

PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2026-D29

PROVIDER –

Kaiser Health CY 2016 Outlier Payment
CIRP Group

PROVIDER NUMBERS - 05-0425, 05-0075,
05-0777, 05-0070, 05-0073, 05-0140, 05-0609,
05-0411, 05-0076, 05-0772, 05-0510, 05-0512,
05-0677, 05-0690, 05-0674, 05-0072, 05-0760,
05-0139, 05-0723, 05-0138

vs.

MEDICARE CONTRACTOR –

Noridian Healthcare Solutions c/o Cahaba
Safeguard Administrators

HEARING DATE –

August 21, 2024

**COST REPORTING PERIOD
ENDED –**

December 31, 2016

CASE NUMBER – 21-0039GC

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ISSUE STATEMENT:

Whether it is proper for Noridian Healthcare Solutions (the “Medicare Contractor”) to use a statewide average cost-to-charge ratio (“CCR”) for the calculation of Kaiser Health’s (“Kaiser”, each Kaiser hospital individually a “Hospital” and collectively the “Hospitals”) outlier payments for fiscal year (“FY”) 2016 or whether, instead, the Medicare Contractor should have reconciled the Hospitals’ outlier payments, using each Hospital’s actual CCR, during the cost-report settlement process.¹

DECISION:

After considering Medicare law, regulations, and program guidance, the arguments presented, and the evidence admitted,² the Provider Reimbursement Review Board (“Board”) finds the Medicare Contractor properly calculated Kaiser’s outlier payments for all Hospital cost reports in fiscal year (“FY”) 2016.

INTRODUCTION:

Medicare normally pays hospitals a fixed amount for each patient stay based on diagnosis, but some patients cost more than expected due to complications or unusually intensive care. When a hospital’s actual costs for a case run significantly above that standard payment, even after accounting for extra funding the hospital may already receive, Medicare provides an additional “outlier payment” to help cover the gap.³ Kaiser’s appeal relates to its Medicare outlier payments for the common FY ending December 31, 2016.

This common issue related party group (“CIRP”) appeal consisted of twenty-three (23) hospitals⁴ which are operated by Kaiser. Following withdrawals of three (3) Hospitals from the appeal, the twenty (20) Hospitals remaining in the CIRP group consist of hospitals solely located in the state of California. Each Hospital is a Medicare-participating acute care hospital.⁵

Specifically, Kaiser seeks reconciliation of its Hospitals’ FY 2016 outlier payments in accordance with its interpretation of the criteria set forth in the Medicare Claims Payment Manual (“MCPM”), which is contrary to the Medicare Contractor’s interpretation of the MCPM.⁶ Additionally, Kaiser challenges the Medicare Contractor’s refusal to exercise its

¹ See Transcript of Proceedings (“Tr.”) at 5:11-6:1; *see also* Stipulations (Revised) (“Stip.”) at 2 (Aug. 16, 2024).

² Any arguments or evidence, whether or not specifically referenced or discussed herein, were considered by the Board in the deliberations of this appeal.

³ *See generally* 42 C.F.R. § 412.80.

⁴ Note that Provider No. 05-0138 (Kaiser Foundation Hospital - Los Angeles) was added to the CIRP on July 21, 2023, as the 23rd Hospital in this appeal when it was transferred from Case No. 23-0292. *See* Transfer of Issue and Case Closure (Case No. 23-0292) (July 24, 2023). However, this hospital was not listed in Providers’ Responsive Final Position Paper (alternatively titled “Response to MAC’s Position Paper,” or “Providers’ RFPP”) (Jul. 22, 2024). *See* Providers’ RFPP at 3. *See also* Tr. at 9:4-5 (in which the Providers’ representative refers to “20 hospitals in this group appeal”) and Tr. at 29:21-22 (in which the Medicare Contractor’s representative’s opening statement refers to “22 original providers”).

⁵ *See* Medicare Contractor’s Preliminary Position Paper (“Medicare Contractor’s PPP”) at 1 (Jun. 9, 2022).

⁶ Providers’ RFPP at 1.

discretion to reopen the Hospitals' cost reports for outlier payment reconciliation based on asserted "significant inaccuracies," which the MCPM provides is within its discretion.⁷

Kaiser timely appealed the issue to the Board and met the jurisdictional requirements for a hearing. The Board conducted a video hearing on August 21, 2024. Kaiser was represented by Sven Collins, Esq. of Hooper, Lundy & Bookman, P.C. The Medicare Contractor was represented by Jerrod Olszewski, Esq. of Federal Specialized Services.

STATEMENT OF RELEVANT FACTS:

The Parties' Revised Joint Stipulations provide the relevant facts summarized as follows:

Prior to 2016, the Hospitals' outlier payments were determined using the applicable *statewide average cost to charge ratio* ("CCR"), as Hospitals historically reported on the basis of functional units in lieu of gross charges.⁸ For their FY 2016 cost reports, the Hospitals sought and received Medicare Contractor approval to begin reporting gross charges on Worksheet C, which thereby allowed the Medicare Contractor to determine each Hospital's *actual CCR* during the cost report settlement process.⁹ However, the Medicare Contractor reconciled outlier payments for only one of the remaining Hospitals in the CIRP group, based upon its interpretation of the MCPM criteria.¹⁰ Particularly, the Medicare Contractor determined that although each of the Hospitals had CCRs that were 10 percentage points higher than the statewide average CCR, satisfying the first criterion, their outlier payments for FY 2016 did not exceed \$500,000, which is required to meet the second criterion.¹¹ Thus, for the remaining Hospitals, the Medicare Contractor used the statewide average CCR to calculate the Hospitals' respective outlier payments and did not perform a reconciliation, pursuant its interpretation of the MCPM guidelines.¹²

STATEMENT OF RELEVANT LAW:

42 U.S.C. § 1395ww(d) established an inpatient prospective payment system ("IPPS") to pay hospitals¹³ for the *operating* costs of inpatient hospital services associated with inpatient hospital discharges covered under Medicare Part A.¹⁴ Under IPPS, each such case is categorized into a diagnostic-related group ("DRG") and each DRG has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that DRG.¹⁵ In addition to the DRG payment, hospitals can receive other adjustments or add-on payments, one of which is an *operating* outlier payment for certain cases which are unusually costly.¹⁶

⁷ *Id.* at 4.

⁸ See Stip. at ¶¶ 2, 3.

⁹ See Stip. at ¶¶ 4, 5. See also Ex. P-2 at P0283 – P0284.

¹⁰ See Stip. at ¶ 8 [referring to the second ¶ 8 which appears at page 11].

¹¹ See Stip. at ¶¶ 6, 8 [referring to the second ¶ 8 which appears at page 11].

¹² See Stip. at 2.

¹³ As used here, the term "hospital" is limited to a "subsection (d) hospital" defined at 42 U.S.C. § 1395ww(d)(1)(B).

¹⁴ 42 U.S.C. § 1395ww(d)(1)(A).

¹⁵ 42 C.F.R. § 412.60.

¹⁶ 42 C.F.R. §§ 412.80 - 412.84.

Additionally, 42 U.S.C. § 1395ww(g) requires the Secretary to pay for the *capital*-related costs of hospital inpatient services with a prospective payment system (“Capital PPS”). Under Capital PPS, payments are adjusted by the same DRG for the case, as they are under IPPS. Similarly, a case may also qualify, under Capital PPS, to receive a *capital* outlier payment.¹⁷

To receive an outlier payment, the *combined* operating and capital cost associated with a case (*i.e.*, a Medicare-covered hospital inpatient discharge) must exceed the fixed-loss outlier threshold amount established by CMS, *i.e.*, the specific dollar amount which this cost must exceed in order for the case to qualify for an outlier payment.¹⁸ The operating cost and capital cost associated with a case “are computed separately by multiplying the total covered charges by the operating and capital [CCRs].”¹⁹ The Secretary set this policy as part of the final rule published on September 30, 1988. Specifically, the Secretary chose to use hospital-specific CCRs, rather than a nationwide CCR, to determine hospitals’ costs for assessing whether a case qualified for payment as a cost outlier.²⁰ The Secretary’s rationale for adopting hospital-specific CCRs essentially focuses on the need for “reasonably reliable factors to estimate costs from charges” and enhancing the accuracy of identifying and computing outlier payments:

We proposed to use hospital-specific [CCRs] to adjust charges for the purpose of computing cost outlier payments. The use of hospital-specific [CCRs] should *greatly enhance the accuracy* with which outlier cases are identified and outlier payments are computed, since there is wide variation among hospitals in these [CCRs]. The increased emphasis on cost in computing outlier payments heightens *the need to use reasonably reliable factors to estimate costs from charges*. Therefore, we believe the use of hospital-specific [CCRs] is essential to ensure that outlier payments are made for cases that have extraordinarily high costs, and not merely high charges.²¹

Accordingly, the 1988 Final Rule amended the regulations at 42 C.F.R. § 412.84, adding the new paragraph (h) to set forth the rules for applying CCRs in outlier reconciliation determinations, which originally stated:

(h) The cost-to-charge ratio used to adjust covered charges is computed annually by the intermediary for each hospital based on the latest available settled cost report for that hospital and charge data for the same time period as that covered by the cost report. Statewide cost-to-charge ratios are used in those instances in which a hospital’s cost-to-charge ratio falls outside reasonable parameters. HCFA sets forth these parameters and the Statewide

¹⁷ 42 C.F.R. § 412.312(c).

¹⁸ 68 Fed. Reg. 34494, 34495 (Jun. 9, 2003).

¹⁹ *Id.*

²⁰ 53 Fed. Reg. 38476, 38503 (Sept. 30, 1988).

²¹ *Id.* (Emphasis added).

cost-to-charge ratios in each year's annual notice of prospective payment rates published under § 412.8(b).²²

The 1992 IPPS Final Rule revised paragraph (h) as follows:

The operating cost-to-charge ratio and, effective with cost reporting periods beginning on or after October 1, 1991, the capital cost-to-charge ratio used to adjust covered charges are *computed annually* by the intermediary for each hospital *based on the latest available settled cost report for that hospital* and charge data for the same time period as that covered by the cost report. *Statewide cost-to-charge ratios are used in those instances in which a hospital's operating or capital cost-to-charge ratios fall outside reasonable parameters. [CMS] sets forth these parameters and the statewide cost-to-charge ratios in each year's annual notice of prospective payment rates published under §412.8(b).*²³

Similar to IPPS, Section 1833(t) of the Social Security Act, as amended by § 4523 of the Balanced Budget Act (BBA) of 1997, authorized CMS to implement the outpatient prospective payment system ("OPPS"). Congress enacted an OPPS outlier payment mechanism in 42 U.S.C. § 1395l(t)(5). Specifically, the statutory provision states:

(5) Outlier adjustment

(A) In general

Subject to subparagraph (D), the Secretary shall provide for an additional payment for each covered OPD service (or group of services) for which a hospital's charges, adjusted to cost, exceed—

(i) a fixed multiple of the sum of—

(I) the applicable Medicare OPD fee schedule amount determined under paragraph (3)(D), as adjusted under paragraph (4)(A) (other than for adjustments under this paragraph or paragraph (6)); and

(II) any transitional pass-through payment under paragraph (6); and

(ii) at the option of the Secretary, such fixed dollar amount as the Secretary may establish.

(B) Amount of adjustment

²² *Id.* at 38529.

²³ 56 Fed Reg. 43358, 43448 (Aug. 30, 1991) (Emphasis added).

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

On June 9, 2003, the Secretary published a final rule solely addressing cost outliers and, to that end, it was entitled “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” (“June 2003 Final Rule”).²⁴ In the preamble to the June 2003 Final Rule, the Secretary explains that outlier payments made for discharges on or after October 1, 2003 are “subject to possible reconciliation” when hospitals’ cost reports are settled:

[I]n light of the gross abuses of the current methodology by some hospitals and the negative impact such overpayments ultimately have on other hospitals due to their effect on the threshold, we believe the option of *reconciling outlier payments based on the settled cost report for hospitals* that have been initially paid using a significantly inaccurate cost-to-charge ratio compared to the actual ratio from the cost reporting period is now appropriate. In our view, *reconciling outlier payments* because they were originally paid on the basis of a significantly inaccurate cost-to-charge ratio is similar to recovering outlier payments when adjustments are made to covered charges for any services that are not found to be medically necessary or appropriate Medicare services upon medical or other review. This review is explicitly provided for at § 412.84(d). This provision was established when the IPPS was first implemented for FY 1984 (48 FR 39785).

[I]f we deem it necessary as a result of a hospital-specific data variance to reconcile outlier payments of an individual hospital, such action on our part would not affect the predictability of the entire system. Rather, because *each hospital is on notice as to our revised methodology* for determining cost-to-charge ratios and *that outlier payments are subject to possible reconciliation*, and because each hospital has the necessary data regarding its own costs and charges to predict its actual cost-to-charge ratio, we are able to maintain the predictability of the system as a whole. Further, because reconciliation of outlier payments will affect only certain hospitals, the administrative burden of implementing such a policy is minimized.²⁵

²⁴ 68 Fed. Reg. 34494 (June 9, 2003); *see also* Ex. C-9.

²⁵ *Id.* at 34502 (emphasis added).

Additionally, in the June 2003 Final Rule, the Secretary addressed provisions related to statewide average CCRs:

We are implementing new regulations at §§ 412.84(h) and (i)(1) that are effective 60 calendar days after the date of publication of this final rule, that remove the existing requirement that a fiscal intermediary will assign a hospital the statewide average cost-to-charge ratio when the hospital has a cost-to-charge ratio that falls below the floor. Hospitals will receive their actual cost-to-charge ratios, no matter how low their ratios fall.

*The statewide average cost-to-charge ratios will still apply in those instances in which a hospital's operating or capital cost-to-charge ratios fall outside of reasonable parameters (that is, exceed the upper threshold). In addition, hospitals that have not yet filed their first Medicare cost reports with their fiscal intermediaries would still receive the statewide average cost-to-charge ratios. CMS will continue to set forth the reasonable parameters and the statewide cost-to-charge ratios in each year's annual notice of prospective payment rates published in the Federal Register in accordance with §412.8(b)*²⁶

Accordingly, as part of the June 2003 Final Rule, the Secretary modified 42 C.F.R. § 412.84, in relevant part, to address CCRs applicable to outlier determinations on a prospective basis in a new subsection (i). In pertinent part, this regulation, as revised, states:

(i)(1) For discharges occurring on or after August 8, 2003, CMS may specify an alternative to the ratios otherwise applicable under paragraphs (h) or (i)(2) of this section. A hospital may also request that its fiscal intermediary use a different (higher or lower) cost-to-charge ratio based on substantial evidence presented by the hospital. Such a request must be approved by the CMS Regional Office.

(2) For discharges occurring on or after October 1, 2003, the operating and capital cost-to-charge ratios applied at the time a claim is processed are based on either the most recent settled cost report or the most recent tentative settled cost report, whichever is from the latest cost reporting period.

(3) For discharges occurring on or after August 8, 2003, ***the fiscal intermediary may use a statewide average cost-to-charge ratio if it is unable to determine an accurate operating or capital cost-to-charge ratio for a hospital in one of the following circumstances:***

²⁶ *Id.* at 34500 (emphasis added).

(i) New hospitals that have not yet submitted their first Medicare cost report. (For this purpose, a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with § 489.18 of this chapter.)

(ii) Hospitals whose operating or capital cost-to-charge ratio is in excess of 3 standard deviations above the corresponding national geometric mean. This mean is recalculated annually by CMS and published in the annual notice of prospective payment rates issued in accordance with § 412.8(b).

(iii) ***Other hospitals for whom the fiscal intermediary obtains accurate data with which to calculate either an operating or capital cost-to-charge ratio (or both) are not available.***

(4) *For discharges occurring on or after August 8, 2003*, any reconciliation of outlier payments will be based on operating and capital cost-to-charge ratios calculated based on a ratio of costs to charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled.²⁷

Therefore, this 2003 modification of 42 C.F.R. § 412.84(i)(4) allows for reconciliation and final settlement of outlier payments using actual CCRs based on the cost reporting period being settled.

Finally, as part of the June 2003 Final Rule, the Secretary adopted a “time value of money” or “TVM” adjustment because a hospital that receives *excess* outlier payments would have access to those funds until the amount was repaid to the Medicare trust fund (or, in the case of an underpayment, would not have had access to the appropriate amount during the same period).²⁸ The Secretary gave the following explanation regarding the TVM adjustment:

[O]utlier payments are uniquely susceptible to manipulation because hospitals set their own level of charges and are able to change their charges without notification to, or review by, their fiscal intermediary. Such changes by a hospital directly affect its level of outlier payments, unlike IME or DSH where the fiscal intermediary must agree to a change to the underlying data. Therefore, even though the money may be recouped if the outlier payments are reconciled, the hospital would essentially be able to unilaterally increase its charges and acquire an interest-free loan in the meantime. For that reason, we believe it is appropriate to apply an adjustment for the time value of overpayments or underpayments identified at cost report reconciliation. Because the

²⁷ *Id.* at 34515 (emphasis added).

²⁸ *Id.* at 34504.

other changes we are making in this final rule will largely ensure the payments hospitals receive for outlier cases are accurate, ***we do not anticipate it will be necessary to apply this adjustment broadly***. Therefore, the actual total impact of this adjustment should be relatively small.²⁹

Accordingly, the June 2003 Final Rule promulgated the time value of money adjustment at 42 C.F.R. § 412.84(m) which states:

Effective for discharges occurring on or after August 8, 2003, at the time of any reconciliation under paragraph [(i)(4)]³⁰ of this section, outlier payments *may be adjusted to account for **the time value** of any underpayments or overpayments*. Any adjustment will be based upon a widely available index to be established ***in advance*** by the Secretary, and will be applied from the midpoint of the cost reporting period to the date of reconciliation.³¹

In adopting the CCR reconciliation process, the Secretary specified in the preamble to the June 2003 Final Rule that she would issue additional instructions on the threshold that would trigger mandatory reconciliation and confirmed that Medicare contractors have “administrative discretion” to perform reconciliation “when analysis indicates the outlier payments made . . . are significantly inaccurate.” Specifically, the Secretary explained:

In addition, most of the changes in this regulation will apply for approximately the last 2 months of FY 2003. We intend to limit the impact of this provision during FY 2003 to ensure that the limited resources of fiscal intermediaries are focused upon those hospitals that appear to have disproportionately benefited from the time lag in updating their [CCRs] and to maintain the overall predictability of FY 2003 payments for most hospitals. Accordingly, we intend to issue a program instruction in the near future to assist fiscal intermediaries in implementing this provision during the remainder of FY 2003.

In the same program instruction, we will issue thresholds for fiscal intermediaries to reconcile outlier payments for other hospitals during FY 2003.

For cost reporting periods beginning during FY 2004, we are *considering* instructing fiscal intermediaries to conduct reconciliation for hospitals whose actual cost-to-charge ratios are found to be ***plus or minus 10 percentage points*** from the [CCR]

²⁹ *Id.* (emphasis added).

³⁰ The regulation originally cross-referenced paragraph (h)(3); however, it was later amended in 2006 to reference paragraph (i)(4), *see* 71 Fed. Reg. 47870 at 48098 (Aug. 18, 2006).

³¹ 68 Fed. Reg. at 34515 (Bold and italics emphasis added).

used during that time period to make outlier payments, and that have total FY 2004 outlier payments that exceed \$500,000. We believe these thresholds would appropriately capture those hospitals whose outlier payments will be substantially inaccurate when using the ratio from the contemporaneous cost reporting period. Hospitals exceeding these thresholds during their applicable cost reporting periods would become subject to reconciliation of their outlier payments. These thresholds would be reevaluated annually and, if necessary, modified each year. However, *fiscal intermediaries would also **have the administrative discretion** to reconcile additional hospitals' cost reports based on analysis that indicates the outlier payments made to those hospitals are significantly inaccurate.*³²

The OPPS regulations contain a reconciliation provision similar to the IPPS regulation:

(6) Reconciliation. For hospital outpatient services furnished during cost reporting periods beginning on or after January 1, 2009 –

(i) Any reconciliation of outlier payments will be based on an overall ancillary cost-to-charge ratio calculated based on a ratio of costs to charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the service is settled.

(ii) At the time of any reconciliation under paragraph (d)(6)(i) of this section, outlier payments may be adjusted to account for the time value of any under payments or over payments. Any adjustment will be based on a widely available index to be established in advance by CMS, and will be applied from the midpoint of the cost reporting period to the date of reconciliation.³³

CMS Program Instructions Addressing Outlier Reconciliation

Consistent with the preamble discussion from the June 2003 Final Rule (above), CMS issued Program Memorandum Intermediaries (“PMI”) Transmittal A-03-058 on July 3, 2003³⁴ to provide guidance to Medicare contractors on the reconciliation process and, in particular, finalizing the 10 percent threshold discussed in the June 9, 2003 Final Rule. This Transmittal states, in pertinent part:

[F]or discharges occurring in cost reporting periods beginning on or after October 1, 2003 for all other IPPS hospitals, fiscal

³² *Id.* at 34503 (Bold, italics and underline emphasis added).

³³ 42 C.F.R. § 419.43(d)(6).

³⁴ CMS, Program Memorandum Intermediaries, Transmittal A-03-058, Change Req. 2785 (Jul. 3, 2003) (*available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/a03058.pdf>* (last visited Sept. 14, 2026)). CMS later incorporated this memorandum’s instructions into MCPM, Ch. 3, § 20.2 (Rev. 707, Oct. 12, 2005).

intermediaries are to reconcile outlier payments at the time of cost report final settlement if:

1) Actual operating or capital CCRs are found to be plus or minus 10 percentage points from the CCRs used during that time period to make outlier payments, and

2) Total outlier payments in that cost reporting period exceed \$500,000.³⁵

On October 12, 2005, CMS issued Transmittal 707 for the Medicare Claims Processing Manual (“MCPM”), to “tell[] FIs how to implement the policies of IPPS reconciliation and how to apply the time value money to reconciliation.”³⁶ Through Transmittal 707, CMS essentially incorporated PMI Transmittal A-03-58 dated July 3, 2003 into the MCPM, Ch. 3, § 20. In particular, this Transmittal added the provisions to MCPM, Ch. 3, § 20.1.2.7 to detail the steps that, effective November 7, 2005, Medicare Contractors were to follow when performing an outlier reconciliation. These provisions were slightly modified in October 2006 such that the eight (8) steps detailed at MCPM, Ch. 3, § 20.1.2.7 read:

The following is a step-by-step explanation of how FIs are to notify CMS and hospitals that reconciliation should be performed and to record reconciled outlier claims for hospitals that meet the criteria for reconciliation:

- 1) The FI sends notification to the CMS central office (not the hospital), via the street address and email address provided in §20.1.2.1 (B)) and regional office that a hospital has met the criteria for reconciliation.
- 2) If the FI receives approval from the CMS central office that reconciliation is appropriate, the FI follows steps 3-8 below.
- 3) The FI shall notify the hospital and copy the CMS regional office and central office in writing and via email (through the addresses provided in §20.1.2.1 (B)) that the hospital’s outlier claims are to be reconciled.
- 4) The FI shall submit to the central office PSF data that were used for discharges to compute outlier payments during the cost reporting year being final settled as well as new CCR data that have been determined as part of the settlement process of that cost report. The FI submits this data (preferably in electronic format) to the central office via the addresses provided above. Data fields

³⁵ *Id.* at 3. (Bold, italics and underline emphasis added).

³⁶ MCPM Transmittal 707, Change Req. 3966 at 1 (Oct. 12, 2005) (available at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R707CP.pdf> (last visited Sept. 18, 2026)).

that shall be submitted include PSF fields 23, Intern to Bed Ratio, 24, Bed Size, 25, all relevant Operating Cost to Charge Ratios (including CCRs from the date of discharge of claims being reprocessed as well as updated CCRs that has been determined as part of the settlement process of that cost report), 27, SSI Ratio, 28, Medicaid Ratio, 47, all relevant Capital Cost to Charge Ratios (including CCRs from the date of discharge of claims being reprocessed as well as updated CCRs that has been determined as part of the settlement process of that cost report) 49, Capital IME and 21, Case Mix Adjusted Cost Per Discharge.

5) Central office will use data from National Claims History (NCH) to reprocess claims in a Pricer utility program to determine the correct outlier payment amounts.

6) CMS will calculate the time value of money attributable to the adjustment. CMS will provide the FI with a log of individual claims on which the total adjustment was determined.

7) The FI shall record the reconciled amount, the original outlier amount from Worksheet E, Part A line 2.01, the time value of money and the rate used to calculate the time value of money on lines 50-53, of Worksheet E, Part A of the cost report.

8) The FI shall finalize the cost report, issue a NPR and make the necessary adjustment from or to the provider.

The central office will work as quickly as possible to reconcile these claims in order to allow FIs to finalize the cost report and issue an NPR within the normal CMS timeframes. If an FI has any questions regarding this process, it should contact the central and regional office, using the address and email address provided in §20.1.2.1 (B).³⁷

So, initially, any outlier reconciliation was to be performed *by CMS upon referral by the relevant Medicare contractor*.

However, CMS later revised the outlier reconciliation process. Specifically, on December 3, 2010, CMS issued MCPM Transmittal 2111 “instruct[ing] FISS to update the Lump Sum Utility . . . for the IPPS . . . with additional output fields and to use the appropriate versions of Pricer” and instructing Medicare contractors to use the updated utility “to re-price outlier claims

³⁷ MCPM, Ch. 3, § 20.1.2.7 (Rev. 1072, Issued Oct. 6, 2006) (available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1072CP.pdf>) (last visited Sept. 18, 2026).

offline” when conducting outlier reconciliations.³⁸ This transmittal also revised MCPM, Ch. 3, § 20.1.2.7 to instruct Medicare contractors to conduct the outlier reconciliation using the following fourteen (14) steps:

The following is a step-by-step explanation of the procedures that Medicare contractors are to follow if a hospital is eligible for outlier reconciliation:

- 1) The Medicare contractor shall send notification to the CMS Central Office (not the hospital), via the street address and email address provided in §20.1.2.1 (B)) and regional office that a hospital has met the criteria for reconciliation. Medicare contractors shall include in their notification the provider number, provider name, cost reporting begin date, cost reporting end date, total operating and capital outlier payments in the cost reporting period, the operating CCR or weighted average operating CCR from the time the claims were paid during the cost reporting period eligible for reconciliation and the final settled operating and capital CCR.
- 2) If the Medicare contractor receives approval from the CMS Central Office that reconciliation is appropriate, the Medicare contractor follows steps 3-14 below. **NOTE:** Hospital cost reports will remain open until their claims have been processed for outlier reconciliation.
- 3) The Medicare contractor shall notify the hospital and copy the CMS Regional Office and Central Office in writing and via email (through the addresses provided in §20.1.2.1 (B)) that the hospital’s outlier claims are to be reconciled.
- 4) Prior to running claims in the *Lump Sum Utility, Medicare contractors shall update the applicable provider records in the Inpatient Provider Specific File (IPSF) by entering the final settled operating and capital CCR from the cost report in the operating and capital CCR fields. Specifically, for hospitals paid under the IPPS, Medicare contractors shall enter the revised operating CCR in PSF field 25 -Operating Cost to Charge Ratio and the revised capital CCR in PSF field 47 -Capital Cost to Charge Ratio. No other elements in the IPSF (such as elements related to the DSH and IME adjustments) shall be updated for the applicable provider records in the IPSF that span the cost reporting period being

³⁸ MCPM Transmittal 2111, Change Req. 7192 (Dec. 3, 2010) (providing, effective Apr. 1, 2011, certain “technical direction” on conducting outlier reconciliations) (available at: <https://www.cms.gov/regulations-and-guidance/guidance/transmittals/downloads/r2111cp.pdf> (last visited Sept. 18, 2026)).

reconciled aside from the elements for the operating and capital CCRs.

***NOTE:** The FISS Lump Sum Utility is a Medicare contractor tool that, depending on the elements that are input, will produce an extract that will calculate the difference between the original PPS payment amounts and revised PPS payment amounts into a Microsoft Access generated report. The Lump Sum Utility calculates the original and revised payments offline and will not affect the original claim payment amounts as displayed in various CMS systems (such as NCH).

5) Medicare contractors shall ensure that, prior to running claims through the FISS Lump Sum Utility, all pending claims (e.g., appeal adjustments) are finalized for the applicable provider.

6) Medicare contractors shall only run claims in the Lump Sum Utility that meet the following criteria:

- Type of Bill (TOB) equals 11X
- Previous claim is in a paid status (P location) within FISS
- Cancel date is 'blank'

7) The Medicare contractor reconciles the claims through the applicable IPPS Pricer software and not through any editing or grouping software.

8) Upon completing steps 3 through 7 above, the Medicare contractor shall run the claims through the Lump Sum Utility. The Lump Sum Utility will produce an extract, according to the elements in Table 1 below. **NOTE:** The extract must be importable by Microsoft Access or a similar software program (Microsoft Excel).

9) Medicare contractors shall upload the extract into Microsoft Access or a similar software program to generate a report that contains elements in Table 1. Medicare contractors shall ensure this report is retained with the cost report settlement work papers.

10) For hospitals paid under the IPPS, the Lump Sum Utility will calculate the difference between the original and revised operating and capital outlier amounts. If the difference between the original and revised operating and capital outlier amounts (calculated by the Lump Sum Utility) is positive, then a credit amount (addition) shall be issued to the provider. If the difference between the original and revised operating and capital amounts (calculated by

the Lump Sum Utility) is negative, then a debit amount (deduction) shall be issued to the provider. **NOTE:** The difference between the original and revised operating outlier amounts and the difference between the original and revised capital outlier amounts are two distinct amounts calculated by the lump sum utility and are recorded on two separate lines on the cost report.

11) The operating and capital time value of money amounts are two distinct calculations that are recorded separately on the cost report. Medicare contractors shall determine the applicable time value of money amount by using the calculation methodology in §20.1.2.6. If the difference between the original and revised operating and capital outlier amounts is a negative amount then the time value of money is also a negative amount. If the difference between the original and revised operating and capital outlier amounts is a positive amount then the time value of money is also a positive amount. Similar to step 10, if the time value of money is positive, then a credit amount (addition) shall be issued to the provider. If the time value of money is negative, then a debit amount (deduction) shall be issued to the provider. **NOTE:** The time value of money is applied to the difference between the original and revised operating and capital outlier amounts.

12) For cost reporting periods beginning before May 1, 2010, under cost report 2552-96, the Medicare contractor shall record the original operating and capital outlier amounts, the operating and capital outlier reconciliation adjustment amount (the difference between the original and revised operating and capital outlier amounts calculated by the Lump Sum Utility), the operating and capital time value of money and the rate used to calculate the time value of money on lines 50-56, of Worksheet E, Part A of the cost report (**NOTE:** the amounts recorded on lines 50-53 and 55 thru 56 can be positive or negative amounts per the instructions above). The total outlier reconciliation adjustment amount (the difference between the original and revised operating and capital outlier amount (calculated by the Lump Sum Utility) plus the time value of money) shall be recorded on line 24.99 of Worksheet E, Part A. For complete instructions on how to fill out these lines please see § 3630.1 of the Provider Reimbursement Manual, Part II. **NOTE:** Both the operating and capital amounts are combined and recorded on line 24.99 of Worksheet E, Part A.

For cost reporting periods beginning on or after May 1, 2010, under cost report 2552-10, the Medicare contractor shall record the original operating and capital outlier amounts, the operating and capital outlier reconciliation adjustment amounts (the difference

between the original and revised operating and capital outlier amounts calculated by the Lump Sum Utility), the operating and capital time value of money and the rate used to calculate the time value of money on lines 90-96, of Worksheet E, Part A of the cost report (**NOTE:** the amounts recorded on lines 90-93 and 95 thru 96 can be positive or negative amounts per the instructions above). The total outlier reconciliation adjustment amount (the difference between the original and revised operating and capital outlier amount (calculated by the Lump Sum Utility) plus the time value of money) shall be recorded on line 69 of Worksheet E, Part A. **NOTE:** Both the operating and capital amounts are combined and recorded on line 69 of Worksheet E, Part A.

13) The Medicare contractor shall finalize the cost report, issue a NPR and make the necessary adjustment from or to the provider.

14) After determining the total outlier reconciliation amount and issuing a NPR, Medicare contractors shall restore the operating and capital CCR(s) elements to their original values (that is, the CCRs used to pay the claims) in the applicable provider records in the IPSF to ensure an accurate history is maintained. Specifically, for hospitals paid under the IPPS, Medicare contractors shall enter the original operating CCR in PSF field 25 - Operating Cost to Charge Ratio and the original capital CCR in PSF field 47 -Capital Cost to Charge Ratio.³⁹

As a result of this change, Medicare contractors, rather than CMS, were directed to perform actual outlier reconciliation calculations with CMS oversight.

CMS also issued instructions in the MCPM regarding when to reconcile OPPS outlier payments that parallel those for IPPS outlier payments.

The following is a step-by-step explanation of how Medicare contractors are to notify CMS and hospitals (or CMHCs) that OPPS outlier reconciliation should be performed and to record reconciled OPPS outlier claims for hospitals and CMHCs that meet the criteria for reconciliation:

1) The Medicare contractor sends notification to the CMS central office (not the hospital or CMHC), via the street address and email address provided in section 10.11.3.1 and to the regional office that a hospital or CMHC has met the criteria for OPPS outlier reconciliation.

2) If the Medicare contractor receives approval from the CMS

³⁹ *Id.*

central office and regional office that OPPS outlier reconciliation is appropriate, the Medicare contractor follows steps 3-8 below.

- 3) Hospital and CMHC cost reports will remain open until their claims have been processed for OPPS outlier reconciliation.
- 4) The Medicare contractor shall notify the hospital or CMHC and copy the CMS regional office and central office in writing and via email (through the address provided in §10.11.3.1) that the hospital or CMHC's OPPS outlier claims are to be reconciled.
- 5) CMS will reprocess claims in an offline Pricer/FISS utility program to determine the correct OPPS outlier payment amounts. Items paid at charges adjusted to cost using the prospective overall CCR are not subject to reconciliation.
- 6) CMS will calculate the time value of money attributable to the adjustment.
- 7) The Medicare contractor shall record the reconciled amount, the original OPPS outlier amount, the time value of money, and the rate used to calculate the time value of money in the cost report. (TOPS payments will be calculated including the reconciled OPPS outlier payments and time value of money.)
- 8) The Medicare contractor shall finalize the cost report, issue an NPR, and make the necessary adjustment from or to the provider.⁴⁰

Similar to the IPPS outliers, the MCPM was revised on December 3, 2010, effective April 1, 2011, via Revision 2111, expanding the procedures to a similar fourteen (14) steps, as shown below:

The following is a step-by-step explanation of the procedures that Medicare contractors are to follow if a hospital (or CMHC) is eligible for outlier reconciliation:

- 1) The Medicare contractor sends notification to the CMS Central Office (not the hospital), via the street address and email address provided in §10.11.3.1 and to the CMS Regional Office that a hospital or CMHC has met the criteria for OPPS outlier reconciliation. Medicare contractors shall include in their notification the provider number, provider name, cost reporting begin date, cost reporting end date, total outlier payments in the cost reporting period, the CCR or weighted average CCR from the

⁴⁰ MCPM, Ch. 4, § 10.7.2.4 (Rev. 1760, Issued Jun. 23, 2009).

time the claims were paid during the cost reporting period eligible for reconciliation and the final settled CCR.

2) If the Medicare contractor receives approval from the CMS Central Office and Regional Office that OPPS outlier reconciliation is appropriate, the Medicare contractor follows steps 3-14 below. **NOTE:** Hospital and CMHC cost reports will remain open until their claims have been processed for OPPS outlier reconciliation.

3) The Medicare contractor shall notify the hospital or CMHC and copy the CMS Regional Office and Central Office in writing and via email (through the addresses provided in §10.11.3.1) that the hospital or CMHC's OPPS outlier claims are to be reconciled.

4) Prior to running claims in the FISS Lump Sum Utility*, Medicare contractors shall update the applicable provider records in the Outpatient Provider Specific File (OPSF) by entering the final settled CCR from the cost report in the Outpatient Cost to Charge Ratio field. No other elements in the OPSF shall be updated for the applicable provider records in the PSF that span the cost reporting period being reconciled aside from the CCR.

***NOTE:** The FISS Lump Sum Utility is a Medicare contractor tool that, depending on the elements that are input, will produce an extract that will calculate the difference between the original PPS payment amounts and revised PPS payment amounts into a Microsoft Access generated report. The Lump Sum Utility calculates the original and revised payments offline and will not affect the original claim payment amounts as displayed in various CMS systems (such as NCH).

5) Medicare contractors shall ensure that, prior to running claims through the FISS Lump Sum Utility, all pending claims (e.g., appeal adjustments) are finalized for the applicable provider.

6) Medicare contractors shall only run claims in the Lump Sum Utility that meet the following criteria:

- TOB 12X, 13X, 34X, 75X, 76X or any TOB with a condition code 07
- Claim has a line item date of service of January 1, 2009 or later that also contains a Pay Method Flaig of '0'
- Previous claim is in a paid status (P location) within FISS
- Cancel date is 'blank'

7) The Medicare contractor reconciles the claims through the OIPPS Pricer software and not through any editing or grouping software.

8) Upon completing steps 3 through 7 above, the Medicare contractor shall run the claims through the Lump Sum Utility. The Lump Sum Utility will produce an extract, according to the elements in Table 1 below. **NOTE:** The extract must be importable by Microsoft Access or a similar software program (Microsoft Excel).

9) Medicare contractors shall upload the extract into Microsoft Access or a similar software program to generate a report that contains elements in Table 1. Medicare contractors shall ensure this report is retained with the cost report settlement work papers.

10) For hospitals paid under the OPPS, the Lump Sum Utility will calculate the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17). If the difference between the original and revised outlier amount is positive, then a credit amount (addition) shall be issued to the provider. If the difference between the original and revised outlier amount is negative, then a debit amount (deduction) shall be issued to the provider.

11) Medicare contractors shall determine the applicable time value of money amount by using the calculation methodology in §10.7.2.3. If the difference between the original and revised outlier amount (calculated by the Lump Sum Utility) is a negative amount then the time value of money is also a negative amount. If the difference between the original and revised outlier amount (calculated by the Lump Sum Utility) is a positive amount then the time value of money is also a positive amount. Similar to step 10, if the time value of money is positive, then a credit amount (addition) shall be issued to the provider. If the time value of money is negative, then a debit amount (deduction) shall be issued to the provider. **NOTE:** The time value of money is applied to the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17).

12) For cost reporting periods beginning before May 1, 2010, under cost report 2552-96, the Medicare contractor shall record the original outlier amount from Worksheet E, Part B, line 1.02 (prior to the inclusion of line 54 of Worksheet E, Part B), the outlier reconciliation adjustment amount (the difference between the original and revised outlier amount (calculated by the Lump Sum

Utility), the time value of money, the rate used to calculate the time value of money and the sum of lines 51 and 53 on lines 50-54, of Worksheet E, Part B of the cost report (**NOTE:** the amounts recorded on lines 50, 51, 53 and 55 can be positive or negative amounts per the instructions above). The total outlier reconciliation amount (Worksheet E, Part B, line 54) shall be included on Worksheet E, Part B, line 1.02. For complete instructions on how to fill out these lines please see § 3630.2 of the Provider Reimbursement Manual, Part II.

For cost reporting periods beginning on or after May 1, 2010, under cost report 2552-10, the Medicare contractor shall record the original outlier amount from Worksheet E, Part B, line 4 (prior to the inclusion of line 94 of Worksheet E, Part B), the outlier reconciliation adjustment amount (the difference between the original and revised outlier amount (calculated by the Lump Sum Utility), the time value of money, the rate used to calculate the time value of money and the sum of lines 91 and 93 on lines 90-94, of Worksheet E, Part B of the cost report (**NOTE:** the amounts recorded on lines 90, 91, 93 and 94 can be positive or negative amounts per the instructions above). The total outlier reconciliation amount (Worksheet E, Part B, line 94) shall be included on Worksheet E, Part B, line 1.02.

13) The Medicare contractor shall finalize the cost report, issue a NPR and make the necessary adjustment from or to the provider.

14) After determining the total outlier reconciliation amount and issuing a NPR, Medicare contractors shall restore the CCR(s) elements to their original values (that is, the CCRs used to pay the claims) in the applicable provider records in the PSF to ensure an accurate history is maintained. Specifically, for hospitals paid under the OPPTS, Medicare contractors shall enter the original CCR in PSF field 25 - Operating Cost to Charge Ratio.⁴¹

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW:

Hospitals' Position

It is the Hospitals' position that they should have been paid outlier amounts using their actual CCRs plus the time value of money for services during their FY 2016.⁴² As previously stated, prior to FY 2016, the Hospitals reported "functional units" instead of charges, and therefore were subject to the statewide CCR when being paid for outlier claims. However, as of FY 2016, "the Hospitals sought and received approval to begin reporting charges on Worksheet

⁴¹ MCPM, Ch. 4, § 10.7.2.4 (Rev. 2111, Issued Dec. 3, 2010).

⁴² Providers' Preliminary Position Paper (hereinafter "Providers' PPP") at 4 (Mar. 2, 2022).

C.”⁴³ Even so, the Hospitals’ outlier payments were still determined using the statewide average cost to charge ratios (“CCRs”) and the Hospitals claim that:

The statewide average CCRs, however, were much lower than the Hospitals’ actual CCRs—more than ten percentage points lower. As a result, the Hospitals’ outlier payments were artificially significantly less than what they would have received applying their actual CCRs. For more than half of the Hospitals, the application of the actual CCRs **would have generated** outlier payments of over \$500,000.⁴⁴

The Hospitals contend that the Medicare Contractor should have reconciled all of their outlier payments, both IPPS and OPPI, either because they contend that the post-reconciliation outlier payments would have been at least \$500,000 for most of the Hospitals and/or because all of the Hospitals’ FY 2016 outlier payments were significantly inaccurate.⁴⁵ Further, the Hospitals contend interest (the time value of money) is applicable and payable to the Hospitals, as of the midpoint of the cost reporting period, or July 1, 2016, for which the Medicare trust fund rate is 1.5%.⁴⁶

Regarding the requirements that must be met for outlier reconciliation, the Hospitals argue:

The Board should read the \$500,000 criterion in harmony with [the] statutory commands [] to apply when, as here, reconciliation impacts \$500,000 in total outlier payments. The plain wording of CMS’s guidance in the MCPM states “outlier claims will be reconciled” if, *inter alia*, “Total outlier payments ... exceed \$500,000.” Nothing in this text suggests that this criterion refers solely to payments that were made pre-reconciliation. Moreover, the Board should reject the MAC’s reading of the criterion because it would arbitrarily and capriciously allow CMS to recoup \$500,000 in outlier overpayments that had been made based on an erroneously high CCR during the hospital’s FY, but to deny paying \$500,000 in outlier underpayments where, as here, the CCR had been erroneously low during the hospital’s FY.⁴⁷

The table below⁴⁸ summarizes the additional reimbursement the Hospital expected to receive, based on Kaiser’s calculations, if the hospital’s CCR was used instead of the statewide average:

⁴³ *Id.* at 1.

⁴⁴ *Id.* (Bold and italics emphasis added).

⁴⁵ Providers’ RFPP at 1; *see also* Stip. at ¶ 8. Note the estimated amount quoted by the Provider in its RFPP, before three Providers were withdrawn, differs from those stated in the Stipulations. Therefore, the Board notes the corrected estimated amount in controversy for all Providers remaining in the CIRP group is \$18,945,489.

⁴⁶ Providers’ PPP at 17.

⁴⁷ Providers’ RFPP at 8.

⁴⁸ *See also* Stip. at ¶¶ 7, 8. The table has been edited to reflect the remaining Hospitals (Westside (38-0103), Hawaii (12-0011), and Sunnyside (38-0091) were withdrawn from the CIRP group on Aug. 15, 2024. *See also* Stip. at 2.)

Provider Number	Kaiser Hospital	Additional Part A Outlier Payments – Using Actual CCR	Additional Part B Outlier Payments – Using Actual CCR	Total Additional Outlier Payments - Actual CCR
05-0425	Sacramento	\$1,377,682	\$442,715	\$1,820,397
05-0075	Oakland ⁴⁹	-	\$852,903	\$852,903
05-0777	San Leandro	\$590,659	\$155,864	\$746,523
05-0070	So. San Francisco	\$547,953	\$116,244	\$664,197
05-0073	Vallejo	\$3,052,987	\$588,460	\$3,641,447
05-0140	Fontana	\$1,649,476	\$342,403	\$1,991,879
05-0609	Anaheim	\$342,516	\$57,784	\$400,300
05-0411	South Bay	\$387,439	\$117,311	\$504,750
05-0076	San Francisco	\$267,953	\$115,386	\$383,339
05-0772	Roseville	\$498,504	\$99,462	\$597,966
05-0510	San Rafael	\$270,391	\$63,694	\$334,085
05-0512	Fremont	\$314,306	\$150,237	\$464,543
05-0677	Woodland Hills	\$258,369	\$63,073	\$321,442
05-0690	Santa Rosa	\$376,670	\$118,474	\$495,144
05-0674	So. Sacramento	\$1,526,614	\$710,933	\$2,237,547
05-0072	Walnut Creek	\$651,442	\$161,590	\$813,032
05-0760	Antioch	\$716,613	\$276,795	\$993,408
05-0139	Downey	\$606,479	\$165,251	\$771,730
05-0723	Baldwin Park	\$335,790	\$82,396	\$418,186
05-0138	Los Angeles ⁵⁰	\$356,041	\$136,630	\$492,671
	Grand Total Amt. in Controversy			\$18,945,489

Medicare Contractor's Position

The Medicare Contractor contends that its decision not to reconcile the Hospitals' outlier payments was proper, based on the \$500,000 criterion set forth in the reconciliation guidelines, because it applies to total outlier payments made to the provider *pre-reconciliation*.⁵¹ The

⁴⁹ Medicare Contractor reconciled Oakland's IPPS Outlier payments. Oakland remains in the appeal challenging its OPPOS payments. Stip. at ¶ 8 and Ex. C-2.

⁵⁰ Los Angeles was added to the CIRP on July 21, 2023; however, it was not listed in Providers' RFPP submitted July 22, 2024. See Providers' RFPP at 3.

⁵¹ Medicare Contractor's PPP at 11-12.

Medicare Contractor also states that it properly exercised discretion not to reconcile where the \$500,000 in outlier payments received was not met.⁵² On February 3, 2021, the Medicare Contractor also subsequently denied reopening of these cost reports to reconcile outlier payments, stating:

The reopening request of outlier reconciliation is denied due to the nature of all-inclusive rate provider charges and the inaccuracy of reconciling outlier payments to cost-to-charge ratios (CCRs) based on inconclusive data from the cost reports. Also, the outlier reconciliation request is below the manual threshold for reconciliation and we are exercising our discretion in not proceeding with the reconciliation.⁵³

Board Analysis

Of the remaining Hospitals in the CIRP group, the parties stipulate that the outlier payments received during FY 2016 based on the application of the statewide average CCRs⁵⁴ were as follows:

Kaiser Hospital	Provider Number	Part A Outlier Payments	Part B Outlier Payments
Sacramento	05-0425	\$236,912	\$18,345
Oakland	05-0075	\$1,251,279	\$18,895
San Leandro	05-0777	\$72,986	\$10,565
So. San Francisco	05-0070	\$72,500	\$5,013
Vallejo	05-0073	\$327,153	\$6,058
Fontana	05-0140	\$429,989	\$2,479
Anaheim	05-0609	\$92,400	\$9,937
South Bay	05-0411	\$225,103	\$8,467
San Francisco	05-0076	\$317,947	\$12,528
Roseville	05-0772	\$15,966	\$11,266
San Rafael	05-0510	\$3,263	\$0
Fremont	05-0512	\$31,151	\$5,684
Woodland Hills	05-0677	\$56,380	\$2,370
Santa Rosa	05-0690	\$122,905	\$1,691
So. Sacramento	05-0674	\$429,175	\$30,948
Walnut Creek	05-0072	\$48,742	\$7,905
Antioch	05-0760	\$112,738	\$9,754

⁵² *Id.* at 13.

⁵³ *Id.* at 14. *See also* Ex. C-8.

⁵⁴ *Stip.* at ¶ 7; *see also* Ex. P-1 for excerpts from the Providers' FY 2016 Medicare cost reports.

Downey	05-0139	\$40,553	\$5,017
Baldwin Park	05-0723	\$3,643	\$5,749
Los Angeles	05-0138	\$637,440	\$16,983

1. Whether Hospitals met the two mandatory criteria that trigger outlier payment reconciliation.

Kaiser argues that most of the Hospitals met both of the criteria for automatic outlier reconciliation, and asserts that reconciliation was warranted given the uniqueness of the Hospitals' reporting on the basis of "functional units" instead of gross charges on the Medicare cost reports, thus subjecting them to the statewide CCRs in all fiscal years prior to FY 2016. Specifically, Kaiser argues:

[M]ost of the Hospitals' FY 2016 cost reports satisfied both of the criteria for automatic outlier payment reconciliation—(1) a ten percentage point change in the CCR and (2) \$500,000 in outlier payments. There is no dispute that each Hospital had a more than a ten-percentage-point increase in its actual CCR based on the FY 2016 cost reports compared to the statewide average CCR that had been applied during FY 2016....The second criteria—outlier payments that "exceed \$500,000"—was met for at least fourteen of the Hospitals *when considering both IPPS and OPPS payments* and for eleven of them when considering only IPPS payments.⁵⁵

As previously stated, the MCPM sets forth two criteria that are to be satisfied in order to *trigger* an outlier reconciliation:

1. The actual operating CCR is found to be plus or minus 10 percentage points from the CCR used during that time period to make outlier payments, and
2. Total outlier payments in that cost reporting period exceed \$500,000.⁵⁶

Accordingly, Hospitals must meet both criteria to trigger a reconciliation. In reviewing the stipulations,⁵⁷ the Board notes that only one Hospital – Oakland – met the criteria by demonstrating Part A outlier payments in excess of the \$500,000 threshold. As the parties agree, Oakland Part A outlier payments were reconciled by the Medicare Contractor.⁵⁸

Here too, the Board dispels Kaiser's interpretation of the 2nd criterion—that the \$500,000 threshold is based upon payments the Hospitals "would have received" had the actual CCRs been applied and that the total payments may also refer to payments made post-reconciliation.⁵⁹ This interpretation simply fails. The plain language set forth in the MCPM provides that fiscal

⁵⁵ Providers' RFPP at 5-6.

⁵⁶ MCPM Ch. 3. § 20.1.2.5A. (consistent with PMI Transmittal A-03-058).

⁵⁷ Stip. at ¶ 7. See also Ex. P-1 for excerpts from the Providers' FY 2016 Medicare cost reports.

⁵⁸ *Id.* at ¶ 8 [referring to the second ¶ 8 which appears at page 11] and Ex. C-2.

⁵⁹ See Providers' PPP at 1, 3, 4, 6-7, 14-15, 16.

intermediaries are to reconcile outlier payments “*at the time of cost report final settlement if*” the two criteria are met. Thus, if, at the time of cost report final settlement, a provider’s total outlier payments in that settlement cost reporting period do not exceed \$500,000, the reconciliation process *is not triggered* even if they meet the 1st criterion. Moreover, MCPM Ch. 3, § 20.1.2.5B provides two (2) clear examples that demonstrate that the 2nd criterion is specific to a “total outlier *payout*” during the relevant cost reporting period and the “payout” is defined as an amount greater than \$500,000 that the “provider *received*” during the relevant cost reporting period.⁶⁰ In no way can the second criterion be read to mean outlier payments the provider “would have received” or “would receive” under different circumstances.

Based on the foregoing, the Board finds that all of the Hospitals in the instant appeal, with the exception of Oakland’s Part A outlier payments, *did not satisfy the second criterion*—total outlier payments in that cost reporting period exceeding \$500,000—to trigger such reconciliation of Part A or Part B payments by the Medicare Contractor in the first place.

2. Whether the Hospitals demonstrated that their most recent cost and charge data indicate that outlier payments were “significantly inaccurate” invoking the Medicare Contractor’s discretion to request a reconciliation?

Notwithstanding the foregoing, the Hospitals argue:

Furthermore, even for any of the Hospitals that the Board finds did not meet the \$500,000 criteria, reconciliation was nevertheless warranted. Reconciliation here was justified by the unique circumstances and the substantial inaccuracy of the original outlier payments. The circumstances were unique because all of the Hospitals, and the entire part of the KFH system for which Noridian is the MAC, obtained actual CCRs after a long period of being paid under the statewide average CCR. Noridian expressly approved the new process and anticipated calculating the Hospitals’ specific CCRs.

Further, the cost and charge data in the Hospitals’ settled FY 2016 cost reports demonstrated that the Hospitals had substantially higher actual CCRs during FY 2016 and, thus, that their estimated costs per case were grossly understated for treating outlier patients and they should have received much higher amounts of total outlier payments, because their “charges, adjusted, to cost” exceeded the fixed loss threshold.⁶¹

During the hearing, the Hospitals maintained their position:

[BOARD CHAIR]: [Is it] your position that based on the [Hospitals’] or Kaiser Health’s calculations[,] that each of the

⁶⁰ See MCPM Ch. 3, § 20.1.2.5, Examples A and B.

⁶¹ Providers’ RFPP at 5-6.

hospital's outpatient cost outliers would exceed 500,000 if reconciliation were performed for 2016?

[PROVIDER REPRESENTATIVE]: No. If -- so, as paragraph 7 of the stipulations lists their actual Part B outlier payments received, and most of them were well under 10K and a few approach \$20,000 in actual payments received. But compared to, in paragraph 8 of the stipulations, the table there, it shows the additional outlier payments calculated that Kaiser calculated with a rough estimate. Some of them are over 500,000 in additional -- 100 percent of the hospitals didn't receive \$500,000 initially, and that's reflected in paragraph 7. ***But after reconciliation, many of the hospitals would have received more than 500,000.*** Under Kaiser's estimates, several of them ***would receive*** more than 500,000. We think more under actual, using the lump sum utility, more would fall into the \$500,000-plus category. ***But our position is that all of them, their payments are substantially inaccurate.*** When you look at the difference between, say, 20,000 and \$852,000 for Oakland, which didn't have its Part B payments reconciled, which had its Part A payments reconciled, just as an example. And we could go through each of them line by line, but in virtually every case, the increase is substantial. And aside from about five of them, it's more than \$100,000. Many of them, it's several hundred -- it's hundreds of thousands of dollars. ***So we think that this also is a door two situation for reconciliation for the Part B payments, to the extent they didn't have 500,000.***

[BOARD CHAIR]: And has the Provider stated its position on how [] the term of art "significantly inaccurate" should be interpreted?

[PROVIDER REPRESENTATIVE]: Well, we think that that should be interpreted in its plain meaning, significantly. And -- but applying to the circumstances here, I don't see how and the Providers don't see how receiving one-fifth to one-tenth of your actual payments calculated could be anything but significantly inaccurate. The millions of dollars less than what you received, we don't think that could, under anyone's definition, could be anything other than significantly inaccurate. So it's kind of like there may be some -- it may leave some room to interpretation, but there are some things that all reasonable minds must agree are significantly inaccurate, these types of dollar differences.⁶²

⁶² Tr. at 60:7-62:22.

To this point, the Board looks back to the Secretary's commentary in the June 2003 Final Rule:

[I]n light of the gross abuses of the current methodology by some hospitals and the negative impact such overpayments ultimately have on other hospitals due to their effect on the threshold, we believe the option of reconciling outlier payments based on the settled cost report for hospitals that have been initially paid using a significantly inaccurate cost-to-charge ratio compared to the actual ratio from the cost reporting period is now appropriate. ***In our view, reconciling outlier payments because they were originally paid on the basis of a significantly inaccurate cost-to-charge ratio is similar to recovering outlier payments when adjustments are made to covered charges for any services that are not found to be medically necessary or appropriate Medicare services upon medical or other review.*** This review is explicitly provided for at § 412.84(d). This provision was established when the IPPS was first implemented for FY 1984 (48 FR 39785).

[I]f we deem it necessary as a result of a hospital-specific data variance to reconcile outlier payments of an individual hospital, such action on our part would not affect the predictability of the entire system. Rather, because each hospital is on notice as to our revised methodology for determining cost-to-charge ratios ***and that outlier payments are subject to possible reconciliation***, and because each hospital has the necessary data regarding its own costs and charges to predict its actual cost-to-charge ratio, we are able to maintain the predictability of the system as a whole. Further, because reconciliation of outlier payments will affect only certain hospitals, the administrative burden of implementing such a policy is minimized.⁶³

The Board also acknowledges that in MCPM, Chapter 3, CMS further elaborated on Medicare contractor discretion for reconciliations:

Even if a hospital does not meet the criteria for reconciliation, subject to approval of the Regional and Central Office, ***the Medicare contractor has the discretion to request that a hospital's outlier payments in a cost reporting period be reconciled*** if the hospital's most recent cost and charge data indicate that the outlier payments to the hospital were significantly inaccurate.⁶⁴

⁶³ 68 Fed. Reg. at 34502 (emphasis added).

⁶⁴ MCPM, Chapter 3, § 20.1.2.5A; *see also* Ex. C-3 at C0022.

As it relates to the above-referenced abuse concerns cited by the Secretary, the Board inquired as to whether there was evidence in the record demonstrating a consistency in the charges between FY 2015 and FY 2016 that would demonstrate that the Hospital had not turbo-dropped their respective charges in order to impact their CCRs. Kaiser responded:

[PROVIDER REPRESENTATIVE]: It's -- the Contractor determined these charge ratios in the settled cost reports. And based on that, there's no indication that they were turbo-dropped. They had the statewide average charge ratios applied. There's no indication that the hospitals did anything to manipulate this. That's just not in the record. That's -- the contractor.

[BOARD MEMBER]: Forgive me, I understand the concept. What I'm saying is the MAC had nothing in 2015 with which to compare the 2016 charges. That is an audit step for auditors of cost reports. It is something they would do if they had the information. Because there was no prior information, there's nothing they could do. Therefore, yes, they audited the cost report. They allowed those charges. But the question I'm asking is, is there any proof in this case, in this record, as I'm looking at this, to get a comfort with the situation, because I have a reasonable comfort with cost reporting, to understand that this is fairly and properly presented year over year? ***Because we're now going to try and use a cost-to-charge ratio that we have nothing to compare with in prior years*** because the Provider chose not to provide anything. Is there something in the record that gives me an idea that these are consistent?

[PROVIDER REPRESENTATIVE]: Well, it's not possible to compare to past charges reporting because this was the first time they were reporting them, so. But clearly, the MAC did not see any objection to the charge ratios -- I'm sorry, to the charges. The MAC settled them. The MAC, for example, the MAC did reconciliation for Oakland. So I think all of that, the record -- you're asking for, basically, information that the MAC has never objected to. And instead, the undisputed record is the charge ratios were calculated by the Contractor. And their defense here is, well, we would have applied it, we would have reconciled everyone if they had simply had over \$500,000, but they didn't. They don't have a defense of, well, something's wonky about your calculated charge ratios. ***And under CMS's regulations, the point of comparison is whether the cost-to-charge ratio applied during the year here, which was the statewide average charge ratio, is 10***

*percentage points or more different than the charge ratio that the hospital's settled cost report calculated.*⁶⁵

As for the Medicare Contractor's discretionary reconciliation based upon the "significant inaccuracies" raised by the Hospitals, the Medicare Contractor explained why it did not perform reconciliations:

As the Providers' PPP explains on page 5, the Hospitals historically had not submitted charge data on Worksheet C of their cost reports as is normally reported. The Hospitals had made the choice to report functional units on Worksheet C instead of charges. A natural consequence of this choice was the determination of outlier amounts on the basis of the statewide-average CCR. The change from the statewide-average CCRs to the hospital specific CCRs is the direct cause of the significant increase in the CCR that is the driving factor in this issue. The MAC asserts this change that is the result of the Providers' choice to historically report functional units on the cost report and their later choice to make the change in 2016 to begin to report ancillary charges on Worksheet C is not a compelling reason for the Providers' outliers to be reconciled despite those outliers not meeting the reconciliation criteria. It was the Providers' choice to complete their cost reports in this manner. Those Provider choices do not constitute a compelling reason for the Providers to receive special treatment under the outlier reconciliation procedures.⁶⁶

Here, the Board finds persuasive the Medicare Contractor's contention regarding any alleged "significant inaccuracies" for this first fiscal year in which the Hospitals reported gross charges on Worksheet C. For instance, the California statewide CCR, 0.20, was used to determine outlier payments for Part A claims, and 0.19 was used to determine outlier payments for Part B claims.⁶⁷ In its review of the various Hospitals, the Board notes the actual cost-to-charge ratios well-exceed the statewide average, and in some cases even double the statewide averages. For example, Woodland Hills (Prov. No. 05-0677) had a FY 2016 actual Part A CCR of 0.464, an over 230% increase when comparing it to the statewide average.⁶⁸ Notably, Woodland Hills received \$56,380 in Part A outlier payments for FY 2016, well below the second criterion required to trigger an outlier reconciliation.⁶⁹ Moreover, based on the Hospitals' stipulated calculation, had the Medicare Contractor recalculated Woodland Hills' outlier payments using its actual CCR, it still would have fallen below the second criterion threshold.⁷⁰

⁶⁵ Tr. at 43:15-46:2 (emphasis added).

⁶⁶ Medicare Contractor's PPP at 13.

⁶⁷ Stip. at ¶ 8 [referring to the first ¶ 8 which appears at page 10].

⁶⁸ *Id.*

⁶⁹ *Id.* at ¶ 7.

⁷⁰ *Id.* at ¶ 8 [referring to the first ¶ 8 which appears at page 10].

With regard to the denial of the Hospitals' respective cost report reopening requests, the Medicare Contractor explained that:

[t]he reopening request of outlier reconciliation [was] denied due to the nature of all-inclusive rate provider charges and the inaccuracy of reconciling outlier payments to cost-to-charge ratios (CCRs) based on inconclusive data from the cost reports. Also, the outlier reconciliation request is below the manual threshold for reconciliation and we are exercising our discretion in not proceeding with the reconciliation.⁷¹

It is unclear from the record whether the Medicare Contractor sought input from the CMS Regional or Central Offices regarding a reconciliation for all Hospitals.⁷² The Board views the term "discretion" as subjective but clearly notes that, given the stark increase in cost-to-charge ratios amongst the Hospitals, significant inaccuracies appear present in the CCRs for which no verifiable source documentation exists. Therefore, the Board finds that the Medicare Contractor's choice to not exercise its discretion to reconcile the Hospitals' respective outlier payments is appropriate. Furthermore, had the Medicare Contractor exercised such discretion and reconciled outlier payments, several Hospitals still would have fallen below the second criterion threshold, based upon the Hospitals' own calculations.

Notwithstanding the foregoing, the Board takes issue with the Medicare Contractor's argument that its discretion cannot be questioned.⁷³ Section 706(2)(A) of the Administrative Procedure Act ("APA") explicitly permits claims challenging agency actions as unlawful when it is alleged that such actions were an abuse of the agency's discretion. Accordingly, if the Secretary's discretionary actions may be challenged, so may a Medicare Contractor's discretionary actions, even where such discretion itself is prescribed by law. Here, the Hospitals contend that their estimates of the significant inaccuracies between the statewide CCR and their hospital specific CCRs warrant the Medicare Contractor's discretionary reconciliation of its payment. But as stated above, the Board finds that, based on insufficient evidence provided by the Hospitals, the Medicare Contractor's decision to decline the requested reconciliations and/or reopenings for that purpose was a proper exercise of its discretion.

Moreover, the Secretary explained that reconciliations should be performed on a limited basis, despite a Medicare contractors' discretion:

In the proposed rule, we proposed to establish the authority for CMS to reconcile outlier payments, ***but we did not propose to require that all hospitals' outlier payments be reconciled.*** We acknowledge the commenters' concerns about the administrative costs associated with reprocessing and reconciling all inpatient claims and the desirability of limiting which hospitals' outlier

⁷¹ Medicare Contractor's PPP at 14.

⁷² The Medicare Contractor did receive CMS Central and Regional offices' approval to reconcile Oakland (Prov. No. 05-0075) outlier payments for FY 2016. See Ex. C-2 at C0008 and C0009.

⁷³ See Tr. 30 – 32.

payments will be reconciled. **Therefore, we agree that any reconciliation of outlier payments should be done on a limited basis.**

...

For cost reporting periods beginning during FY 2004, we are considering instructing fiscal intermediaries to conduct reconciliation *for hospitals whose actual cost-to-charge ratios are found to be plus or minus 10 percentage points from the cost-to-charge ratio used during that time period to make outlier payments, **and** that have total FY 2004 outlier payments that exceed \$500,000. We believe these thresholds would appropriately capture those hospitals whose outlier payments will be substantially inaccurate when using the ratio from the contemporaneous cost reporting period.* Hospitals exceeding these thresholds during their applicable cost reporting periods would become subject to reconciliation of their outlier payments. These thresholds would be reevaluated annually and, if necessary, modified each year. **However, fiscal intermediaries would also have the administrative discretion to reconcile additional hospitals' cost reports based on analysis that indicates the outlier payments made to those hospitals are significantly inaccurate.**

We continue to believe that cost report reconciliation is the most appropriate way to ensure that outlier payments are made only for truly costly cases. We believe the type of ongoing reviews suggested by the commenter referenced above would be an inefficient approach to addressing this problem, because it would require extensive ongoing reviews of every hospital's cost and charge data. *However, we believe the problems leading to this final rule actually occur among a limited number of hospitals.*⁷⁴

Further, the Board recognizes that Kaiser made a business decision to not report gross charges on Worksheet C of the Medicare Cost Report in prior years due to the fact that, historically, "the Hospitals had reported functional units instead of charges because the bulk of the Hospitals' services were furnished to members of the Kaiser Foundation Health Plan whose care at the Hospitals was generally included under the health plan."⁷⁵ However, Kaiser's business decision had consequences. In this regard, the Board notes the record as of the hearing date contains no detail of prior year reporting, such as a reconciliation of functional units to gross charges for a prior year.

At the conclusion of the hearing, the Board requested a copy of the pre-2016 agreement between the Medicare Contractor and Kaiser which illustrates the alternative statistics used prior to the

⁷⁴ 68 Fed. Reg. at 34503. See also Ex. C-9 (Bold, italics and underline emphasis added).

⁷⁵ Providers' PPP at 5.

Hospitals' switch to reporting charges on Worksheet C of the Medicare Cost Report.⁷⁶ In response to the request, Kaiser submitted an August 30, 2011 letter titled "Alternative Cost-To-Charge Ratio – FYE December 31, 2009" for its Oakland, Fontana, and Hawaii hospitals.⁷⁷ The letter explained that as of July 2010, statewide CCRs were utilized for purposes of interim outlier payments, and it included Kaiser's request that alternate cost-to-charge ratios be reviewed by the Medicare Contractor/CMS for those three (3) Hospitals.⁷⁸ Additionally, Kaiser supplied Worksheet C for one of the Hospitals – Oakland (Prov. No. 05-0075) – for FY 2014 which reported functional units of 12,917,623 (reported as gross charges on Worksheet C)⁷⁹ for comparison to the same worksheet from FY 2016 which showed gross charges of \$2,313,015,915, 2016 being the first year that gross charges were captured.⁸⁰ However, the Hospital failed to show how functional units could be compared with the current charge environment, such as redacted patient accounting records or billing documents which could be used to calculate what the charge for a similar procedure or outpatient visit would have been before FY 2016 versus in FY 2016 and after.

The Hospitals did not argue or illustrate that they were satisfied with the CCRs calculated/used in future periods, such as offering evidence that the FY 2017 CCRs were comparable to FY 2016, a stance which may have provided more support for the Hospitals' contentions that its 2016 CCRs were reasonable.

During the hearing, the Board inquired whether it was the Hospitals' position that payments should be applied retroactively in a prospective payment system.⁸¹ In response, Kaiser argued that 42 C.F.R. § 412.84(i)(4) is applicable to its request:

Any reconciliation of outlier payments will be based on operating and capital cost-to-charge ratios calculated based on the ratio of cost and charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled. So, and that's exactly the scenario we have here for reconciliation. It would be based on the settled cost report data, the cost and charge ratio. And that's what occurred here where the Contractor calculated the hospital's cost and charge ratios.⁸²

Citing *Clarian Health West, LLC v. Hargan*, 878 F.3d 346, 356 (D.C. Cir. 2017), Kaiser continued arguing that the Court held that the reconciliation criteria set forth in the MCPM are

⁷⁶ Tr. at 65:19-66:16.

⁷⁷ Providers' Supplemental Documentation Letter at A1 (Sept. 20, 2024).

⁷⁸ *Id.*

⁷⁹ See Supplemental Documentation Letter at A2 at 10.

⁸⁰ See Supplemental Documentation Letter at A2 at 24.

⁸¹ Tr. at 50:25-55:9. See also Ex. C-6 which references 42 C.F.R. § 412.84(i)(3) which states: "For discharges occurring on or after August 8, 2003, the fiscal intermediary may use a statewide average cost-to-charge ratio if it is unable to determine an accurate operating or capital cost-to-charge ratio for a hospital in one of the following circumstances: . . . (iii) Other hospitals for whom the fiscal intermediary obtains accurate data with which to calculate either an operating or capital cost-to-charge ratio (or both) are not available."

⁸² *Id.* at 52:10-25.

not binding upon the Board and “give the guideposts for reconciliation. And one of those guideposts is, of course, the provision that says where the hospital’s outlier payments are significantly inaccurate.”⁸³ Furthermore, in characterizing this as “Door 2,” Kaiser averred:

[W]e’re the poster child for that clause. If that clause has any meaning, it has to apply here. Like, no case would satisfy that unless, of course, if CMS only wanted to use it to recoup and claw back outlier payments, which would be invalid under the law. But we think, you know, on its face, that applies to us, and if it doesn’t apply to us, then it’s invalid and their entire reconciliation process is invalid. And again, just to your question about -- you seem concerned about the retroactively changing the prospective payment, that is exactly what this outlier reconciliation is about. It’s an exception CMS made to the ordinary prospective payment for outlier payments, which it did in 2003 due to turbocharging. But CMS, of course, can’t apply it as a one-way street. So when hospitals’ charge ratios go up significantly compared to the ones used during the fiscal year, hospitals are entitled to receive money back, additional money.⁸⁴

First, in its response to the Board’s question, Kaiser essentially contends that since the Court in *Clarian* held that the Board is not bound by the reconciliation threshold criteria set forth in the MCPM instructions in adjudications before it, the Board should find that the Hospitals’ respective outlier payments were “significantly inaccurate.”⁸⁵ In *Clarian*, the Court specifically stated:

Indeed, the instructions bind neither CMS nor the Board in adjudications. In adjudicated cases, CMS and the Board apply the formulas described in the regulations, not the thresholds contained in the Manual instructions, in determining hospitals’ outlier-payment totals. *See* CMS Manual at 34-35, J.A. 129-30 (“Even if a hospital does not meet the criteria ... the Medicare contractor has the discretion to request that a hospital’s outlier payments in a cost reporting period be reconciled...”); *id.* at 34, J.A. 129 (“Subject to the approval of the CMS Central Office, a hospital’s outlier claims will be reconciled ... ***if they meet the ... criteria.***”); 42 C.F.R. § 405.1867 (explaining that the Board must “afford great weight” to CMS policy statements, but is not bound by such statements as it is by regulations).

To put it simply, reconciliation can be initiated in any situation in which CMS deems it appropriate, ***irrespective of whether the***

⁸³ *Id.* at 53:6-11.

⁸⁴ *Id.* at 53:12-54:12.

⁸⁵ *Clarian Health W., LLC v. Hargan*, 878 F.3d 346, 356 (D.C. Cir. 2017). In its PPP, Kaiser referenced this premise multiple times. *See* Providers’ PPP at 16, 18.

criteria in the Manual instructions are met. When read in context, it is clear that the Manual’s use of the words “will” and “shall” does not indicate otherwise. See CMS Manual at 34-35, J.A. 129-30. The agency’s authority is accordingly exactly as it would be if the Manual instructions did not exist.⁸⁶

To this point, in addition to the Board’s findings as discussed above, the Board finds that the Hospitals have failed to provide substantial, reliable evidence to establish that their respective outlier payments were based on “significantly inaccurate” CCRs. The Hospitals simply repeat the argument and reference the potential differences in what they “would have received” had their own CCRs been used in the calculations. However, the Hospitals have not provided any: 1) evidence demonstrating that their costs exceeded the fixed loss threshold; 2) claims data that they believe would qualify them for the additional outlier payments; or 3) Provider Statistical and Reimbursement (“PS&R”) system reports that were relied on when they filed their cost reports for FYE 2016. That is, none of the data presumably used by the Hospitals in their calculations to demonstrate that the statewide averages were significantly inaccurate and deflated their outlier payments has been provided. In fact, the Hospitals’ Exhibit List included the following disclaimer:

<u>Exhibit Number</u>	<u>Description</u>	<u>Number of Pages</u>
P-1	Excerpts of Hospitals’ FY 2016 settled Medicare cost reports: Worksheets S-10, C, E, Part A, and E, Part B	282
P-2	March 20, 2017 Letter from Noridian approving Hospitals’ request to begin reporting charges on Worksheet C for cost reporting periods ending on and after December 31, 2016	2
P-3	Summary of Outlier Payments and Calculated Underpayments	1
	<u>Additional Exhibits That are Not Available or Too Voluminous</u> <i>The Hospitals Intend to rely on the following additional documents at the hearing in this case, but they either are (a) not available to the Hospitals at this time, (b) too voluminous to produce, and/or (c) already in the possession of the MAC⁸⁷</i>	
P-4	The MAC’s workpapers calculating the Hospitals’ CCRs for FY 2016 during cost report settlement	
P-5	The Hospitals’ Medicare FY 2016 settled cost reports and NPRs	
P-6	CMS data files for federal fiscal years 2016 and 2017, containing the Hospitals’ IPPS and OPDS claims data necessary to recalculate their outlier payments with the Hospitals’ actual CCRs	

⁸⁶ *Id.*

⁸⁷ (Emphasis added).

P-7	The MAC's reconciliation workpapers and underlying data for KFH Oakland for FY 2016	
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When addressing preliminary matters at the hearing, the Board inquired about the documentation identified but not submitted for consideration: “In particular, [the documentation submitted to the Board] does not include the potential Exhibits P-4 to P-7 that were listed in the exhibit list attached to the [Hospitals’] preliminary position paper....Is that correct[?]?”⁸⁸ The Hospitals’ representative replied, “That is correct.”⁸⁹ Notably, Exhibit P-6 was identified as “claims data necessary to recalculate their outlier payments with Hospitals’ actual CCRs,” yet the Hospitals’ determined that it was not necessary to present to meet their burden of proof in this matter.⁹⁰ Moreover, the Hospitals overlook certain regulatory provisions that place the burden upon them in situations where they wish to use a different CCR. Particularly, 42 C.F.R. 412.84(i)(1) states, in pertinent part: “A hospital may also request that its fiscal intermediary use a different (higher or lower) cost-to-charge ratio based on *substantial evidence presented by the hospital*.”⁹¹ Ultimately, the Board finds that the Hospitals: 1) failed to produce substantial evidence that the statewide average CCRs were “significantly inaccurate” to shift the burden to the Medicare Contractor to utilize the Lump Sum Utility,⁹² and 2) failed to meet their burden of proof to warrant the Board’s deviation from the MCPM instructions implementing the regulatory formulas for calculating outlier payments.⁹³

As it relates to the Hospitals’ assertion that outlier reconciliation is retroactive as it is “an exception CMS made to the ordinary prospective payment for outlier payments,”⁹⁴ the Board disagrees and again references the June 2003 Final Rule, which clarified the Secretary’s intent regarding outlier payments in the prospective payment environment, which was to ensure predictability of the system as a whole and ensure Hospitals are able to approximate payments while beneficiaries are receiving care:

[T]he fixed-loss outlier threshold is an important aspect of the prospective nature of the IPPS. *The outlier payment policy is designed to alleviate any financial disincentive hospitals may have against providing any medically necessary care their patients may require, even those patients who become very sick and require extraordinary resources.* The pre[-]established threshold allows

⁸⁸ Tr. 6:13-18.

⁸⁹ Tr. 6:22.

⁹⁰ While the Board generally requires parties appearing before it to redact any protected health information (“PHI”) or other personally identifiable information (“PII”), the Board does permit a provider to submit documents with unredacted PHI/PII if it is necessary to support the merits of the case as explained in Board Rule 1.4:

“If the confidential information itself is necessary to support your position, you must file a request seeking permission from the Board to submit unredacted PHI or PII with the Board, at least fourteen (14) days prior to the document deadline. If permission is granted, the Board will instruct how the PHI or PII should be submitted (i.e., in OH CDMS or in hard copy as necessary).

A redacted version of the document should also be filed in OH CDMS.”

(Original emphasis removed and bold and italics emphasis added.)

⁹¹ (Emphasis added).

⁹² See Tr. 42:1-18 (where Kaiser attempts to shift the burden to the Medicare Contractor).

⁹³ See 42 C.F.R. § 405.1867 (explaining that the Board must “afford great weight” to CMS policy statements).

⁹⁴ Tr. 54:3-5.

hospitals to approximate their Medicare payment for an individual patient while that patient is still in the hospital. Even though we proposed to make outlier payments susceptible to a reconciliation based on the hospital's actual cost-to-charge ratios during the contemporaneous cost reporting period, the hospital should still be in a position to make this approximation. Hospitals have immediate access to the information needed to determine what their cost-to-charge ratio will be when their cost reports are settled. Even if the final cost-to-charge ratio is likely to be different from the ratio used initially to process and pay the claim, as noted above, hospitals not only have the information available to estimate their cost-to-charge ratios, but also have the ability to control them, through the structure and levels of their charges.

If we were to make retroactive adjustments to outlier payments to ensure total payments are 5.1 percent of DRG payments (by retroactively adjusting outlier payments), we would be removing this important aspect of the prospective nature of the IPPS. Because such an across-the-board adjustment would either lead to more or less outlier payments for all hospitals, hospitals would no longer be able to reliably approximate their payment for a patient while the patient is still hospitalized. We believe it would be neither necessary nor appropriate to make such an aggregate retroactive adjustment.

Furthermore, we believe it is consistent with the intent of the language at section 1886(d)(5)(A)(iv) of the Act not to do so. This section calls for the Secretary to ensure that outlier payments are equal to or greater than 5 percent and less than or equal to 6 percent of projected or estimated (not actual) DRG payments. We believe this language reflects the intent of Congress regarding the prospectivity of the IPPS.⁹⁵

3. Whether the MAC's use of the statewide average CCR instead of the Hospital's actual CCRs was proper.

At the crux of Hospitals' argument is the concept that the Medicare Contractor should have applied their respective actual CCRs instead of the statewide average CCR in their outlier calculations. As stated above, 42 C.F.R. 412.84(i)(1) states, in pertinent part: "[a] hospital may also request that its fiscal intermediary use a different (higher or lower) cost-to-charge ratio based on ***substantial evidence presented by the hospital.***"⁹⁶ As stated above, the Board finds that Hospitals have failed to present such substantial evidence. Moreover, 42 C.F.R. § 412.84(i)(3) provides that under certain circumstances, "the fiscal intermediary may use a statewide average cost-to-charge ratio if it is unable to determine an accurate operating or capital

⁹⁵ 68 Fed. Reg. at 34502 (bold, italics and underline emphasis added). See also Ex. C-9.

⁹⁶ (Emphasis added).

cost-to-charge ratio for a hospital[.]” Additionally, 42 C.F.R. § 412.84(i)(3) sets forth three (3) circumstances where the statewide average CCRs may be used: 1) “[n]ew hospitals that have not yet submitted their first Medicare cost report”; 2) “[h]ospitals whose operating or capital cost-to-charge ratio is in excess of 3 standard deviations above the corresponding national geometric mean”; and 3) “Other hospitals for whom the fiscal intermediary obtains accurate data with which to calculate either an operating or capital cost-to-charge ratio (or both) are not available.” The latter circumstance applies to “other hospitals” meaning hospitals that do not fit into the first or second categories and for which accurate data to calculate the CCR is not available.

As previously stated, the Medicare Contractor contends that the Hospitals’ reporting of functional units in years prior to 2016 resulted in the usage of the statewide average CCR. As the parties agree, and the Board finds as fact, in 2016, the Hospitals were permitted to start reporting gross charges on Worksheet C of the cost report. However, this selection for FY 2016 does not automatically result in the application of the actual CCRs for hospitals where the data to calculate an actual operating or capital CCR *is not available*.⁹⁷ In such instances, 42 C.F.R. § 412.84(i)(3) explicitly states that the MAC may use the statewide average CCR—and in this instance, because FY 2016 is the first year in which Worksheet C is being used, the data is new and cannot be compared with any other year for reasonableness or consistency. Essentially, FY 2016 is the baseline year for which the Hospitals will have generated the proper data to calculate an actual CCR going forward. Accordingly, and for the reasons set forth above, the Board finds that the Medicare Contractor was proper in determining Kaiser’s outlier payments for FY 2016 using the statewide average cost-to-charge ratio.

DECISION AND ORDER:

After considering Medicare law, regulations, and program guidance, the arguments presented, and the evidence admitted, the Board finds the Medicare Contractor properly calculated Kaiser’s outlier payments for all Hospital cost reports in fiscal year 2016.

BOARD MEMBERS PARTICIPATING:

Kevin D. Smith, CPA
 Ratina Kelly, CPA
 Nicole E. Musgrave, Esq.
 Shakeba DuBose, Esq.
 Clayton J. Nix, Esq.

FOR THE BOARD:

9/23/2026

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
 Board Chair
 Signed by: KEVIN D. SMITH -A

⁹⁷ Again, the lack of prior year data being available is directly tied to Kaiser’s business decision to not submit charge data on Worksheet C of the Hospitals’ cost reports prior to FY 2016. Provider’s PPP at 5.