

will result in more appropriate outlier payments because it does not overstate the actual cost-to-charge ratio.

Therefore, consistent with the proposed policy change for acute care hospitals under the IPPS, we are proposing that to use an IRF's actual cost-to-charge ratio no matter how low their ratio fall.

### 3. Proposed Adjustment of IRF Outlier Payments

Under the existing methodology for computing IRF outlier payments as described in the preamble of the August 7, 2001 IRF PPS final rule (66 FR 41363) and in the November 1, 2001 Program Memorandum discussed above, we specify that the cost-to-charge ratio used to compute estimated costs are obtained from the most recent settled Medicare cost report. Further, we provided for no retroactive adjustment to the outlier payments to account for differences between the cost-to-charge ratio from the latest settled cost report and the actual cost-to-charge ratio for the cost reporting period in which the outlier payment is made. This policy is consistent with the existing outlier payment policy for acute care hospitals under the IPPS. However, as discussed in the IPPS March 4, 2003 Cost Outlier proposed rule (68 FR 10423), we proposed to revise the methodology for determining cost-to-charge ratios for acute care hospitals under the IPPS because we became aware that payment vulnerabilities exist in the current IPPS outlier policy. Because we believe the IRF outlier payment methodology is likewise susceptible to the same payment vulnerabilities, we are proposing the following:

(1) As proposed for acute care hospitals under the IPPS at proposed § 412.84(i) in the March 4, 2003 proposed rule (68 FR 10420), we are proposing under § 412.624(e)(4), by cross-referencing proposed § 412.84(i), that fiscal intermediaries would use more recent data when determining an IRF's cost-to-charge ratio. Specifically, under proposed § 412.84(i), we are proposing that fiscal intermediaries would use either the most recent settled IRF cost report or the most recent tentative settled IRF cost report, whichever is later to obtain the applicable IRF cost-to-charge ratio. In addition, as proposed under § 412.84(i), any reconciliation of outlier payments will be based on a ratio of costs to charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled. As is the case with the proposed changes to the outlier policy for acute care hospitals under the IPPS, we are still assessing the

procedural changes that would be necessary to implement this change.

(2) As proposed for acute care hospitals under the IPPS at proposed § 412.84(m) in the March 4, 2003 proposed rule (68 FR 10420), we are proposing under § 412.624(e)(4), by cross-referencing proposed § 412.84(m), that IRF outlier payments may be adjusted to account for the time value of money which is the value of money during the time period it was inappropriately held by the IRF as an "overpayment." We also may adjust outlier payments for the time value of money for cases that are "underpaid" to the IRF. In these cases, the adjustment will result in additional payments to the IRF. We are proposing that any adjustment will be based upon a widely available index to be established in advance by the Secretary, and will be applied from the midpoint of the cost reporting period to the date of reconciliation.

### 4. Proposed Change to the Methodology for Calculating the Federal Prospective Payment Rates

#### *Section 412.624(e)(4) Adjustment for high-cost outliers*

We provide for an additional payment to a facility if its estimated costs for a patient exceeds a fixed dollar amount (adjusted for area wage levels and factors to account for treating low-income patients and for rural locations) as specified by CMS. The additional payment equals 80 percent of the difference between the estimated cost of the patient and the sum of the adjusted Federal prospective payment computed under this section and the adjusted fixed dollar amount. Additional payments made under this section will be subject to the adjustments at § 412.84(i) except that national averages will be used instead of statewide averages. Additional payments made under this section will also be subject to adjustments at § 412.84(m).

### VII. Provisions of the Proposed Rule

Overall, in this proposed rule, we are proposing to update the IRF Federal prospective payment rates from FY 2003 to FY 2004 using the methodology described in § 412.624 of the regulations. Our proposed FY 2004 Federal prospective payment rates would be effective for discharges on or after October 1, 2003 and before October 1, 2004.

We are proposing to update the IRF wage indices for FY 2004 by using FY 1999 acute care hospital data. However, any adjustments or updates made under section 1886(j)(6) of the Act must be

made in a budget neutral manner. Therefore, we are proposing a methodology to update the wage indices for FY 2004 using 1999 acute care hospital data in a budget neutral manner.

We are also proposing to modify certain criteria for a hospital or a hospital unit to be classified as an IRF.

#### *Section 412.20 Hospital services subject to the prospective payment systems*

We are proposing to redesignate current § 412.20(b) and add a new paragraph (b)(2) that states inpatient hospital services will not be paid for under the IRF PPS if the services are paid by a health maintenance organization (HMO) or competitive medical plan (CMP) that elects not to have CMS make payments to an IRF for services, which are inpatient hospital services, furnished to the HMO's or CMP's Medicare enrollees under part 417.

#### *Section 412.22 Excluded hospitals and hospital units: General rules*

We are proposing to eliminate application of the bed-number criteria in § 412.22(h)(2)(i) for freestanding satellite IRFs by revising § 412.22(h)(2) and by adding § 412.22(h)(7).

#### *Section 412.25 Excluded hospital units: Common requirements*

We are also proposing to eliminate application of the bed-number criteria for IRF satellite units of a hospital in § 412.25(e)(2)(i) by revising § 412.25(e)(2) and by adding § 412.25(e)(5) to conform with the proposed change in § 412.22(h)(2)(i).

#### *Section 412.29 Excluded rehabilitation units: Additional requirements*

Under § 412.29(a), an IRF unit must have met either the requirements for new units or converted units under § 412.30 in order to be excluded from the inpatient acute care PPS. Section 412.29(a)(2) contains an incorrect reference to the requirements for converted units under "§ 412.30(b)." The correct reference to the requirements for converted units is § 412.30(c). Accordingly, we are proposing to make a technical correction by changing the reference in § 412.29(a)(2) to state "Converted units under § 412.30(c)."

#### *Section 412.30 Exclusion of new rehabilitation units and expansion of units already excluded*

Section 412.30(b)(3) contains an incorrect reference to the required written certification described in