

payment or a new technology add-on payment. This latter calculation is based on the covered charges reported on the bill, which, as discussed above, are also used to estimate the covered costs of the case by applying the cost-to-charge ratio.

The information from the bill is processed through the fiscal intermediary's claims processing system to determine the payment amount for each case. Unless a hospital qualifies for periodic interim payments under § 412.116(b), payment is made on the basis of the actual amount determined for each bill processed. For hospitals that qualify for periodic interim payments, the fiscal intermediary estimates a hospital's IPPS payments and makes biweekly payments equal to $\frac{1}{26}$ of the total estimated amount of payment for the year. However, outlier payments are not made on an interim basis, but are made on a claim-by-claim basis (even for hospitals that qualify for interim payments under § 412.116(b)), and generally represent final payment (§ 412.116(e)).

An exception to this finality is the provision for medical review of a sample of outlier cases and for adjustments to be made to covered charges for any services that are found to be noncovered (§ 412.84(d)). In situations where a pattern of inappropriate utilization by a hospital is found, all outlier cases from that hospital may be subject to prepayment medical review (§ 412.84(e)).

CMS has generally limited the situations in which outlier payments may be reopened. This is in contrast to payments under the IME adjustment and the DSH adjustment, both of which are routinely adjusted when hospitals' cost reports are settled to reflect updated data such as the number of residents or patient days during the actual cost reporting period. With respect to outliers, it has been CMS's policy that payment determinations are made on the basis of the best information available at the time a claim is processed and are not revised, upward or downward, based upon updated data.

As stated earlier in this preamble, we are increasingly aware that some hospitals have taken advantage of the current outlier policy by increasing their charges at extremely high rates, knowing that there would be a time lag before their cost-to-charge ratios would be adjusted to reflect the higher charges. The steps we are proposing in this proposed rule to direct fiscal intermediaries to update cost-to-charge ratios using the most recent tentative settled cost reports (and in some cases,

even later data) and using actual rather than statewide average ratios for hospitals that have cost-to-charge ratios that are more than 3.0 standard deviations below the geometric mean cost-to-charge ratio, would greatly reduce the opportunity for hospitals to manipulate the system to maximize outlier payments. However, they would not completely eliminate all such opportunity. A hospital would still be able to dramatically increase its charges by far above the rate of increase in costs during any given year. This possibility is of great concern, given the recent findings that some hospitals that have been able to receive large outlier payments by doing just that.

Therefore, we are proposing to add a provision to our regulations to provide that outlier payments will become subject to adjustment when hospitals' cost reports are settled (proposed § 412.84(i)(2)). Payments would be processed throughout the year using operating and capital cost-to-charge ratios based on the best information available at that time. When the cost report is settled, any reconciliation of outlier payments by fiscal intermediaries would be based on operating and capital cost-to-charge ratios calculated based on a ratio of costs to charges computed from the cost report and charge data determined at the time the cost report coinciding with the discharge is settled.

This process would require some degree of recalculating outlier payments for individual claims. It is not possible to distinguish, on an aggregate basis, how much a hospital's outlier payments would change due to a change in its cost-to-charge ratios. This is because, in the event of a decline in a ratio, some cases would no longer qualify for any outlier payments while other cases would qualify for lower outlier payments. Therefore, the only way to accurately determine the net effect of a decrease in cost-to-charge ratios on a hospital's total outlier payments is to assess the impact on a claim-by-claim basis. We are still assessing the procedural changes that would be necessary to implement this change.

Because, under our proposal, outlier payments would now be based on the relationship between the hospital's costs and charges at the time a discharge occurred, the proposed methodology would ensure that when final outlier payments are made they would reflect an accurate assessment of the actual costs the hospital incurred. Nevertheless, a final vulnerability remains. Even though the final payment would reflect a hospital's true cost experience, there would still be the

opportunity for a hospital to manipulate its outlier payments by dramatically increasing charges during the year in which the discharge occurs. In this situation, the hospital would receive excessive outlier payments, which, although the hospital would incur an overpayment and have to pay the money back when the cost report is settled, would allow the hospital to obtain excess payments from the Medicare Trust Fund on a short-term basis.

Under section 1886(d)(5)(A)(iii) of the Act, the amount of any outlier payment should "approximate the marginal cost of care" in excess of the DRG payment and the fixed-loss threshold. Accordingly, because a hospital would have had access to any excess outlier payments until they are repaid to the Trust Fund (or, in the case of an underpayment, would not have had access to the appropriate amount during the same period), it may be necessary to adjust the amount of the final outlier payment to reflect the time value of the funds for that time period. Therefore, we are proposing to add § 412.84(m) to provide that when the cost report is settled, outlier payments would be subject to an adjustment to account for the value of the money during the time period it was inappropriately held by the hospital. This adjustment would also apply in cases where outlier payments were underpaid to the hospital. In those cases, the adjustment would result in additional payments to hospitals. Any adjustment would be based upon a widely available index to be established in advance by the Secretary, and would be applied from the midpoint of the cost reporting period to the date of reconciliation (or when additional payments are issued, in the case of underpayments). This adjustment to reflect the time value of a hospital's outlier payments would ensure that the outlier payment received by the hospital at the time its cost report is settled appropriately reflects the hospital's true costs of providing the care.

This adjustment is also intended to account for the unique susceptibility of outlier payments to manipulation. Hospitals set their own level of charges and are able to change their charges, without review by their fiscal intermediaries. As outlined above, changes in charges directly affect the level of outlier payments. This lack of fiscal intermediary review of a factor affecting a hospital's payments is in contrast to other IPPS adjustments, such as the IME adjustment or the DSH adjustment, where the fiscal intermediary must agree to a change to the determining factor (the resident-to-