

bed ratio or the share of low-income patients, respectively).

Under section 1886(d)(5)(A)(iv) of the Act, outlier payments for any year must be projected to be not less than 5 percent nor more than 6 percent of the total estimated operating DRG payments plus outlier payments. Section 1886(d)(3)(B) of the Act requires the Secretary to reduce the average standardized amounts by a factor to account for the estimated proportion of total DRG payments made to outlier cases. Despite the fact that each individual hospital's outlier payments may be subject to adjustment when the cost report is settled, we continue to believe that the fixed-loss outlier threshold should be based on projected payments using the latest available historical data without retroactive adjustments, either mid-year or at the end of the year, to ensure that actual outlier payments are equal to 5.1 percent of total DRG payments. That is, the above proposed change is intended only to allow for use of the actual cost-to-charge ratio from the cost reporting period that corresponds to the discharges for which the outlier payments are made. This adjustment would be made irrespective of whether the nationwide percentage of outlier payments relative to total operating DRG payments is equal to the outlier offset that is applied to the average standardized amounts (generally, 5.1 percent).

Outlier payments are intended to recognize the fact that hospitals occasionally treat cases that are extraordinarily costly and otherwise not adequately compensated under an average-based payment system. However, we can only estimate actual costs based on the charges for a case because charges are the only data available that indicate the resource usage for an individual case. Therefore, our ability to identify true outlier cases is dependent on the accuracy of the cost-to-charge ratios. To the extent some hospitals may be motivated to maximize outlier payments by taking advantage of the lag in updating the cost-to-charge ratios, the payment system remains vulnerable to overpayments to individual hospitals. Therefore, we believe the only way to eliminate the potential for such overpayments is to provide a mechanism for final settlement of outlier payments using actual cost-to-charge ratios from final, settled cost reports.

However, the 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 preestablished threshold allows hospitals to approximate their Medicare payment for an individual patient while that patient is still in the hospital. Because we are proposing to base outlier payments 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 report is 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 ratio, but also have the ability to control it, 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 do not believe it would be consistent with the intent of the language at section 1886(d)(5)(A)(iv) of the Act 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 Congress's intent regarding the prospectivity of the IPPS. However, we do not believe it prevents settling outlier payments based on hospitals' actual cost-to-charge ratios during the period when the discharge occurs.

D. Fixed-loss Outlier Threshold

As noted above, under section 1886(d)(5)(A)(iv) of the Act, outlier payments for any year must be projected to be not less than 5 percent nor more than 6 percent of total estimated operating DRG payments plus outlier payments; and section 1886(d)(3)(B) of the Act requires the Secretary to reduce

the average standardized amounts by a factor to account for the estimated proportion of total DRG payments made to outlier cases. Similarly, section 1886(d)(9)(B)(iv) of the Act requires the Secretary to reduce the average standardized amounts applicable to hospitals in Puerto Rico to account for the estimated proportion of total DRG payments made to outlier cases.

In the August 1, 2002 final rule, we established the FY 2003 outlier fixed-loss threshold at \$33,560 (67 FR 50122). This was a nearly 60 percent increase over the FY 2002 threshold of \$21,025. The primary reason for this dramatic increase was a change in our methodology to use the rate of increase in charges rather than the rate of increase in costs to determine the threshold. That is, because we use FY 2001 cases to project the threshold for FY 2003, it is necessary to inflate the charges on the FY 2001 bills to approximate the charges on a similar claim for FY 2003. Prior to the calculation of the FY 2003 outlier threshold, we used the rate-of-cost increase from the most recent cost reports available to inflate actual charges on the prior year's bills to estimate what the charges would be in the upcoming year.

Our analysis indicated hospitals' charges were increasing at a much faster rate than costs. Therefore, in the August 1, 2002 final rule, we changed our methodology to inflate charges (67 FR 50122). Rather than using the observed rate of increase in costs from the cost reports, we inflated the FY 2001 charges by a 2-year average annual rate of change in actual charges per case from FY 1999 to FY 2000, and from FY 2000 to FY 2001, to estimate what the charges would be in FY 2003 for a similar claim.

This proposed rule would make several changes to better target outlier payments to the most costly cases. As a result, if our present proposals are implemented as part of our final policy, outlier payments to the hospitals that have been most aggressively increasing their charges to maximize outlier payments would be dramatically reduced. However, we are concerned that unrestrained charge increases may continue to occur during FY 2003 prior to the implementation of these proposed changes as final, and possibly may result in outlier payments in excess of the 5.1 percent offset established by the August 1, 2002 final rule. For example, hospitals intending to maximize outlier payments during FY 2003 could continue to do so by increasing charges enough to outpace the increase in the threshold. In fact, given the public attention on this behavior over the past