

Thus, the proposed adjusted payment for facility A will be \$28,264.65, and the proposed adjusted payment for facility B will be \$35,462.82.

#### *F. Computing Total Payments Under the IRF PPS for the Transition Period*

Under section 1886(j)(1) of the Act and § 412.626, payment for all IRFs with cost reporting periods beginning on or after October 1, 2002 will consist of 100 percent of the proposed FY 2004 adjusted Federal prospective payment (plus any applicable outlier payments under § 412.624(e)(4)) and there will not be any blended payments. Accordingly, the proposed FY 2004 IRF PPS rates set forth in this proposed rule would apply to all discharges on or after October 1, 2003 and before October 1, 2004.

#### *G. IRF-Specific Wage Data*

On page 41358 of the August 7, 2001 IRF PPS final rule, we responded to comments regarding the development of a separate wage index for IRFs. Specifically, we responded to these comments as follows:

“At this time, we are unable to develop a separate wage index for rehabilitation facilities. There is a lack of specific IRF wage and staffing data necessary to develop a separate IRF wage index accurately. Further, in order to accumulate the data needed for such an effort, we would need to make modifications to the cost report. In the future, we will continue to research a wage index specific to IRF facilities. Because we do not have an IRF specific wage index that we can compare to the hospital wage index, we are unable to determine at this time the degree to which the acute care hospital data fully represent IRF wages. However, we believe that a wage index based on acute care hospital wage data is the best and most appropriate wage index to use in adjusting payments to IRFs, since both acute care hospitals and IRFs compete in the same labor markets.”

We still do not have any IRF-specific wage data to determine the feasibility of developing an IRF-specific wage index or of developing an adjustment to refine the acute care hospital wage data to reflect inpatient rehabilitation services. We continue to look into alternative ways to collect, analyze, develop, and audit IRF-specific wage data that would reflect the wages and wage-related costs attributable to rehabilitation facilities. We believe that the best source to collect IRF-specific wage data is the Medicare cost report—the same source for the acute care hospital wage data. These data must be accurate and reliable, thus collecting these data would increase the recordkeeping and

reporting burden on IRFs. Initially, this burden would be imposed to collect data just to determine the feasibility of developing an IRF-specific wage index or development of an adjustment to the current IRF wage index.

In addition, as stated earlier in this section of this proposed rule, any adjustment or update to the wage index must be made in a budget neutral manner in accordance with § 1886(j)(6) of the Act. Thus, the PPS rates for any one IRF could be affected in a positive or negative direction, due to the application of the proposed updates to the labor-related share and wage indices in a budget neutral manner. Accordingly, given the current trend of reducing the Medicare cost reporting burden of collecting data and given that any change to the wage index be budget neutral, we are soliciting comments on possible ways to adjust or refine the current IRF wage index, given those restraints.

Since IRFs and hospitals compete in the same labor markets, we propose to continue to use the acute care hospital wage data to develop the IRF wage index as described earlier in this section of this proposed rule.

#### *H. Proposed Adjustment for High-Cost Outliers Under the IRF Prospective Payment System*

In this proposed rule, we are proposing changes to the methodology for determining IRF payments for high-cost outliers. The intent of these proposed changes is to ensure outlier payments are paid only for truly high-cost cases. Further, these proposed changes will allow us to create policies that are consistent among the various Medicare prospective payment systems when appropriate.

We have become aware that under the existing acute care hospital inpatient prospective payment system (IPPS), that some hospitals have taken advantage of two system features in the IPPS outlier policy to maximize their outlier payments. The first 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. Second, statewide average cost-to-charge ratios are used in those instances in which an acute care hospital's operating or capital cost-to-charge ratios fall outside reasonable parameters. We set 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). Currently, these parameters represent 3.0 standard deviations (plus or minus) from the

geometric mean of cost-to-charge ratios for all hospitals. In some cases, 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 the cost-to-charge ratio and a higher statewide average cost-to-charge ratio is applied to determine if the acute care hospital should receive an outlier payment. This disparity results in their cost-to-charge ratios being set too high, which in turn results in an overestimation of their current costs per case.

We believe the Congress intended that outlier payments under both the IPPS and the IRF PPS 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 the existing IPPS outlier methodology, if hospitals' charges are not sufficiently comparable in magnitude to their costs, the legislative purpose underlying the outlier regulations is thwarted. Thus, on March 4, 2003, we published a proposed rule (68 FR 10420–10429) “Proposed Changes in Methodology for Determining Payment for Extraordinarily High-Cost Cases (Cost Outliers) Under the Acute Care Hospital Inpatient Prospective Payment System,” with an extensive discussion proposing new regulations to ensure outlier payments are paid for truly high-cost cases under the IPPS.

We believe the use of parameters is appropriate for determining cost-to-charge ratios to ensure these values are reasonable and outlier payments can be made in the most equitable manner possible. Further, we believe the methodology of computing IRF outlier payments is susceptible to the same payment enhancement practices identified under the IPPS and, therefore, merit similar proposed revisions. Accordingly, as discussed below, we are proposing in this proposed rule to make revisions to the IRF outlier payment methodology.

#### *1. Current Outlier Payment Provision Under the IRF PPS*

Section 1886(j)(4) of the Act provides the Secretary with the authority to make payments in addition to the basic IRF prospective payments for cases incurring extraordinarily high costs. In the August 7, 2001 IRF PPS final rule, we codified at § 412.624(e)(4) of the regulations the provision to make an adjustment for additional payments for outlier cases that have extraordinarily high costs relative to the costs of most discharges. Providing additional payments for outliers strongly improves the accuracy of the IRF PPS in