

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.

In the September 30, 1988 final rule with comment period published in the **Federal Register** (53 FR 38503), we initiated the use of hospital-specific cost-to-charge ratios to determine hospitals' costs for assessing whether a case qualifies for payment as a cost outlier. Prior to that change, we determined the cost of discharges based on a nationwide cost-to-charge ratio of 60 percent. We indicated at the time that the use of hospital-specific cost-to-charge ratios is essential to ensure that outlier payments are made only for cases that have extraordinarily high costs, and not merely high charges.

Currently, cost-to-charge ratios are determined using the most recent settled cost report for each hospital. At the end of the cost reporting period, Medicare charges from all claims are accumulated through the Provider Statistical and Reimbursement Report (PS&R). The PS&R contains data such as the number of discharges and the actual charges from each hospital. The hospital also submits a cost report to its fiscal intermediary, which is used to

determine total allowable inpatient Medicare costs. Once all these data are available, the fiscal intermediary then determines the cost-to-charge ratio for the hospital by using charges from the PS&R and costs from the cost report.

Statewide average 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 the annual notices of prospective payment rates that are published by August 1 of each year in accordance with § 412.8(b). For FY 2003, those parameters are set at operating cost-to-charge ratios lower than 0.194 or greater than 1.258, or capital cost-to-charge ratios lower than 0.012 or greater than 0.163. These ranges represent 3.0 standard deviations (plus or minus) from the geometric mean of cost-to-charge ratios for all hospitals.

The Congress intended that outlier payments would be made only in situations where the cost of care is extraordinarily high in relation to the average cost of treating comparable conditions or illnesses. Under our existing outlier methodology, if hospitals' charges are not sufficiently comparable in magnitude to their costs, the legislative purpose underlying the outlier regulations is thwarted.

Recent analysis indicates that some hospitals have taken advantage of two

vulnerabilities in our methodology to maximize their outlier payments. One vulnerability is the time lag between the current charges on a submitted bill and the cost-to-charge ratio taken from the most recent settled cost report. The second vulnerability, in some cases, is that hospitals may increase their charges so far above costs that their cost-to-charge ratios fall below 3 standard deviations from the geometric mean of cost-to-charge ratios and a higher statewide average cost-to-charge ratio is applied. In this proposed rule, we are proposing to implement new regulations to ensure outlier payments are paid only for truly high-cost cases.

Because the fixed-loss threshold is determined based on hospitals' historical charge data, hospitals that have been inappropriately maximizing their outlier payments have caused the threshold to increase dramatically for FY 2003. As illustrated by the table below, the cost outlier threshold increased by 80 percent from \$9,700 in FY 1997 to \$17,550 in FY 2001. In addition, the cost outlier threshold increased by 91 percent from \$17,550 in FY 2001 to \$33,560 in FY 2003. The table also demonstrates, for the 3 most recent years, the level at which the threshold would have to have been set in order to result in outlier payments equal to 5.1 percent of total DRG payments (absent further behavioral responses by hospitals).

Fiscal year	Outlier percentage	Payments in excess of target of 5.1%* (in billions of dollars)	Outlier threshold	Threshold that would have paid out 5.1%
1997 .....	5.5	0.3	\$9,700	****
1998 .....	6.5	1.0	11,050	****
1999 .....	7.6	1.8	11,100	****
2000 .....	7.6	1.8	14,050	\$21,825
2001 .....	7.7	1.9	17,550	26,200
2002 .....	6.9	1.6	21,025	30,525
2003 .....	5.1	N/A	33,560	****

\*All payments are estimated and reflect operating payments only (not capital payments).

## II. Provisions of this Proposed Rule

### A. Updating Cost-to-Charge Ratios

Currently, we use the most recent settled cost report when determining cost-to-charge ratios for hospitals. The covered charges on bills submitted for payment during FY 2003 are converted to costs by applying a cost-to-charge ratio from cost reports that began in FY 2000 or, in some cases, FY 1999. These covered charges reflect all of a hospital's charge increases to date, in particular those that have occurred since FY 2000 and are not reflected in the FY 2000

cost-to-charge ratios. If the rate-of-charge increases since FY 2000 exceeds the rate of the hospital's cost increases during that time, the hospital's cost-to-charge ratio based on its FY 2000 cost report will be too high, and applying it to current charges will overestimate the hospital's costs per case during FY 2003. Overestimating costs may result in some cases qualifying for outlier payments that, in actuality, are not high cost cases.

Using the Medicare Provider Analysis and Review (MedPAR) file data from FY 1999 to FY 2001, we found 123

hospitals whose percentage of outlier payments relative to total DRG payments increased by at least 5 percentage points over that period, and whose case-mix (the average DRG relative weight value for all of a hospital's Medicare cases) adjusted charges increased at a rate at or above the 95th percentile rate of charge increase for all hospitals (46.63 percent) over the same period. We adjusted for case-mix because a hospital's average charges per case would be expected to change from one year to the next if the