

determining resource costs at the patient and facility level. These additional payments reduce the financial losses that would otherwise be caused by treating patients who require more costly care and, therefore, reduce the incentives to underserve these patients.

Under § 412.624(e)(4), we make outlier payments for any discharges if the estimated cost of a case exceeds the adjusted IRF PPS payment for the CMG plus the adjusted threshold amount (\$11,211 which is then adjusted for each IRF by the facilities wage adjustment, its LIP adjustment, and its rural adjustment, if applicable). We calculate the estimated cost of a case by multiplying the IRF's overall cost-to-charge ratio by the Medicare allowable covered charge. In accordance with § 412.624(e)(4), we pay outlier cases 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted IRF PPS payment for the CMG and the adjusted threshold amount).

On November 1, 2001, we published a Program Memorandum (Transmittal A-01-131) with detailed intermediary instructions for calculating the cost-to-charge ratios for the purposes of determining outlier payments under the IRF PPS. We stated the following:

"Intermediaries will use the latest available settled cost report and associated data in determining a facility's overall Medicare cost-to-charge ratio specific to freestanding IRFs and for IRFs that are distinct part units of acute care hospitals. Intermediaries will calculate updated ratios each time a subsequent cost report settlement is made. Further, retrospective adjustments to the data used in determining outlier payments will not be made. If the overall Medicare cost-to-charge ratio appears to be substantially out-of-line with similar facilities, the intermediary should ensure that the underlying costs and charges are properly reported. We are evaluating the use of upper and lower cost-to-charge ratio thresholds (similar with the outlier policy for acute care hospitals) in the future to ensure that the distribution of outlier payments remains equitable."

For this proposed rule, we are proposing to continue to use the \$11,211 threshold amount. This threshold amount was used in the FY 2003 IRF PPS payment rates and we believe it remains appropriate because the data should not contain any of the inappropriate payment enhancement practices that would result with the implementation of an outlier policy. The data used to construct the existing IRF-PPS outlier threshold consists of cost and charge data that was not

influenced by the incentives the current IRF PPS outlier policy may create. Specifically, we used the IRF cost and charge data from the previous cost-based reimbursement system to establish the outlier threshold. These data were not inappropriately influenced by incentives to inflate charges that are created with the existence of an outlier policy; there is not a need for an outlier policy cost-based reimbursement because IRFs, with some limits, would be paid their costs. This is unlike the outlier situation in IPPS, which used post-PPS data to update its annual threshold amount. The IPPS data reflected the practices that we believe erroneously created inappropriate outlier payments.

We propose to continue to make outlier payments for any discharges if the estimated cost of a case exceeds the adjusted IRF PPS payment for the CMG plus the adjusted threshold amount (\$11,211 which is then adjusted for each IRF by the facility's wage adjustment, its LIP adjustment, and its rural adjustment, if applicable). We propose to continue to calculate the estimated cost of a case by multiplying an IRF's overall cost-to-charge ratio by the Medicare allowable covered charge. However, we are proposing to apply a ceiling to an IRF's cost-to-charge ratios which is discussed below. In accordance with § 412.624(e)(4), we will continue to pay outlier cases 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted IRF PPS payment for the CMG and the adjusted threshold amount). In addition, under the existing methodology described in the preamble to the August 7, 2001 IRF PPS final rule (66 FR 41363), we will continue to assign the applicable national average for new IRFs.

## 2. Proposed Changes to the IRF Outlier Payment Methodology

### *Statistical Accuracy of Cost-to-Charge ratios*

We believe that there is a need to ensure that the cost-to-charge ratio used to compute an IRF's estimated costs should be subject to a statistical measure of accuracy. Removing aberrant data from the calculation of outlier payments will allow us to enhance the extent to which outlier payments are equitably distributed and continue to reduce incentives for IRFs to underserve patients who require more costly care. Further, using a statistical measure of accuracy to address aberrant cost-to-charge ratios will also allow us to be consistent with the proposed outlier policy changes for the acute care

hospital IPPS discussed in the March 4, 2003 Cost Outlier proposed rule, (68 FR 10420). Therefore in this proposed rule, we are proposing the following:

(1) To apply a ceiling to IRF's cost-to-charge ratio if a facility's cost-to-charge ratio is above a ceiling. We will calculate two national ceilings, one for IRFs located in rural areas and one for facilities located in urban areas. We propose to compute this ceiling by first calculating the national average and the standard deviation of the cost-to-charge ratio for both urban and rural IRFs. (Because of the small number of IRF's compared to the number of acute care hospitals, we believe that statewide averages for IRFs, as proposed under the IPPS, would not be statistically valid. Thus, we propose to use national average cost-to-charge ratios in place of statewide averages.) To determine the rural and urban ceiling, we propose to multiply each of the standard deviations by 3 and add the result to the appropriate national cost-to-charge ratio average (rural and urban). We believe this method results in statistically valid ceilings. If an IRF's cost-to-charge ratio is above the applicable ceiling it is considered to be statistically inaccurate and we propose to assign the national (either rural or urban) average cost-to-charge ratio to the IRF. Cost-to-charge ratios above this ceiling are probably due to faulty data reporting or entry, and, therefore, should not be used to identify and make payments for outlier cases because such data are most likely erroneous and therefore should not be relied upon. We propose to update the ceiling and averages using this methodology every year and we will publish these amounts in future program memoranda;

(2) Not assign the applicable national average cost-to-charge ratio when an IRF's cost-to-charge ratio falls below a floor. We are proposing this policy because, as is the case for acute care hospitals, we believe IRFs could arbitrarily increase their charges in order to maximize outlier payments. Even though this arbitrary increase in charges should result in a lower cost-to-charge ratio in the future (due to the lag time in cost report settlement), if we propose the use of a floor, the IRF's cost-to-charge ratio would be raised to the applicable national average. This application of the national average could result in inappropriately higher outlier payments. Accordingly, we are proposing to apply the IRF's actual cost-to-charge ratio to determine the cost of the case rather than creating and applying a floor. Applying an IRF's actual cost-to-charge ratio to charges in the future to determine the cost of a case