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CMS Ordered to Go Back to the Drawing Board Before Applying Outlier Reconciliation Criteria

A federal district court recently reversed CMS's decision to recoup more than $2 million through application of CMS's outlier reconciliation criteria. *Clarian Health West, LLC v. Burwell* (14-cv-0339, Aug. 26, 2016). CMS had established its reconciliation criteria in 2010, in its Medicare Claims Processing Manual. However, the court determined that those criteria comprise substantive regulations that CMS was not permitted to issue or apply without first going through notice and comment procedures. This ruling not only reverses the recoupment at issue in the *Clarian Health West* case, but also provides grounds to challenge other reconciliation actions the agency has taken to date. Providers should review whether they have been (or are currently) subject to any reconciliation initiatives by their contractor, and take steps to protect their appeal rights.

Background Regarding Outlier Reconciliation Requirements

Outlier payments are a supplement to prospective payments and are intended to compensate providers for treating patients where the cost of care is extraordinarily costly. In 2003, CMS learned that a small percentage of hospitals had gamed the agency's outlier payment system by "turbo-charging." Those hospitals had, among other things, taken advantage of the substantial time lag between updates to a hospital's cost-to-charge ratio (used to convert its charges to costs) and its charges for claims submitted later in a given fiscal year. By rapidly increasing its charge master, a hospital would have billed charges that, adjusted by its dated historical cost-to-charge ratio, made it artificially appear as if a given patient case was extraordinarily costly.

In 2003, CMS overhauled its regulations governing outlier payments to use more recent cost-report data to set cost-to-charge ratios and, thus, substantially reduced this time lag. However, because even the most recent cost-report data still lagged claims by about a year, a hospital could continue to artificially inflate its outlier claims by rapidly increasing its charges. Thus, CMS's revised 2003 regulations subjected outlier payments to reconciliation upon settlement of a hospital's cost report and provided for the charging of interest on any reconciled over-payments.

CMS did not, however, establish the criteria for reconciliation in its 2003 rulemaking. Instead, roughly seven years later, CMS spelled out the actual criteria that would trigger reconciliation. Specifically, outlier payments were potentially subject to reconciliation if (1) the provider's cost-to-charge ratio at cost-report settlement was plus or minus 10 percentage points of the prior cost-to-charge ratio used to pay the claims; and (2) the provider's total outlier payments were more than $500,000. If those criteria are met, the Medicare contractor is to initiate the reconciliation process.

Clarian Health West Decision

The hospital in *Clarian Health West* began operating in 2004. As the court noted, a new hospital's cost-to-charge ratio can be expected to change rapidly for at least two reasons unrelated to turbo-charging. First, due to a lack of historical operating data, a new hospital is initially assigned a statewide average cost-to-charge ratio. This can be expected to change in the second or third year of operations when actual data is available. Second, initial hospital operations are inherently costly when evaluated on a per-patient basis. As costs drop during the first few years of operation, so too do the cost-to-charge ratios. The hospital in *Clarion Health West* argued that it had experienced the latter dynamic and that it should not have been a candidate for reconciliation in the first place.

The *Clarian Health West* hospital challenged CMS's application of the reconciliation criteria on several grounds. However, the court was able to decide the case on the procedural question of whether CMS was required to go through the process of notice and comment rulemaking before enforcing reconciliation criteria.

The court determined that CMS's reconciliation criteria comprised substantive reimbursement rules. As such, both the Medicare Act and the Administrative Procedure Act prohibited CMS from relying on the reconciliation criteria to determine Medicare payments without first proposing them in the Federal Register and giving the regulated public the opportunity for comment.

CMS has until the end of October to appeal the decision in *Clarian Health West*.

Practical Steps

The *Clarian Health West* decision effectively upends CMS's outlier reconciliation program. All of its past reconciliation determinations are subject to challenge on grounds that the agency had applied invalid reconciliation criteria. This directly includes decisions under Part A for inpatient care and may spill over to decisions relating to reconciliation of outlier payments under Medicare's other prospective payment systems, such as those for inpatient rehabilitation facilities, outpatient care and long-term care hospitals.

Whether or not CMS decides to appeal the *Clarian Health West* decision, all providers that have been subject to outlier reconciliation should evaluate whether it would be appropriate to challenge the agency's reconciliation determination.

If you have any questions on this topic, please speak to one of the individuals listed in this publication or your usual firm contact.

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