instances, a hospital's options are limited to collecting the balance directly from the patient (a practice prohibited by Medicare and most commercial plans) or taking a loss.

The successful efforts of Medicare and of private payors to control health care spending and the resulting impact on hospitals can be seen in the analysis of hospital margins.<sup>184</sup> Nationwide, the hospital total margin dropped to 3.6 % in 1999, its lowest level since the early 1990s. Approximately thirty-seven percent of hospitals had *negative* total margins in 1999. Margins have increased slightly since, but the total hospital margin was estimated to be only 4.5 % for 2001.<sup>185</sup> A margin of 4.5 % means that hospitals have 4.5 cents for each dollar of revenue earned to reinvest in the hospital or to provide a return to investors – a sum scarcely sufficient to allow hospitals to address critical issues that demand access to capital such as a workforce shortage, an aging physical plant, access to new technology, or an increased and unmet demand for services.

Hospital margins for Medicare were negative after the implementation of the Medicare inpatient prospective payment system in 1983 and slowly reached positive levels in 1996.<sup>186</sup> Since that time, hospital margins for Medicare have hovered around three to five percent, largely as a result of cost containment measures in the Balanced Budget Act of 1997.<sup>187</sup> Hospital margins for private payors decreased consistently since 1992, largely as a result of the evolution of managed care and its resulting impact on health care expenditures.

The divergence in hospital margin trends between Medicare and private payors is important because it demonstrates that, whereas in the past hospitals may have tempered losses from Medicare against healthy margins realized from private payor reimbursement, their ability to do so today has been significantly restrained.<sup>188</sup> Accordingly, the narrowed gap between

---

183. *See id.*

184. *Policy, supra* note 179. A “margin” shows the relationship of payments to costs. It is calculated by subtracting costs from revenues, then dividing the difference by revenues. A positive margin indicates that revenues exceed costs. A negative margin indicates that revenues are not sufficient to cover costs. The margin serves as a good measure of revenue pressure and ability to recover the costs of services provided.

185. *Id.* The hospital total margin includes all payors, not just Medicare. An increase in private payor payment has been identified as the cause of an increased hospital total margin.

186. *Id.*

187. *Policy, supra* note 179. *See generally* Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 378 (1997) (expanding the use of prospective payment methodologies and requiring budget-neutral funding).

188. It is important to note that, as the population ages, large numbers of individuals

Medicare and private payor margins means that, in order to maximize the value of the enterprise, hospital financial managers must attempt to maximize reimbursement from existing sources where possible.<sup>189</sup>

The hospital financial manager's ability to maximize efficiency and value is further limited by rather substantial *regulatory compliance* pressures.<sup>190</sup> Structured regulatory compliance programs are a recommended means of guiding a hospital's governing board, officers, managers, and other employees in the efficient management and operation of a hospital.<sup>191</sup> In practice, regulatory compliance programs may have the effect of limiting the decision-making capabilities of hospital financial managers. It is not simply a matter of identifying the decision that makes the most financial sense; rather, it is the decision that makes the most financial sense while at the same time complying with applicable regulations that must prevail.

Applying this understanding of revenue and regulatory compliance pressures faced by hospital financial managers, one could argue that the actions taken by Tenet and others to increase Medicare reimbursement by inflating charges were by no means illegal; rather, the actions were nothing more than prudent financial management. While the practice of inflating charges at a rate higher than costs appears suspect, below the surface are factors that suggest Tenet and others acted within the law and in a manner that was generally consistent with prevailing practices in the hospital industry.

It is well established that a hospital's charges have little or no relation to

---

covered by private payors will become Medicare eligible. This means that an even greater portion of hospital revenues will come from Medicare, which has traditionally offered lower reimbursement than private payors. This would most likely result in an even lower total hospital margin.

189. Exacerbating the revenue pressures created by private payors and Medicare is the large and growing number of uninsured in the country, currently estimated to be approximately 44.7 million individuals or eighteen percent of non-elderly Americans. Fact Sheet, Kaiser Family Foundation, *The Uninsured and Their Access to Health Care*, (Nov. 2004) at, <http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=49531> (last visited Apr. 21, 2005). In many instances, hospitals cannot refuse access to uninsured patients. For patients that do not have sufficient funds to reimburse the cost of providing services, hospitals run the risk of incurring bad debt expense. Payment for such uncompensated services must come from other revenue sources.

190. See generally Statement, *supra* note 182. While hospitals must comply with various federal, state, and local regulations; financial managers are most impacted by Medicare and Medicaid payment rules and federal and state fraud and abuse statutes. This is largely due to the fact that the billing and claims operations that they control have historically been the focus of government scrutiny and sanctions.

191. OIG Compliance Program Guidance for Hospitals, 63 Fed. Reg. 8,988 (Feb. 23, 1998).

its costs.<sup>192</sup> In many ways charges have become a myth. In practice, payors rarely reimburse hospitals in full for their charges. Instead, hospitals are usually paid either a pre-negotiated fixed price or a percentage discount of charges. Tenet's Barbakow acknowledged this reality when discussing the company's pricing strategy: "[i]n the hospital industry, 'gross charges' are not the same as 'prices.' Gross charges are essentially retail list rates . . . [B]ut gross charges rarely bear any resemblance to how [hospitals] are actually paid for the services [they] provide."<sup>193</sup> A study of the evolution of hospital charging practices demonstrates how this came to be so.<sup>194</sup>

Historically, hospital charges were developed through a process of pricing by *consensus*.<sup>195</sup> Fearing that higher than average charges would signal inefficiencies to regulators or steer business to competing providers, hospitals set charges consistent with other hospitals in the community. Those facilities with higher per-unit costs would simply offset losses by shifting costs and corresponding charges to procedures not delivered by other providers and payors not receiving such procedures from other providers.<sup>196</sup>

The practice of pricing by consensus became largely irrelevant with the passage of Medicare and Medicaid as, under these programs, a substantial portion of a hospital's services would be reimbursed on the basis of reasonable costs, not charges.<sup>197</sup> Thus, increasing charges for Medicare or Medicaid beneficiaries would have no impact on reimbursement.

The realization that only commercial insurers and self-pay patients would reimburse the provider based on charges led to the process of pricing by *financial expediency*.<sup>198</sup> Under financial expediency pricing, losses resulting from Medicare and Medicaid cost reimbursement, the cost of bad debt,<sup>199</sup> and the cost of charity care<sup>200</sup> are identified and shifted to payors

192. MICHAEL NOWICKI, *THE FINANCIAL MANAGEMENT OF HOSPITALS AND HEALTHCARE ORGANIZATIONS* 141 (2d ed. 2001).

193. Press Release, Tenet Healthcare, Tenet Discusses New Pricing Philosophy (Dec. 3, 2002), at <http://www.tenethealth.com/TenetHealth/PressCenter/PressReleases> (last visited Apr. 21, 2005).

194. For an interesting discussion of hospital charge setting practices on the impact of charges on Medicare reimbursement, see Medicare Payment Advisory Commission, Public Meeting (Sept. 10, 2004).

195. NOWICKI, *supra* note 192, at 141.

196. *Id.*

197. *Id.*

198. *Id.* at 142.

199. Bad debt is defined as an account which is written off when it is unpaid, even though the patient may have the ability to pay. BRUCE R. NEUMANN, JAN P. CLEMENT, & JEAN C. COOPER, *FINANCIAL MANAGEMENT: CONCEPTS AND APPLICATIONS FOR HEALTH CARE ORGANIZATIONS* 470 (4th ed. 1999).

200. NOWICKI, *supra* note 192, at 142. Charity care is distinguished from bad debt as a



and patients paying on a charge basis.<sup>201</sup>

The use of financial expediency pricing was tempered by the consumer movement in the 1980s.<sup>202</sup> Hospital bills came under increased scrutiny in this period largely as a result of the Medicare billing requirement that patients receive a copy of their bill from the provider. In response to patient complaints of excessive charges for seemingly nominal items, many providers reduced charges for certain items or services or removed charges altogether.<sup>203</sup>

Today, hospital charges are largely *competition driven*. In an effort to balance the need to maximize reimbursement with the need to remain price-competitive with other hospitals, providers set charges based upon what the market will bear (i.e., what the charge-based patients and their insurers are willing to pay).<sup>204</sup> The advent of managed care combined with the increasingly stringent demands of the Medicare inpatient prospective payment system mean that the market will ultimately bear less of the cost of providing care.

Under competition driven and financial expediency pricing, the financial manager is forced to find ways to compensate for revenues lost as a result of prospective payment systems, negotiated prices, discounts, and competition.<sup>205</sup> Strategies recommended by financial management professionals focus on optimizing revenues by complying with regulations in order to avoid incurring fines and sanctions from payors, setting charges at or above the allowable level, coding claims correctly so that hospitals can legitimately receive the highest possible revenue, and periodically reviewing charges to ensure that they reflect the true cost of services provided.<sup>206</sup>

How do the alleged actions of Tenet and others mesh with the methods of setting charges discussed above? It is alleged that these hospitals increased charges at a rate higher than costs in a concerted effort to “maximize” outlier payments. One could argue that such actions are no different than the common industry practice of a hospital submitting charges that are higher than actual costs in order to achieve reimbursement at the payor’s allowable level. The problem with this argument, however, is

---

deduction from gross revenues (stated at full charges) for free or discounted care provided to the medically indigent.

201. *Id.*

202. *Id.*

203. *Id.*

204. *Id.*

205. *Id.*

206. Bruce P. Murray et al., *Methods for Optimizing Revenue in Rural Hospitals*, HEALTHCARE FIN. MGMT., Mar. 1994, at 56.

that outlier payments are an additional payment intended only for exceptionally high cost patients; outlier payments are not a standard allowable amount.

Alternatively, one could argue that by increasing charges at rates higher than costs in a concerted effort to maximize outlier payments, these hospitals were merely engaging in a combination of competition-driven and financial expediency pricing. As private payors developed more sophisticated reimbursement methodologies and bargaining power increased, the gap between private payor and Medicare margins drastically decreased in the mid-1990s, forcing hospitals to take certain revenue-maximizing measures in an effort to improve revenue streams. The weaknesses of the charge-based outlier payment methodology provided just such an opportunity. By submitting higher charges to Medicare, hospitals were able to reach the outlier threshold on a greater number of cases, thereby increasing Medicare revenues overall. These revenues could be used to offset increasingly lower margins.

Is this any different than the historical practice of shifting the uncompensated costs of providing care from Medicare to private payors? Absent a demonstration that hospitals violated the law, should Medicare be permitted to cry “foul!” where a practice that has benefited it in the past is now engaged to its detriment? The answer to this question lies in Medicare’s definition of “charges.”

The Medicare Provider Reimbursement Manual (“Manual”) defines charges as “the regular rates established by the provider for services rendered to both [Medicare/Medicaid] beneficiaries and to other [non-Medicare/Medicaid] paying patients.”<sup>207</sup> These rates are to be applied uniformly to all patients.<sup>208</sup> Furthermore, charges “*should* be related consistently to the cost of services.”<sup>209</sup> It is these charges that make up the hospital’s “charge structure.”

A hospital’s charge structure is to be used as the basis for cost apportionment in the Medicare cost reporting process.<sup>210</sup> Intermediaries are charged with the task of determining whether cost reports represent reasonable cost reimbursement.<sup>211</sup> In doing so, the intermediary “evaluates

---

207. Centers for Medicare and Medicaid Services, Medicare Provider Reimbursement Manual, Part I § 2202.4, *available at* [http://www.cms.hhs.gov/manuals/pub151/pub\\_15\\_1.asp](http://www.cms.hhs.gov/manuals/pub151/pub_15_1.asp) (last visited Apr. 21, 2005).

208. *Id.*

209. *Id.*

210. *See generally* Centers for Medicare and Medicaid Services, Medicare Provider Reimbursement Manual, Part I § 2203, *available at* [http://www.cms.hhs.gov/manuals/pub151/pub\\_15\\_1.asp](http://www.cms.hhs.gov/manuals/pub151/pub_15_1.asp) (last visited Mar. 24, 2005).

211. *Id.*

the charging practice of the provider to ascertain whether it results in an *equitable* basis for apportioning costs.”<sup>212</sup> Although what is meant by an *equitable* basis is not explicitly stated, the Manual explains that charges may only be used in apportioning costs where an established charge structure is “applied uniformly to each patient as services are furnished to the patient and which is reasonably and consistently related to the cost of providing the services.”<sup>213</sup>

Applied to Tenet and others, it appears that these provisions give intermediaries the authority to reject charge structures that are grossly inflated as they could arguably bear no reasonable and consistent relation to costs. However, the Manual qualifies intermediary authority by stating that, while “[Medicare] may determine whether or not the charges are allowable for use in apportioning costs under the program,” it “cannot dictate to a [hospital] what its charges or charge structure may be.”<sup>214</sup>

It appears that, just as with private payors, hospitals have the freedom to engage in competition-driven and financial expediency pricing for Medicare as well. By systematically employing strategies that focus on maximizing revenues (i.e., by complying with regulations in order to avoid incurring fines and sanctions from payors, setting charges at or above the allowable level, coding claims correctly so that hospitals can legitimately receive the highest possible revenue, and periodically reviewing charges to ensure that they reflect the true cost of services provided),<sup>215</sup> Medicare revenues could be used to offset increasingly lower margins for private payors.

The preceding discussion begs consideration of ethical issues in financial management. At what point do strategies intended to optimize overall reimbursement and shift losses among payors begin to test the limits of ethical conduct? While a complete discussion of the role of ethics in financial management practices is beyond the scope of this article, it is clear that hospital financial managers are expected to consider ethical implications in decision-making. Indeed, the OIG has expressed its view that regulatory compliance programs should not be limited to ensuring compliance with the law; rather, ethical leadership is an additional element which extends regulatory compliance into a realm beyond the law.<sup>216</sup> Providing additional stimulus for incorporating ethics into financial practices, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires facilities to develop and operate in

---

212. *Id.* (emphasis added).

213. *Id.*

214. *Id.*

215. *See* Murray et al., *supra* note 206, at 56.

216. *See* Publication of the OIG Compliance Program Guidance for Hospitals, 63 Fed. Reg. 8,988 (Feb. 23, 1998).

accordance with a code of ethics for business, as well as professional conduct as a condition of accreditation.<sup>217</sup>

#### V. . . . OR ENGAGED IN ILLEGAL CONDUCT?

If what Tenet and others did steps beyond prudent financial management, then can it be said that any law was violated?<sup>218</sup> There is great uncertainty as to whether increasing charges for the purpose of achieving greater outlier payments constituted unlawful conduct.<sup>219</sup> The lack of statutes or regulations specifically directed towards controlling a hospital's ability to raise charges as it sees fit, coupled with the ambiguous nature of setting charges generally,<sup>220</sup> makes reaching consensus on this issue very difficult.

While the government could aptly argue that Tenet and others violated the *spirit* of the outlier payment policy,<sup>221</sup> it has little basis for asserting that the *letter* of any law was violated.<sup>222</sup> CMS responded to concerns that hospitals were "gaming" the system by increasing audits of hospitals with unusually high numbers of outlier payments and directing intermediaries to scrutinize hospital billing practices carefully.<sup>223</sup> At that time, Administrator Scully implicitly acknowledged the uncertainty surrounding the issue of whether the acts of Tenet and others were illegal by stating that Tenet's actions "were clearly inappropriate and unethical" and "extremely shortsighted and foolish and a major abuse of the system," but failed to identify any legal action that could be taken.<sup>224</sup>

217. *New Standards Seek to Protect Integrity of Clinical Decision Making*, JOINT COMMISSION PERSPECTIVE (Joint Commission of the Accreditation of Health Care Organizations), Jan.-Feb. 1997, at 18-19.

218. An outline prepared by Mark R. Fitzgerald, *see supra* note 129, was used as a foundation for establishing the legal analysis of fraud and abuse and Medicare exclusion contained in this section.

219. *See Hospitals Outlier Payment Probe Seen Questionable, But Still Likely to Create New Audit Exposure*, HEALTH CARE DAILY REPORT, (Bureau of National Affairs, Inc.), Jan. 24, 2003; Robert G. Homchick, *In the Wake of the Tenet Investigation, CMS Issues Program Memorandum on DRG Outliers*, (Davis Wright Tremaine L.L.P.), available at <http://library.findlaw.com/2002/dec/1/132595.htm> (last visited Mar. 29, 2005); Fitzgerald, *supra* note 129.

220. *See supra* notes 141-154 and accompanying text.

221. *See* Outlier Final Rule, *supra* note 24, at 34,496 (stating that Congressional intent behind outlier payments was to ensure that additional payments would only be made where the cost of care is extraordinarily high in relation to the average cost of treating comparable conditions).

222. *See generally infra* notes 177-270 and accompanying text; *see also* Fitzgerald, *supra* note 129.

223. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Program Memorandum Transmittal A-02-122, Dec. 3, 2002 available at [http://www.cms.hhs.gov/manuals/pm\\_trans/ao2122.pdf](http://www.cms.hhs.gov/manuals/pm_trans/ao2122.pdf) (last visited Apr. 21, 2005).

224. *Hospital Finances Do Not Warrant Increased Medicare Funding*, Scully Says,

Within the last ten years, health care fraud and abuse has become a top priority of federal law enforcement agencies. Contributing to this increased emphasis on anti-fraud and abuse enforcement is the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which, among other things, established a national Health Care Fraud and Abuse Control Program (HCFAC).<sup>225</sup> Under the HCFAC, federal, state, and local law enforcement activities are coordinated through the joint direction of the Attorney General and the HHS Secretary.<sup>226</sup> Additionally, HIPAA expanded civil and criminal enforcement powers to enhance the effectiveness of fraud and abuse detection and prevention efforts.<sup>227</sup>

The results of the HCFAC have been profound. In fiscal year 1997, the OIG and the DOJ recovered \$1.2 billion in judgments, settlements, and administrative impositions, filed 89 new health care civil fraud cases, convicted 363 health care defendants, and excluded 1,000 individuals and entities from participation in federal health programs.<sup>228</sup> The impact of the HCFAC has continued since its initial years of implementation. In fiscal year 2002, the OIG and DOJ won or negotiated \$1.8 billion in judgments, settlements, and administrative impositions, filed 361 health care indictments, convicted 480 health care defendants, filed 221 health care civil cases with 1,529 health care civil matters pending, and excluded 3,448 individuals and entities from participation in federal health programs.<sup>229</sup>

In general, the federal government's health care fraud and abuse efforts are directed toward the following prohibited acts: submission of false claims or other fraudulent billing practices,<sup>230</sup> the receipt of kickbacks and other remuneration in exchange for referrals in violation of the so-called "anti-kickback statute,"<sup>231</sup> and physician referrals to entities in which the physician has a financial interest in violation of federal self-referral prohibitions (i.e., the "Stark law").<sup>232</sup> As the alleged conduct of Tenet and

---

HEALTH CARE DAILY REPORT, (Bureau of National Affairs, Inc.) Dec. 10, 2002.

225. 42 U.S.C. § 1128C(a) (2000).

226. See Department of Health & Human Services and Department of Justice, *Health Care Fraud Annual Report for FY 1999 (2000)*, available at <http://www.usdoj.gov/dag/pubdoc/hipaa99ar21.htm> (last visited Mar. 29, 2005).

227. See *id.*

228. See Department of Health & Human Services and Department of Justice, *Health Care Fraud Annual Report for FY 1997 (1998)*, available at <http://www.usdoj.gov/dag/pubdoc/health97.htm> (last visited Mar. 29, 2005).

229. See Department of Health & Human Services and Department of Justice, *Health Care Fraud and Abuse Control Program Annual Report for FY 2002 (2003)*, available at <http://www.usdoj.gov/dag/pubdoc/hefacreport2002.htm> (last visited Mar. 29, 2005).

230. See generally 31 U.S.C. §§ 3729-3733 (2000); 18 U.S.C. § 1347 (2000).

231. See generally 42 U.S.C. § 1320a-7b(b) (2000).

232. See generally 42 U.S.C. § 1395nn (2000).

others is most closely related to the submission of false claims or other fraudulent billing practices, the enforcement tools that address this prohibited act will be a focal point of the discussion that follows.

False claims and fraudulent billing activities encompass a wide range of activities including: submission of claims for services not actually rendered, provision of medically unnecessary services, “upcoding” DRGs to receive higher reimbursements,<sup>233</sup> unbundling services,<sup>234</sup> and violation of DRG payment windows.<sup>235</sup> The objective of each of these activities is the same: a maximum reimbursement; but each varies by degree in terms of its legitimacy.<sup>236</sup> Two legal scholars have organized provider responses to the incentive to maximize reimbursement along a continuum ranging from beneficial to inexcusable:

At one end of this continuum is appropriate and efficient conduct, such as increasing the number of patients served . . . or decreasing costs through increased productivity. Further along the continuum are what might be called ‘enthusiastic’ responses to incentives. These include responses that the designers of the incentive system perhaps did not contemplate, but they are not yet beyond the bounds of either reasonableness or manageability. . . . Following the continuum across the boundary between legal and illegal reactions to incentives, one comes to responses that are properly characterized as fraud and abuse: excessive and illegal upcoding, unbundling, provision of unnecessary care . . . or provision of care of substandard quality. At the far end of the spectrum [are] fraudulent enterprises . . . entities that bill for goods and services never rendered or that provide no goods and services at all.<sup>237</sup>

In the context of this legitimate-illegitimate continuum, it appears that the alleged conduct of Tenet and others (i.e., increasing charges in an effort to maximize reimbursement) is most akin to “enthusiastic” responses to

---

233. See 63 Fed. Reg. 8,990. The phenomenon known as “DRG creep” is a form of upcoding that occurs in the hospital setting. Essentially, this is the practice of miscategorizing patients into a higher-paying DRG classification in an effort to maximize reimbursement for Medicare admissions overall.

234. *Id.* The practice of “unbundling” involves submitting multiple claims for single components of a service where an appropriate global or all-inclusive code is provided. As with other forms of billing fraud, the intent is to maximize overall reimbursement.

235. Under Medicare payment rules, reimbursement for any outpatient services or other services rendered by any entity wholly owned or operated by the hospital incurred within three days of inpatient admission is included in the DRG payment for that admission.

236. See Timothy S. Jost & Sharon L. Davies, *The Empire Strikes Back: A Critique of the Backlash Against Fraud and Abuse Enforcement*, 51 ALA. L. REV. 239, 254-56 (1999) (discussing the concept that provider responses to incentives offered by various payment structures cannot always easily be categorized as legitimate or illegitimate).

237. *Id.* at 254-55.

incentives. Surely Congress and HHS did not contemplate that hospitals would begin to increase charges at such an excessive rate to achieve higher reimbursements under a methodology intended only to assist those hospitals experiencing truly high-cost cases. But the question is: does this practice go beyond the bounds of either “reasonableness or manageability?” The authors that developed the legitimate-illegitimate continuum suggest that “the system can accommodate a reasonable amount of gaming,” referencing Medicare’s response to upcoding or “DRG creep”<sup>238</sup> in the early years of DRG reimbursement, which was to simply decrease the amount paid per case (i.e., to reduce the return on the incentive) rather than by aggressively prosecuting such marginal violations.<sup>239</sup>

The federal government most likely perceives that the potential abuses of the outlier payment calculation methodology by Tenet and others do go beyond the bounds of reasonableness or manageability. Outlier payments exceeded CMS’s target by over \$9 billion over a short period of four years and a majority of the payments went to a relatively small number of hospitals.<sup>240</sup> This result seems neither manageable nor reasonable. The outlier payment issue is unlike the “DRG creep” phenomenon experienced in the early years of IPPS, which was a system-wide and gradually increasing phenomenon. Consequently, the federal government may well believe that simply adjusting the outlier payment calculation methodology is an inadequate response to a problem that it perceives as unreasonable and unmanageable.

The federal government has at its disposal a number of *criminal* sanctions to enforce false claims and fraudulent billing practices on behalf of hospitals.<sup>241</sup> The Social Security Act contains criminal provisions rendering unlawful one who “knowingly and willfully makes or causes to be made any false statement or representation of material fact in any application for any benefit or payment under a federal health care program. . . .”<sup>242</sup> The criminal False Claims Act, which makes it illegal to submit “any claim upon or against the United States . . . knowing such claim to be false, fictitious, or fraudulent” is a statute of general

238. See *supra* note 233 and accompanying text.

239. Jost & Davies, *supra* note 236, at 251-54.

240. Medicare News Press Release, Centers for Medicare and Medicaid Services, *CMS issues Final Rule for Outlier Payments to Hospitals* (June 5, 2003), at <http://cms.hhs.gov/media/press/release.asp?Counter=749> (last visited Apr. 21, 2005).

241. See generally *Fraud and Abuse*, [Vol. 2, HLM 177] Hosp. L. Manual (Aspen) ¶ 2-15 to 2-23 (Sept. 2003).

242. Criminal Penalties for Acts Involving Federal Health Care Programs, 42 U.S.C. § 1320a-7(b)(a)(1) (2000).

applicability that can be used to enforce Medicare fraud and abuse.<sup>243</sup> Another criminal statute of general applicability that can be used to enforce Medicare fraud and abuse is the prohibition against false statements, which makes it illegal to “knowingly and willfully [falsify, conceal, or cover up] by any trick, scheme, or device a material fact, or [make] any false, fictitious or fraudulent statement or representation. . . .”<sup>244</sup> Similarly, statutes prohibiting mail and wire fraud can also be used to prosecute false or fraudulent claims.<sup>245</sup> Most recently, HIPAA amended the criminal code to create the new federal offense of “health care fraud,”<sup>246</sup> which makes it unlawful to:

knowingly and willfully [execute or attempt to execute], a scheme or artifice – (1) to defraud any health care benefit program; or (2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program, in connection with the delivery of or payment for health care benefits. . . .<sup>247</sup>

Similar to the wealth of criminal sanctions available, the federal government has at its disposal a number of *civil* sanctions to enforce false claims and fraudulent billing practices on behalf of hospitals.<sup>248</sup> Civil sanctions to enforce false claims and fraudulent billing practices on behalf of hospitals are enumerated by the Civil Monetary Penalties Law in the Social Security Act, which establishes monetary penalties for false claims and a variety of other fraudulent activities by health care providers.<sup>249</sup> Liability under the statute can be substantial; the maximum civil monetary penalty is \$10,000 for each false claim, in addition to treble damages (i.e., three times the total amount claimed).<sup>250</sup> The Civil Monetary Penalties Law is also provided under the federal False Claims Act, which makes persons liable for:

---

243. 18 U.S.C. § 287 (2000).

244. 18 U.S.C. § 1001 (2000); *Cf.* *United States v. O’Brien*, 14 F.3d 703 (1st Cir. 1994) (convicting defendant of making false statements by submitting bills for ambulance services where patients only truly needed automobile or van transportation).

245. 18 U.S.C. § 1343 (2000); *Cf.* *United States v. Collins*, 596 F.2d 166 (6th Cir. 1979) (convicting defendant of mail fraud for sending falsely inflated Medicaid cost reports to the state government).

246. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, § 242, 110 Stat., 2016.

247. 18 U.S.C. § 1347 (2000); *Cf.* *United States v. Daniels*, 159 F. Supp. 2d 1285 (D.C. KS 2001).

248. *See generally Fraud and Abuse*, [Vol. 2, HLM 177] *Hosp. L. Manual* (Aspen) ¶ 2-24 to 2-32 (Sept. 2003).

249. *See* 42 U.S.C. § 1320 a-7a(a)-(b) (2000).

250. 42 C.F.R. § 1003.103 (2004).



knowingly [presenting] or [causing] to be presented, to an officer or employee of the United States Government . . . a false or fraudulent claim for payment . . . [or for] knowingly [making, using, or causing] to be made or used, a false record or statement to get a false or fraudulent claim paid. . . .<sup>251</sup>

Civil monetary penalties under the False Claims Act can also be substantial as penalties per claim range from a minimum of \$5,500 to a maximum of \$11,000, in addition to treble damages sustained by the government.<sup>252</sup> In addition to civil monetary penalties, the federal government can exclude from participation in federal health care programs those health care providers that have been found liable for submitting false claims to such programs.<sup>253</sup> The effect of this sanction can be profound. For many hospitals, Medicare represents the hospital's largest single revenue source.

Despite the wide range of criminal and civil sanctions and enforcement tools available to the federal government, federal prosecutors have exhibited a preference for civil sanctions in their health care fraud and abuse enforcement efforts. The prevalence and incidence of civil sanctions sought by the federal government has been far greater than for criminal sanctions.<sup>254</sup> Accordingly, any assessment of potential legal liability that Tenet and others may have for their attempts to receive outlier payments should concentrate on civil sanctions and enforcement tools rather than criminal ones.

Despite the range of civil sanctions and enforcement tools available to the federal government, most of the government's health care fraud cases are brought under the civil False Claims Act,<sup>255</sup> a trend that has been supported in large part by the influence of the *qui tam* or "whistleblower" provision<sup>256</sup> that attaches.<sup>257</sup> Due to its status as a favored enforcement tool, the civil False Claims Act will likely be key in the legal action against

251. 31 U.S.C. § 3729 (2000).

252. 64 Fed. Reg. 47,104 (1999).

253. See 42 U.S.C. § 1320a-7(6)(A) (2000).

254. See U.S. DEP'T. OF JUSTICE, HEALTH CARE FRAUD REPORT, FISCAL YEARS 1995 & 1996, available at <http://www.usdoj.gov/opa/health/hefl.htm> (last visited Apr. 21, 2005) (indicating a total of 2,488 civil matters pending for 1996 versus a total of 1,346 criminal matters for the same year and a 821% increase in civil matters pending between years 1992 and 1996 versus an increase of only 292% of criminal matters between the same years).

255. 31 U.S.C. § 3729 (2000).

256. 31 U.S.C. § 3730(c) (2000).

257. See U.S. DEP'T. OF JUSTICE, HEALTH CARE FRAUD REPORT, FISCAL YEARS 1995 & 1996, available at <http://www.usdoj.gov/opa/health/hefl.htm> (last visited Apr. 21, 2005) (stating that "many health care fraud cases are brought under [the civil False Claims Act]" and that "the influence of *qui tam* cases in health care fraud cannot be overstated").

Tenet and others, assuming the federal government determines that such action is warranted. Additionally, exclusion from participation in federal health programs remains as a likely vehicle for enforcement. Exclusion can be pursued in addition to false claims sanctions, or separately.<sup>258</sup> Each of these two likely alternatives for enforcement action by the federal government – exclusion from Medicare participation and the civil False Claims Act – will be discussed in turn below.

#### A. *Exclusion from Participation in Medicare*

HHS is authorized to exclude a provider from participation in Medicare and state health care programs where the Secretary determines that a provider “has submitted or caused to be submitted bills or requests for payment (where such bills or requests are based on charges or cost) . . . for items or services furnished *substantially in excess* of such [provider’s] usual charges. . . .”<sup>259</sup> Accordingly, if HHS could demonstrate that Tenet’s or other hospitals’ charges for inpatient hospital stays were “substantially in excess” of “usual charges,” then it could exclude them from Medicare.<sup>260</sup>

Such a position, however, would be greatly complicated by the fact that neither the statute nor the regulations explicitly define what “substantially in excess” or “usual charges” mean.<sup>261</sup> In response to comments regarding whether or not the terms should be explicitly defined, the OIG decided in 1992 that while some additional guidance would be helpful to the public, evaluation of billing patterns should be conducted on a case-by-case basis.<sup>262</sup>

The statute and the regulations are also difficult to apply in that they do not clearly specify to whom a provider’s excess charges or costs apply. In 1997, the OIG proposed to revise the regulations in an effort to more clearly define the scope of Medicare exclusion for excessive charges or costs.<sup>263</sup> The proposed language expanded the circumstances for exclusion to bills submitted by a provider in substantial excess of that provider’s usual

258. Cf. 42 U.S.C. § 1320a-7(a)-(b) (2000).

259. 42 U.S.C. § 1320a-7(b)(6)(A) (2000) (emphasis added).

260. See *id.*

261. See 42 U.S.C. § 1320a-7 (2000); 42 C.F.R. § 1001.701 (2002).

262. Health Care Programs: Fraud and Abuse; Amendments to OIG Exclusion and CMP Authorities Resulting From Public Law 100-93, 57 Fed. Reg. 3,298, 3,307 (Jan. 29, 1992) (to be codified at 42 C.F.R. pts. 1001 through 1007). Comments submitted suggested that a variety of factors must be considered in an evaluation of charges. Such factors included: the higher costs associated with Medicare patient, differences in overhead costs between geographies, supply and demand for provider services, and provider intent to overbill.

263. Health Care Programs: Fraud and Abuse; Revised OIG Exclusion Authorities Resulting From Public Law 104-191, 62 Fed. Reg. 47,182, 47,186 (Sept. 8, 1997) (to be codified at 42 C.F.R. pts. 1001-02, 1005).

charges or costs “to *any* of [its] customers, clients or patients.”<sup>264</sup>

Comments in response to this proposed revision revealed that “many strongly objected to what they believed was the OIG’s setting of Medicare payment policy . . . at the best price charged to any payer.”<sup>265</sup> The OIG responded to this concern by pointing out that liability for exclusion only exists where bills submitted are “‘substantially in excess’ of the lowest prices charged to any customer” not simply higher than the lowest prices charged to any customer.<sup>266</sup>

Regardless, in 1998, the OIG ultimately determined that the proposed revision was not worthy of pursuit.<sup>267</sup> The OIG had “become convinced” by “persuasive arguments” that “the prohibitions [against submitting bills substantially in excess of usual costs or charges had] very limited applicability with respect to the current Medicare reimbursement system.”<sup>268</sup> With the advent of the then recently enacted Balanced Budget Act of 1997,<sup>269</sup> which mandated prospective payment and provided authority for the Secretary to replace most of the then-existing cost- or charged-based reimbursement methodologies, the ability of the OIG to sanction providers by excluding them from Medicare for submitting bills in excess of usual charges was of limited relevance.<sup>270</sup> The OIG ironically commented that “providers may have less incentive and less opportunity to claim Medicare payment that is substantially in excess of their usual charges.”<sup>271</sup>

Nevertheless, the statute and regulations are still the law. The language of the statute and regulations, as well as the OIG’s subsequent interpretations and comments, lead to the conclusion that an essential element of Medicare exclusion for excessive charges is that charges must be “substantially in excess” of their “usual charges.” Even without explicit definitions for these terms, it stands to reason that there must be some significant disparity between what a provider charges Medicare and what a provider charges other payors for the same service. Accordingly, Tenet and others could categorically rebut allegations that charges are substantially in

---

264. *Id.* at. 47,192 (emphasis added).

265. *Id.* at 46,681.

266. *Id.*

267. Health Care Programs: Fraud and Abuse, Revised OIG Exclusion Authorities Resulting From Public Law 104-191, 63 Fed. Reg. 46, 681 (Sept. 2, 1998) (to be codified at 42 C.F.R. pts. 1001-02, 1005).

268. *Id.*

269. Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 378 (1997).

270. Health Care Programs: Fraud and Abuse; Revised OIG Exclusion Authorities Resulting From Public Law 104-191, 63 Fed. Reg. 47,192 (Sept. 2, 1998) (to be codified at 42 C.F.R. pts. 1001-02, 1005).

271. *Id.*

excess of usual charges by demonstrating that their charges were uniform across payors.<sup>272</sup>

The OIG acknowledged this understanding in a 2000 letter from Kevin McAnaney, then Chief, Industry Branch, OIG, stating “[W]e do not believe that the section 1128(b)(6)(A) [of the Social Security Act (Act)]<sup>273</sup> is implicated unless a provider’s charge to Medicare is substantially in excess of its median non-Medicare/Medicaid charge. In other words, a provider need not even worry about section 1128(b)(6)(A) of the Act, unless it is discounting close to half of its non-Medicare/Medicaid business.”<sup>274</sup> In theory, however, technical compliance with the Medicare Provider Reimbursement Manual (“Manual”) makes a disparity in charges between Medicare/Medicaid and non-Medicare/Medicaid an impossibility as “[c]harges should be . . . uniformly applied to all patients whether inpatient or outpatient.”<sup>275</sup> Regardless, it is clear that, based upon current interpretation of § 1128(b)(6)(A), Tenet and others could not be excluded from Medicare participation on this basis if charges are in fact uniform to all payors.

Providing strong evidence that the federal government agrees with the conclusion that § 1128(b)(6)(A) of the Act does not readily apply to the outlier controversy, the OIG has recently proposed regulations that seem tailored for this purpose. The proposed rulemaking could resurrect § 1128(b)(6)(A) of the Act by drastically changing the interpretation of “substantially in excess” and “usual charges” on a prospective basis, thus creating a valuable weapon against provider efforts to “game” the system by increasing charges at a rate higher than costs.<sup>276</sup> Contrary to comments

272. It does not appear that Tenet and others would need to demonstrate that the actual price (i.e. the amount paid) was the same for all providers; rather, they would only need to demonstrate that the gross charges to all payors were the same. Discounts or contractual allowances to payors and individuals would almost certainly vary. However, proposed revisions to § 1128(b)(6)(A) of the Social Security Act could drastically change this understanding. See Medicare and Federal Health Care Programs: Fraud and Abuse; Clarification of Terms and Application of Program Exclusion Authority for Submitting Claims Containing Excessive Charges, 68 Fed. Reg. 53,939 (Sept. 15, 2003) (to be codified at 42 C.F.R. pt. 1001).

273. 42 U.S.C.A. § 1320a-7(b)(6) (2000).

274. Letter from Kevin McAnaney, Chief, Industry Guidance Branch, OIG, Apr. 26, 2000, at <http://www.oig.hhs.gov/fraud/docs/safeharborregulations/lab.htm> (last visited Apr. 21, 2005).

275. Center for Medicare and Medicaid Services, MEDICARE PROVIDER REIMBURSEMENT MANUAL, Part I, § 2202.4, available at [http://www.cms.hhs.gov/manuals/pub151/pub\\_15\\_1.asp](http://www.cms.hhs.gov/manuals/pub151/pub_15_1.asp) (last visited Apr. 21, 2005).

276. See Medicare and Federal Health Care Programs: Fraud and Abuse; Clarification of Terms and Application of Program Exclusion Authority for Submitting Claims Containing Excessive Charges, 68 Fed. Reg. 53,939 (Sept. 15, 2003) (to be codified at 42 C.F.R. pt. 1001).

made in 1998,<sup>277</sup> the OIG now asserts that § 1128(b)(6)(A) of the Act “has continuing relevance for, and applicability to, bills and requests for payment submitted for items of services for which payment is based directly or indirectly on the provider’s charges or costs, especially in Medicare Part B. . . .”<sup>278</sup> Signaling its purpose behind the proposed rulemaking, the OIG notes that “Medicare payment provisions, such as the inpatient outlier payment methodology . . . depend in whole or part on a provider’s costs or charges.”<sup>279</sup>

The proposed rule defines “usual charges” to include “the amounts billed to cash paying patients; the amounts billed to patients covered by indemnity insurers with which the provider has no contractual arrangement; and any fee-for-service rates it contractually agrees to accept from any payor, including any discounted fee-for-services rates negotiated with managed care plans.”<sup>280</sup> Essentially, the usual charges would no longer be understood to mean gross charges (i.e., the amount of charges before contractual allowances or discounts are taken into account). The effect of this definition would be to limit a hospital’s ability to set charges at an arbitrarily high level bearing little or no relationship to costs.<sup>281</sup> The proposed rule attacks such practices arguing that the negotiated rate should be used to determine usual charges “even if the bill submitted to the payor lists a higher charge, because the higher charge is never collected.”<sup>282</sup> Similarly, for charges billed directly to patients, the usual charge will be determined based upon the amount the hospital routinely accepts as

---

277. See Health Care Programs: Fraud and Abuse; Revised OIG Exclusion Authorities Resulting From Public Law 104-191, 63 Fed. Reg. 46, 681 (Sept. 2, 1998) (to be codified at 42 C.F.R. pts. 1001-02, 1005).

278. Medicare and Federal Health Care Programs: Fraud and Abuse; Clarification of Terms and Application of Program Exclusion Authority for Submitting Claims Containing Excessive Charges, 68 Fed. Reg. 53,940 (Sept. 15, 2003) (to be codified at 42 C.F.R. pt. 1001).

279. *Id.*

280. *Id.* at 53,941.

281. Similar to costs, the price (the amount actually expected to be paid) of hospital services bears little or no relationship to charges. A hospital’s charges may represent nothing more than a total retail accounting of all services and items used in the course of a patient’s stay. Price is dictated by either the patient’s ability to pay or the terms previously agreed to by the third party payor. Setting charges well above price may, in some instances, have the effect of maximizing reimbursement. For example, this would be true where a hospital is reimbursed on a percent of charges methodology, or where the terms of a payor contract reimburse at the lesser of the negotiated rate or charges.

282. Medicare and Federal Health Care Programs: Fraud and Abuse; Clarification of Terms and Application of Program Exclusion Authority for Submitting Claims Containing Excessive Charges, 68 Fed. Reg. 53,941 (Sept. 15, 2003) (to be codified at 42 C.F.R. pt. 1001).

payment, not the actual charged amount.<sup>283</sup>

Applying this definition of “usual charges” to Tenet and others, a hospital could no longer rely upon the argument that its charges are applied uniformly across all payors. Where a hospital has negotiated rates with different payors, it is those negotiated rates that are used to determine usual charges, not the charge amount that appears on the claim submitted to the payor which is later adjusted to reflect the negotiated rate.<sup>284</sup> Even if the claims submitted to all payors, patients, and Medicare listed the same charge for a given service, the OIG no longer considers that amount; it only considers the amount that is paid. Consequently, it is now possible that bills submitted to Medicare could be “substantially in excess” of a hospital’s “usual charges.”

The proposed rulemaking defines “substantially in excess” as “only those charges or costs that are more than [one-hundred twenty] percent of a provider’s usual charges or costs.”<sup>285</sup> The OIG expressed its belief that the one-hundred twenty percent measure “is a reasonable interpretation of ‘substantially in excess’ and is high enough to permit reasonable variation.”<sup>286</sup>

If finalized, the proposed rulemaking would make it very difficult for hospitals to achieve higher outlier payments by submitting bills for inflated charges without subjecting themselves to exclusion from federal health programs under § 1128(b)(6)(A) of the Act. Under current law, however, the federal government has little support for an assertion that Tenet and others have violated § 1128(b)(6)(A) of the Act, especially considering its current efforts to tailor sanctions to that end.

283. *Id.* Defining “usual charges” in this manner is inconsistent with the use of the word “charges” in the Provider Reimbursement Manual. For the purpose of developing of cost apportionment ratios, patient charges are to be “recorded at the gross value, i.e., charges before the application of allowances and discounts deductions.” MEDICARE PROVIDER REIMBURSEMENT MANUAL, Part I, § 2202.4, *available at* [http://www.cms.hhs.gov/manuals/pub151/pub\\_15\\_1.asp](http://www.cms.hhs.gov/manuals/pub151/pub_15_1.asp) (last visited Apr. 21, 2005).

284. For example, a hospital contracts with Payor A to provide a service for \$500. The same hospital contracts with Payor B to provide the same service for \$400. When the hospital provides the service to Payor A, Payor B or Medicare, it charges \$1000, regardless of the negotiated rate or DRG payment. Under the current rule, the \$1000 charge applied uniformly to all payors would be used to determine usual charges. To the contrary, under the proposed rule, the \$500 and \$400 negotiated rates would be used to determine usual charges.

285. Medicare and Federal Health Care Programs: Fraud and Abuse; Clarification of Terms and Application of Program Exclusion Authority for Submitting Claims Containing Excessive Charges, 68 Fed. Reg. 53,942 (Sept. 15, 2003) (to be codified at 42 C.F.R. pt. 1001).

286. *Id.*

### B. Civil False Claims Act

The civil False Claims Act (FCA) provides liability for false *claims* and for false *statements*. The provision related to false *claims* provides that any person who knowingly presents false or fraudulent claims to the federal government shall be liable for civil monetary penalties.<sup>287</sup> The provision related to false *statements* provides that any person who knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the federal government shall likewise be liable for civil monetary penalties.<sup>288</sup> As discussed previously, per claim monetary penalties shall be no less than \$5,500 and not more than \$11,000, plus treble damages.<sup>289</sup> While either of these provisions could arguably apply to the outlier controversy, the provisions related to false *claims* are most frequently relied upon by the government.<sup>290</sup>

The false claims provision of the FCA can be interpreted as requiring five elements: (1) a claim; (2) submitted to the United States government; (3) which is false or fraudulent; (4) with sufficient knowledge by the defendant of the falsity of the claim; and (5) which constitutes a negative and direct effect on the federal treasury.<sup>291</sup> As the rampant success of national initiatives applying the FCA to hospital billing practices under Medicare demonstrates,<sup>292</sup> the federal government would have little difficulty satisfying the first, second, and third elements of the statute with regard to the outlier payment controversy. However, satisfying the third and fourth elements – falsity and knowledge – could prove to be a difficult undertaking.<sup>293</sup>

#### 1. Knowledge

The FCA defines “knowing” and “knowingly” as including actual knowledge, acts in deliberate ignorance of the truth or falsity of the

287. 31 U.S.C. § 3729(a)(1) (2000).

288. 31 U.S.C. § 3729(a)(2) (2000).

289. 31 U.S.C. § 3729(a) (2000).

290. JOHN T. BOESE, CIVIL FALSE CLAIMS AND *QUI TAM* ACTIONS § 2-9 (1993 & Supp. 2003).

291. *Id.* at §§ 2-8-2-9.

292. See General Accounting Office, *Medicare: Application of the False claims Act to Hospital Billing Practices*, Jul. 1998.

293. See Memorandum from Eric H. Holder, Jr., Deputy Attorney General, Department of Justice, on Guidance on the Use of the False Claim Act in Civil Health Care Matters to All United States Attorneys, All First Assistant United States Attorneys, All Civil Health Care Fraud Coordinators in the Offices of United States Attorneys, All Trial Attorneys in the Civil Division Commercial Litigation Section (June 3, 1998), at <http://www.usdoj.gov/dag/readingroom/chcm.htm> (last visited Apr. 21, 2005) (identifying falsity and knowledge as two key factual predicates before alleging violations of the FCA).

## 2005] The Effect of Hospital Charges on Outlier Payments 313

information, or acts in reckless disregard of the truth or falsity of the information.<sup>294</sup> The definition also provides that no proof of specific intent to defraud is required.<sup>295</sup>

In the context of the outlier controversy, the federal government will have difficulty proving the knowledge element because it must prove that Tenet and others knew that the claims submitted were false.<sup>296</sup> For claims to be considered false, there must be some statute, regulation, or rule that essentially says to hospitals: “you do not have the authority to increase charges as you see fit.” Otherwise, it cannot be said that hospital claims submitted to Medicare with charges grossly in excess of, and bearing no relationship to, costs are “false” or “fraudulent.” It is not enough to show that Tenet and others intended to maximize reimbursement by taking advantage of certain vulnerabilities in the outlier payment calculation methodology; rather, the federal government must show that Tenet and others knew that doing so was a violation of an existing statute, regulation, or rule.<sup>297</sup>

Perhaps acknowledging the difficulty involved in establishing knowledge as an element in FCA causes of action, the DOJ issued guidance on the use of the FCA in civil health care matters.<sup>298</sup> In addressing the knowledge element, the DOJ established the following list of factors that must be considered in determining whether a given health care provider knowingly submitted false claims:

- a) Notice to the Provider.
- b) The Clarity of the Rule or Policy.
- c) The Pervasiveness and Magnitude of the False Claims.

---

294. 31 U.S.C. § 3729(b) (2002).

295. *Id.*

296. *See Hagood v. Sonoma County Water Agency*, 929 F.2d 1416, 1421 (9th Cir. 1991) (holding that “what constitutes the offense is not intent to deceive but knowing presentation of a claim that is either fraudulent or simply false. The requisite intent is the knowing presentation of what is known to be false.”); *Hindo v. Univ. of Health Sciences*, 65 F.3d 608, 613 (7th Cir. 1995).

297. *See Hagood*, 929 F.2d at 1421.

298. *See* Memorandum from Eric H. Holder, Jr., Deputy Attorney General, Department of Justice, on Guidance on the Use of the False Claim Act in Civil Health Care Matters to All United States Attorneys, All First Assistant United States Attorneys, All Civil Health Care Fraud Coordinators in the Offices of United States Attorneys, All Trial Attorneys in the Civil Division Commercial Litigation Section (June 3, 1998), at <http://www.usdoj.gov/dag/readingroom/chcm.htm> (last visited Apr. 21, 2005).



- d) Compliance Plans and Other Steps to Comply with Billing Rules
- e) Past Remedial Efforts
- f) Guidance by the Program Agency or its Agents
- g) Have There Been Prior Audits or other Notice to the Provider of the same or Similar billing Practices?
- h) Any Other Information That Bears on the Provider's State of Mind in Submitting the False Claims.<sup>299</sup>

Based upon the factors listed above, it is not at all clear that the federal government could establish the predicate knowledge for a successful FCA action against Tenet and others. Arguably there was no notice to the provider. Prior to enactment of the revised outlier payment calculation methodology, there was no rule or policy upon which a potential case could be based. If the knowledge were to be based upon some rule or policy not directly related to outlier payment, e.g. certain provisions in the Medicare Provider Reimbursement Manual,<sup>300</sup> it would not necessarily be reasonable to conclude that providers understood the rule or policy to apply to the outlier payment calculation methodology. For the same reason that there could not be notice to the provider, hospitals could not be expected to have compliance plans in place or other steps to comply with billing rules that were not in existence at the time the alleged false claims were submitted. In the case of Tenet, it did initiate remedial efforts<sup>301</sup> once it became clear that the government would not look favorably upon future efforts to maximize reimbursement by taking advantage of vulnerabilities in the outlier payment calculation methodology. The balance of these factors seems to weigh in favor of the conclusion that the requisite knowledge to find a violation of the FCA did not exist.

## 2. Falsity

A recent law review article on the application of the federal False Claims Act to regulatory compliance issues in health care identified two dimensions to "falsity" under the FCA: (1) *factual* falsity; and (2) *legal*

---

299. *Id.*

300. *See supra* notes 155-161 and accompanying text.

301. REPORT 2, *supra* note 150 (discussing sweeping changes to the way that it calculates outlier payments).

falsity.<sup>302</sup> *Factual* falsity refers to the idea that a claim may be intrinsically false because it seeks reimbursement for services or goods not provided or for services or goods provided in a manner different from that described in the claim form.<sup>303</sup> For example, factual falsity is generally indicative of outright fraud or illegal upcoding or unbundling. *Legal* falsity, on the other hand, refers to the idea that claims are not factually false, but are false for an extrinsic legal, regulatory, or contractual reason.<sup>304</sup> As the practices of Tenet and others do not fall under the guise of factual falsity, the federal government must rely upon a demonstration of legal falsity. What extrinsic legal or contractual reason could the federal government employ as a basis for finding a false claim with regard to the outlier controversy?

A likely basis for finding a false claim with regard to the outlier controversy would be the theory of “certification.” The federal government has resorted to this theory in a number of cases when presented with the need to enforce regulatory compliance with vague standards such as inadequate quality of care allegations.<sup>305</sup> In general, the theory of certification in the health care context provides that where a party either impliedly or expressly certifies that it will comply with applicable regulatory standards as a condition of participating in and submitting bills to federal health care programs, such parties are liable for the submission of false claims and false statements under the FCA when not in compliance with those regulatory standards.<sup>306</sup> While this theory stands in direct opposition to the well-established principle that the FCA is not a vehicle for regulatory compliance,<sup>307</sup> and the Supreme Court’s cautionary statement that the FCA is not designed to punish every type of fraud committed upon the government,<sup>308</sup> there are examples of a willingness to allow the certification theory to provide a basis for liability under the FCA.<sup>309</sup> However, as a practical matter, success under the certification theory has been varied and in most cases, there was failure to comply with a clear-cut

---

302. Robert Fabrikant & Glenn E. Solomon, *Application of the Federal False Claims Act to Regulatory Compliance Issues in the Health Care Industry*, 51 ALA. L. REV. 105, 111-12 (1999).

303. *Id.*

304. *Id.*

305. *Id.* at 139-44.

306. *See id.* at 125; *see, e.g.*, *Luckey v. Baxter Healthcare Corp.*, 2 F. Supp. 2d 1034, 1044 (N.D. Ill. 1998) (discussing application of the “implied certification” theory).

307. *See Luckey*, 2 F. Supp. 2d at 1045 (citing *United States ex rel. Hopper v. Anton*, 91 F.3d 1261, 1267 (9th Cir. 1996)).

308. *See United States v. McNinch*, 356 U.S. 595, 599 (1958).

309. *See, e.g.*, *Ab-Tech Constr. v. United States*, 57 F.3d 1084 (Fed. Cir. 1995); *United States ex rel. Pogue v. Am. Health Corp.*, 914 F. Supp. 1507 (M.D. Tenn. 1996).

statute or regulation.<sup>310</sup>

If the federal government were to employ the certification theory in enforcement actions against Tenet and others, how would it establish that certification existed? In *United States ex rel. Thompson v. Columbia/HCA Healthcare Corp.*, another of the nation's largest investor-owned hospital companies, Columbia/HCA (now "HCA"), was accused of violating the FCA by falsely certifying in annual cost reports that the Medicare services identified therein were provided in compliance with laws and regulations regarding the provision of health care services.<sup>311</sup> The court noted that submission of cost reports requires a representative of the hospital to certify familiarity "with the laws and regulations regarding the provision of health care services and that the services identified in this cost report were provided in compliance with such laws and regulations."<sup>312</sup>

However, *Thompson* draws a distinction between "express" and "implied" certification. An express certification exists where the party certifies its compliance with a particular statute or regulation. For example, cost report certification contains the "express" certification that "if services identified in this report were provided or procured through the payment directly or indirectly of a kickback or were otherwise illegal, criminal, civil and administrative fines and/or imprisonment may result."<sup>313</sup> An implied certification exists in the absence of an express certification where the party certified compliance with all statutes and regulations that may apply.<sup>314</sup>

This distinction is important in the context of the outlier controversy because cost reports do not contain an express certification of compliance with regard to outlier payment or to billed charges and their relationship to costs as it does for federal anti-kickback prohibitions. Accordingly, the federal government would be limited to asserting an implied certification theory.

Reliance upon implied certification substantially lessens the likelihood that the federal government would be capable of demonstrating a false claim as "a finding of a false implied certification under the FCA for every request for payment accompanied by a failure to comply with all applicable regulations, without more, improperly broadens the intended reach of the

---

310. See *United States ex rel. Thompson v. Columbia/HCA Healthcare Corp.*, 20 F. Supp. 2d 1017, 1047 (S.D. Tex. 1998) (holding that alleged violations of federal anti-self-referral and anti-kickback laws are actionable under the FCA).

311. *United States ex rel. Thompson v. Columbia/HCA Healthcare Corp.*, 938 F. Supp. 399, 401-03 (S.D. Tex. 1996).

312. See *Columbia/HCA Healthcare Corp.*, 20 F. Supp. 2d at 1035 n.21 (quoting HCFA Form 2552).

313. *Columbia/HCA Healthcare Corp.*, 938 F. Supp. at 406 (quoting HCFA Form 2552).

314. See *Luckey*, 2 F. Supp. 2d at 1044.

FCA.”<sup>315</sup> Implied certification requires not only a certification of compliance with regulations, but also violation of a material regulation.<sup>316</sup> In *Hopper v. Anton*, the Ninth Circuit reasoned that non-material violations were not the type of fraudulent activity envisioned by the FCA.<sup>317</sup> Mere regulatory violations do not give rise to a viable FCA action; rather, the test for determining materiality is whether the defendant’s compliance with the statutes and regulations in question was a condition of receiving payment from the government.<sup>318</sup> Accordingly, in the context of Tenet and others, in situations where the federal government would have paid claims regardless of whether or not it had knowledge of any violation of the cost report certification, the FCA should not apply.

It has been suggested that:

The simplest way to determine whether the government would have paid the bill had it been aware of the defendant’s non-compliance is to consult the underlying statutory and regulatory scheme. If the statute and regulations state that non-payment is a mandatory penalty for a violation, such as with the Stark II self-referral law, this would provide an adequate basis for imposing FCA liability under an express or implied certification theory. Where, however, the underlying statutory and regulatory scheme do not mandate non-payment in the event of a violation, which is the case under the federal health care anti-kickback statute and the conditions of participation, there is no principled basis for imposing FCA liability.<sup>319</sup>

While this algorithm is helpful, it does little to assist the federal government in developing FCA liability on the part of Tenet and others since there is no underlying statutory or regulatory scheme that can be identified with regard to the outlier controversy. It remains unclear what statute or regulation the federal government could identify to establish a material violation under the implied certification theory.

Exacerbating the significant hurdles that the federal government must overcome to establish liability under the FCA or grounds for exclusion from federal health programs, there exists the undeniable conclusion that CMS had prior knowledge of weaknesses in the outlier methodology, yet chose to do nothing about it. As early as 1988, comments provided in response to a

---

315. *Id.* at 1045 (citing *United States ex rel. Joslin v. Cmty. Home Health of Md.*, 984 F. Supp. 374, 384-85 (D. Md. 1997)).

316. *See Ab-Tech Constr., Inc. v. United States*, 31 Fed. Cl. 429, 434 (Fed. Cl. 1994).

317. *United States ex rel. Hopper v. Anton*, 91 F.3d 1261, 1267 (9th Cir. 1996) (stating that mere regulatory violations do not give rise to a viable FCA action and that absent actionable false certifications upon which funding is conditioned, the False Claims Act does not provide such a remedy).

318. *Id.* at 1266-68.

319. *See generally Fabrikant & Solomon, supra* note 302.

proposed rule to make certain changes to the IPPS for fiscal year 1989 expressed concern “that the increased emphasis on cost outliers . . . would provide an incentive for hospitals to increase their charges and to manipulate their charge structures.”<sup>320</sup> In response to these concerns, CMS (then the Health Care Finance Administration) explicitly acknowledged that “hospitals can conceivably change their charge structures . . . to maximize their outlier payments.”<sup>321</sup> CMS also noted “that this incentive to manipulate charges is not new.”<sup>322</sup> But rather than incorporating safeguards into the regulations to prevent potential abuse of certain vulnerabilities within the outlier payment calculation methodology, CMS chose to rely on several factors that would mitigate the effects of such activity. Mitigating factors included a cost-to-charge ratio that would reflect increases in a hospital’s overall charges, other third-party and state law restrictions on arbitrary increases in charges, and the fact that outlier payments comprise a small percent of total hospital payments under IPPS. Nowhere did CMS indicate that raising charges in an effort increase outlier reimbursement would constitute illegal conduct.

## VI. CONCLUSION

Given the difficulties involved in demonstrating that increasing charges at a rate higher than costs equates to the knowing submission of a false claim, and given the undeniable conclusion that CMS had prior knowledge of weaknesses in the outlier payment calculation methodology from its inception, it is unlikely that the federal government would be successful on the merits in a suit against Tenet and others alleging liability under the FCA relating to outlier payments. In fact, one could make a strong argument that the real problem with outlier payments is the fundamental flaws in the design of the outlier payment methodology as opposed to anything that hospitals did with respect to outlier payments.

This reality does not, however, preclude the possibility that the federal government will raise criminal charges and civil liabilities in an effort to force Tenet and others to agree to a settlement. Through a combination of highly suspicious allegations and the threat of exclusion from Medicare and Medicaid participation,<sup>323</sup> the federal government has forced enormous

---

320. Medicare Program; Changes to the Inpatient Hospital Prospective Payment System and Fiscal Year 1989 Rates; Final Rule, 53 Fed. Reg. 38,509 (Sept. 30, 1988) (to be codified at 42 C.F.R. pts. 405, 412, 413, and 489).

321. *Id.*

322. *Id.*

323. *See generally* 42 U.S.C. § 1320a-7 (2003).

settlements without the need to prove its case.<sup>324</sup> Most recently, the federal government entered into a record-breaking \$875 million settlement with TAP Pharmaceutical Products, Inc. in a case alleging fraudulent drug pricing schemes.<sup>325</sup> Clearly, Tenet and others will find little solace in the federal government's inability to absolutely identify a law that was violated, as legal liability for even alleged abuses of the outlier payment calculation methodology is a large and looming threat to the financial and legal health of those facilities identified.<sup>326</sup>

For hospitals, the demands of revenue and compliance pressures are a reality. Increasing constraints on resources ensure that harsh regulatory scrutiny of hospital billing practices will likewise continue into the foreseeable future. In this environment, hospitals will inevitably be presented with other opportunities, similar to the vulnerabilities presented in the outlier payment calculation methodology, to "game" the system in an effort to maximize reimbursement. The wisdom of a decision in favor of pursuing such opportunities is highly questionable, and the veracity of the federal government in seeking to prevent and eliminate health care fraud should not be tested.

Hospitals are well advised to educate themselves with regard to regulatory compliance matters in conjunction with state and federal regulators and legal counsel. The purpose of such activity should not be to identify opportunities to "game" the system, but rather to clearly discern such "gaming" opportunities from legitimate and prudent financial management practices that can lead to enhanced revenues and ultimately a hospital's improved and sustained financial performance.

---

324. Ronald H. Clark, Gabriel L. Imperato, & Robert Salcido, *HHS Expanded Use of Fraud Law's "Corporate Death Sentence" is Legally Suspect*, 18 WASH. LEGAL FOUND. 21 (2003).

325. Press Release, Department of Justice, TAP Pharmaceutical Products, Inc. and Seven Others Charged with Health Care Crimes; Company Agrees to Pay \$875 Million to Settle Claims (Oct., 3, 2001), available at <http://www.usdoj.gov/opa/pr/2001/October/513civ.htm> (last visited Apr. 15, 2005).

326. The Department of Health and Human Services Office of the Inspector General has included scrutiny of outlier payments in its Work Plan for 2002, 2003, 2004 and 2005. See generally Work Plans for 2002-05, available at <http://www.oig.hhs.gov/reading/workplan/2002/work%202002.pdf> (last visited Apr. 15, 2005).

**Appendix I**  
***Inpatient Prospective Payment Calculation for DRG 286 (Adrenal and Pituitary Procedures) for Hospital A***<sup>1</sup>

**Assumptions:**

- Hospital A Located in Appleton, Wisconsin (Urban Area)			
- Billed charges =		\$105,000	
- Discharge date January 15, 2004			
- Hospital qualifies for the full update to the operating standardized amount			
- The hospital did qualify for any Disproportionate Share Hospital (DSH) or Indirect (IME) adjustments			
- Operating Cost-to-Charge Ratio		0.50	
- Capital Cost-to-Charge Ratio		0.06	
- Total Cost-to-Charge Ratio		0.56	
		89.3%	
		10.7%	
- Location Classification		Urban	(IPPS Table 4A1)
- Wage Index		0.9507	(IPPS Table 4A1)
		0.9660	(IPPS Table 4A1)
- Operating Standardized Amounts			
Labor		\$2,823.64	(IPPS Table 1B)
% Total		62%	
Non-Labor		\$1,730.62	(IPPS Table 1B)
% Total		38%	
- Standard Federal Capital Rate		\$416.53	(IPPS Table 1D)
- DRG Relative Weight		1.9324	(IPPS Table 5)
- Fixed Loss Threshold		\$25,800.00	(IPPS Final Rule)
- Outlier Marginal Cost Factor		80%	(IPPS Final Rule)

**STEP ONE: Determine the Base IPPS Payment:**

*This is the base IPPS payment for this DRG before considering any outlier payment.*

**Operating Payment**

		(\$2,823.64 x 0.9507) =	\$2,684.43
+ <u>Nonlabor-Related Standardized Amount</u>			\$1,730.62
Total Standardized Amount			\$4,415.05
x <u>DRG Relative Weight</u>			1.9324
Total Operating Payment			<b>\$8,531.65</b>

**Capital Payment**

Capital Standard Federal Payment Rate		\$416.53
x <u>DRG Relative Weight</u>		1.9324
Unadjusted Capital Payment		\$804.90
x <u>Capital Geographic Adjustment Factor</u>		0.9660
Total Capital Payment		<b>\$777.54</b>

<b><u>Total Base IPPS Payment</u></b>		<b><u>\$9,309.19</u></b>
---------------------------------------	--	--------------------------

**STEP TWO: Determine Operating and Capital Costs****Operating Costs**

Total Billed Charges (excluding charges for non-covered services)		\$105,000.00
x <u>Operating Cost-to-Charge Ratio</u>		0.50

**Appendix I**  
***Inpatient Prospective Payment Calculation for DRG 286 (Adrenal and Pituitary Procedures) for Hospital A***<sup>1</sup>

Operating Costs	\$52,500.00
<b>Capital Costs</b>	
Total Billed Charges (excluding charges for non-covered services)	\$105,000.00
x Capital Cost-to-Charge Ratio	0.06
Capital Costs	\$6,300.00

STEP THREE: Determine the outlier threshold:

**Operating Threshold**

Fixed Loss Threshold	\$25,800.00
x Operating Portion of Fixed Loss Threshold	89.3%
Percentage of Operating Costs Attributable to Labor-Related Costs	\$23,035.71
x Portion of Operating Costs Attributable to Labor-Related Costs	62.0%
Portion of Operating Fixed Loss Threshold Attributable to Labor-Related Costs	\$14,282.14
x Wage Index	0.9507
Wage Adjusted Portion of Operating Fixed Loss Threshold Attributable to Labor-Related Costs	\$13,578.03
+ Nonlabor Portion of Fixed Loss Threshold	\$8,753.58
Total Adjusted Operating Fixed Loss Threshold	\$22,331.60
+ Base Operating Payment	\$8,531.65
Operating Outlier Threshold	\$30,863.26

**Capital Threshold**

Fixed Loss Threshold	\$25,800.00
x Capital Costs as a Percentage of Total Costs	11%
Capital Portion of Fixed Loss Threshold	\$2,764.29
x Geographic Adjustment Factor	0.9660
Geographically Adjusted Capital Portion of Fixed Loss Threshold	\$2,670.30
+ Base Capital Payment	\$777.54
Capital Outlier Threshold	\$3,447.84

STEP FOUR: Determine the outlier payment:

**Operating Outlier Payment**

Operating Costs	\$52,500.00
- Operating Outlier Threshold	\$30,863.26
Excess Operating Costs	\$21,636.74
x Marginal Cost Factor	80%
Operating Outlier Payment	\$17,309.39

**Capital Outlier Payment**

Capital Costs	\$6,300.00
- Capital Outlier Threshold	\$3,447.84
Excess Capital Costs	\$2,852.16
x Marginal Cost Factor	80%
Capital Outlier Payment	\$2,281.73

Total Outlier Payment	\$19,591.13
-----------------------	-------------

STEP FIVE: Determine total IPPS Payment

Total IPPS Payment Rate	\$9,309.19
Total Outlier Payment	\$19,591.13
	\$28,900.31



**Appendix I**  
***Inpatient Prospective Payment Calculation for DRG 286 (Adrenal and Pituitary Procedures) for Hospital A***<sup>1</sup>

*In this example, the hospital received an outlier payment equivalent to about 210% of the base IPPS payment for the case, but the total payment made to the hospital for the case only amounted to about 28% of billed charges. Whether or not the outlier payment was "accurate" depends upon whether the cost amounts used in the calculation (determined by applying the hospital's cost-to-charge ratios to the hospital's billed charges) are truly reflective of the hospital's actual costs to furnish the care.*

<sup>1</sup> See 68 Fed. Reg. 34495-96. Copyright 2004 HRAI Coding Specialists, LLC. All rights reserved. These materials may not be duplicated without express written permission of HRAI Coding Specialists, LLC. No claim asserted of any U.S. Government or American Medical Association works.

**Appendix II**  
***Inpatient Prospective Payment Calculation for DRG 286 (Adrenal and Pituitary Procedures) for Hospital B<sup>1</sup>***

**Assumptions:**

- Hospital B Located in Appleton, Wisconsin (Urban Area)		
- Billed charges =	\$50,000	
- Discharge date January 15, 2004		
- Hospital qualifies for the full update to the operating standardized amount		
- The hospital did qualify for any Disproportionate Share Hospital (DSH) or Indirect (IME) adjustments		
- Operating Cost-to-Charge Ratio	0.50	
- Capital Cost-to-Charge Ratio	0.06	
- Total Cost-to-Charge Ratio	0.56	
	89.3%	
	10.7%	
- Location Classification	Urban	(IPPS Table 4A1)
- Wage Index	0.9507	(IPPS Table 4A1)
	0.9660	(IPPS Table 4A1)
- Operating Standardized Amounts		
Labor	\$2,823.64	(IPPS Table 1B)
% Total	62%	
Non-Labor	\$1,730.62	(IPPS Table 1B)
% Total	38%	
- Standard Federal Capital Rate	\$416.53	(IPPS Table 1D)
- DRG Relative Weight	1.9324	(IPPS Table 5)
- Fixed Loss Threshold	\$25,800.00	(IPPS Final Rule)
- Outlier Marginal Cost Factor	80%	(IPPS Final Rule)

**STEP ONE: Determine the Base IPPS Payment:**

*This is the base IPPS payment for this DRG before considering any outlier payment.*

**Operating Payment**

	(\$2,823.64 x 0.9507) =	\$2,684.43
+ <u>Nonlabor-Related Standardized Amount</u>		<u>\$1,730.62</u>
Total Standardized Amount		\$4,415.05
x <u>DRG Relative Weight</u>		<u>1.9324</u>
Total Operating Payment		<u><b>\$8,531.65</b></u>

**Capital Payment**

Capital Standard Federal Payment Rate	\$416.53
x <u>DRG Relative Weight</u>	<u>1.9324</u>
Unadjusted Capital Payment	\$804.90
x <u>Capital Geographic Adjustment Factor</u>	<u>0.9660</u>
Total Capital Payment	<u><b>\$777.54</b></u>

<b><u>Total Base IPPS Payment</u></b>	<u><u><b>\$9,309.19</b></u></u>
---------------------------------------	---------------------------------

**STEP TWO: Determine Operating and Capital Costs**

**Operating Costs**

Total Billed Charges (excluding charges for non-covered services)	\$50,000.00
x <u>Operating Cost-to-Charge Ratio</u>	<u>0.50</u>

**Appendix II**  
***Inpatient Prospective Payment Calculation for DRG 286 (Adrenal and Pituitary Procedures) for Hospital B<sup>1</sup>***

Operating Costs	\$25,000.00
<b><u>Capital Costs</u></b>	
Total Billed Charges (excluding charges for non-covered services)	\$50,000.00
x <u>Capital Cost-to-Charge Ratio</u>	<u>0.06</u>
Capital Costs	\$3,000.00

STEP THREE: Determine the outlier threshold:

**Operating Threshold**

Fixed Loss Threshold	\$25,800.00
x <u>Operating Portion of Fixed Loss Threshold</u>	<u>89.3%</u>
Percentage of Operating Costs Attributable to Labor-Related Costs	\$23,035.71
x <u>Portion of Operating Costs Attributable to Labor-Related Costs</u>	<u>62.0%</u>
Portion of Operating Fixed Loss Threshold Attributable to Labor-Related Costs	\$14,282.14
x <u>Wage Index</u>	<u>0.9507</u>
Wage Adjusted Portion of Operating Fixed Loss Threshold Attributable to Labor-Related Costs	\$13,578.03
+ <u>Nonlabor Portion of Fixed Loss Threshold</u>	<u>\$8,753.58</u>
Total Adjusted Operating Fixed Loss Threshold	\$22,331.60
+ <u>Base Operating Payment</u>	<u>\$8,531.65</u>
<b>Operating Outlier Threshold</b>	<b>\$30,863.26</b>

**Capital Threshold**

Fixed Loss Threshold	\$25,800.00
x <u>Capital Costs as a Percentage of Total Costs</u>	<u>11%</u>
Capital Portion of Fixed Loss Threshold	\$2,764.29
x <u>Geographic Adjustment Factor</u>	<u>0.9660</u>
Geographically Adjusted Capital Portion of Fixed Loss Threshold	\$2,670.30
+ <u>Base Capital Payment</u>	<u>\$777.54</u>
<b>Capital Outlier Threshold</b>	<b>\$3,447.84</b>

STEP FOUR: Determine the outlier payment:

**Operating Outlier Payment**

Operating Costs	\$25,000.00
- <u>Operating Outlier Threshold</u>	<u>\$30,863.26</u>
Excess Operating Costs	\$0.00
x <u>Marginal Cost Factor</u>	<u>80%</u>
<b>Operating Outlier Payment</b>	<b>\$0.00</b>

**Capital Outlier Payment**

Capital Costs	\$3,000.00
- <u>Capital Outlier Threshold</u>	<u>\$3,447.84</u>
Excess Capital Costs	\$0.00
x <u>Marginal Cost Factor</u>	<u>80%</u>
<b>Capital Outlier Payment</b>	<b>\$0.00</b>

**Total Outlier Payment**

**\$0.00**

STEP FIVE: Determine total IPPS Payment

Total IPPS Payment Rate	\$9,309.19
Total Outlier Payment	\$0.00
	<u>\$9,309.19</u>

**Appendix II**  
***Inpatient Prospective Payment Calculation for DRG 286 (Adrenal and Pituitary Procedures) for Hospital B***<sup>1</sup>

*In this example, the hospital did not receive an outlier payment because neither operating or capital costs exceeded the respective thresholds.*

<sup>1</sup> See 68 Fed. Reg. 34495-96. Copyright 2004 HRAI Coding Specialists, LLC. All rights reserved. These materials may not be duplicated without express written permission of HRAI Coding Specialists, LLC. No claim asserted of any U.S. Government or American Medical Association works.

**Appendix III**  
***Inpatient Prospective Payment Calculation for DRG 286 (Adrenal and Pituitary Procedures) For Hospital C<sup>1</sup>***

**Assumptions:**

- Hospital C Located in Appleton, Wisconsin (Urban Area)		
- Billed charges =	\$105,000	
- Discharge date January 15, 2004		
- Hospital qualifies for the full update to the operating standardized amount		
- The hospital did qualify for any Disproportionate Share Hospital (DSH) or Indirect (IME) adjustments		
- Operating Cost-to-Charge Ratio	0.25	
- Capital Cost-to-Charge Ratio	0.03	
- Total Cost-to-Charge Ratio	0.28	
	89.3%	
	10.7%	
- Location Classification	Urban	(IPPS Table 4A1)
- Wage Index	0.9507	(IPPS Table 4A1)
	0.9660	(IPPS Table 4A1)
- Operating Standardized Amounts		
Labor	\$2,823.64	(IPPS Table 1B)
% Total	62%	
Non-Labor	\$1,730.62	(IPPS Table 1B)
% Total	38%	
- Standard Federal Capital Rate	\$416.53	(IPPS Table 1D)
- DRG Relative Weight	1.9324	(IPPS Table 5)
- Fixed Loss Threshold	\$25,800.00	(IPPS Final Rule)
- Outlier Marginal Cost Factor	80%	(IPPS Final Rule)

**STEP ONE: Determine the Base IPPS Payment:**

*This is the base IPPS payment for this DRG before considering any outlier payment.*

**Operating Payment**

	(\$2,823.64 x 0.9507) =	\$2,684.43
+ <u>Nonlabor-Related Standardized Amount</u>		\$1,730.62
Total Standardized Amount		\$4,415.05
x <u>DRG Relative Weight</u>		1.9324
Total Operating Payment		<u>\$8,531.65</u>

**Capital Payment**

Capital Standard Federal Payment Rate	\$416.53
x <u>DRG Relative Weight</u>	1.9324
Unadjusted Capital Payment	\$804.90
x <u>Capital Geographic Adjustment Factor</u>	0.9660
Total Capital Payment	<u>\$777.54</u>

**Total Base IPPS Payment**

\$9,309.19

**STEP TWO: Determine Operating and Capital Costs****Operating Costs**

Total Billed Charges (excluding charges for non-covered services)	\$105,000.00
x <u>Operating Cost-to-Charge Ratio</u>	<u>0.25</u>

**Appendix III**  
***Inpatient Prospective Payment Calculation for DRG 286 (Adrenal and Pituitary Procedures) For Hospital C***<sup>1</sup>

Operating Costs	\$26,250.00
 <b>Capital Costs</b>	
Total Billed Charges (excluding charges for non-covered services)	\$105,000.00
x <u>Capital Cost-to-Charge Ratio</u>	0.03
Capital Costs	\$3,150.00

STEP THREE: Determine the outlier threshold:

**Operating Threshold**

Fixed Loss Threshold	\$25,800.00
x <u>Operating Portion of Fixed Loss Threshold</u>	89.3%
Percentage of Operating Costs Attributable to Labor-Related Costs	\$23,035.71
x <u>Portion of Operating Costs Attributable to Labor-Related Costs</u>	62.0%
Portion of Operating Fixed Loss Threshold Attributable to Labor-Related Costs	\$14,282.14
x <u>Wage Index</u>	0.9507
Wage Adjusted Portion of Operating Fixed Loss Threshold Attributable to Labor-Related Costs	\$13,578.03
+ <u>Nonlabor Portion of Fixed Loss Threshold</u>	\$8,753.58
Total Adjusted Operating Fixed Loss Threshold	\$22,331.60
+ <u>Base Operating Payment</u>	\$8,531.65
<b>Operating Outlier Threshold</b>	\$30,863.26

**Capital Threshold**

Fixed Loss Threshold	\$25,800.00
x <u>Capital Costs as a Percentage of Total Costs</u>	11%
Capital Portion of Fixed Loss Threshold	\$2,764.29
x <u>Geographic Adjustment Factor</u>	0.9660
Geographically Adjusted Capital Portion of Fixed Loss Threshold	\$2,670.30
+ <u>Base Capital Payment</u>	\$777.54
<b>Capital Outlier Threshold</b>	\$3,447.84

STEP FOUR: Determine the outlier payment:

**Operating Outlier Payment**

Operating Costs	\$26,250.00
- <u>Operating Outlier Threshold</u>	\$30,863.26
Excess Operating Costs	\$0.00
x <u>Marginal Cost Factor</u>	80%
<b>Operating Outlier Payment</b>	\$0.00

**Capital Outlier Payment**

Capital Costs	\$3,150.00
- <u>Capital Outlier Threshold</u>	\$3,447.84
Excess Capital Costs	\$0.00
x <u>Marginal Cost Factor</u>	80%
<b>Capital Outlier Payment</b>	\$0.00

<b>Total Outlier Payment</b>	<b>\$0.00</b>
------------------------------	---------------

STEP FIVE: Determine total IPPS Payment

Total IPPS Payment Rate	\$9,309.19
Total Outlier Payment	\$0.00
	\$9,309.19

**Appendix III**  
***Inpatient Prospective Payment Calculation for DRG 286 (Adrenal and Pituitary  
Procedures) For Hospital C***<sup>1</sup>

*In this example, the hospital did not receive an outlier payment because neither operating or capital costs exceed the respective thresholds.*

<sup>1</sup> See 68 Fed. Reg. 34495-96. Copyright 2004 HRAI Coding Specialists, LLC. All rights reserved. These materials may not be duplicated without express written permission of HRAI Coding Specialists, LLC. No claim asserted of any U.S. Government or American Medical Association works.