

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412

[CMS-1243-F]

RIN 0938-AM41

Medicare Program; Change in Methodology for Determining Payment for Extraordinarily High-Cost Cases (Cost Outliers) Under the Acute Care Hospital Inpatient and Long-Term Care Hospital Prospective Payment Systems

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: In this final rule, we are revising the methodology for determining payments for extraordinarily high-cost cases (cost outliers) made to Medicare-participating hospitals under the acute care hospital inpatient prospective payment system (IPPS).

Under the existing outlier methodology, the cost-to-charge ratios from hospitals' latest settled cost reports are used in determining a fixed-loss amount cost outlier threshold. We have become aware that, in some cases, hospitals' recent rate-of-charge increases greatly exceed their rate-of-cost increases. Because there is a time lag between the cost-to-charge ratios from the latest settled cost report and current charges, this disparity in the rate-of-increases for charges and costs results in cost-to-charge ratios that are too high, which in turn results in an overestimation of hospitals' current costs per case. Therefore, we are revising our outlier payment methodology to ensure that outlier payments are made only for truly expensive cases.

We also are revising the methodology used to determine payment for high-cost outlier and short-stay outlier cases that are made to Medicare-participating long-term care hospitals (LTCHs) under the long-term care hospital prospective payment system (LTCH PPS). The policies for determining outlier payment under the LTCH PPS are modeled after the outlier payment policies under the IPPS.

EFFECTIVE DATE: The provisions of this final rule are effective on August 8, 2003.

FOR FURTHER INFORMATION CONTACT: Stephen Phillips, (410) 786-4548 (IPPS

Outlier Policy) Miechal Lefkowitz, (410) 786-5316 (LTCH PPS Outlier Policy)

SUPPLEMENTARY INFORMATION:

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I. Background

A. Description of the Acute Care Hospital Inpatient Prospective Payment System (IPPS)

Section 1886(d) of the Social Security Act (the Act) sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively set rates. This payment system is referred to as the acute care hospital inpatient prospective payment system (IPPS). Under the IPPS, each case is categorized into a diagnosis-related group (DRG). Each DRG has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that DRG.

The IPPS base payment rate (also referred to as the average standardized amount) is divided into a labor-related share and a nonlabor-related share. The labor-related share is adjusted by the wage index applicable to the area where the hospital is located, and if the hospital is located in Alaska or Hawaii, the nonlabor-related share is adjusted by a cost-of-living adjustment factor. This base payment rate is multiplied by the DRG relative weight.

If a hospital treats a high percentage of low-income patients, it receives a percentage add-on payment applied to

the DRG-adjusted base payment rate. This add-on payment, known as the disproportionate share hospital (DSH) adjustment, provides for a percentage increase in Medicare payments to hospitals that qualify under either of two statutory formulas that are designed to identify hospitals that serve a disproportionate share of low-income patients. For qualifying hospitals, the amount of the DSH adjustment may vary based on the outcome of the statutory calculation.

Also, if a hospital is an approved teaching hospital it receives a percentage add-on payment for each case paid under the IPPS. This add-on payment, known as the indirect medical education (IME) adjustment, varies depending on the ratio of residents-to-beds for operating costs and according to the ratio of residents-to-average daily census for capital costs under the IPPS.

Additional payments may be made for cases that involve new technologies that have been approved for special add-on payments. In order to qualify, a new technology must demonstrate that it is a substantial clinical improvement over technologies otherwise available, and that, absent an add-on payment, it would be inadequately paid under the regular DRG payment.

For particular cases that are unusually costly, known as outlier cases (discussed below), the IPPS payment is increased. This additional payment is designed to protect a Medicare-participating hospital from large financial losses due to unusually expensive cases. Any outlier payment due to the hospital is added to the DRG-adjusted base payment rate, plus any DSH, IME, and new technology add-on adjustments.

The regulations governing payments for operating costs under the IPPS are located in 42 CFR Part 412. The specific regulations governing payments for outlier cases are located at 42 CFR 412.80 through 412.86.

Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of inpatient hospital services "in accordance with a prospective payment system established by the Secretary." The basic methodology for determining capital prospective payments is set forth in our regulations at §§ 412.308 and 412.312. Under the capital prospective payment system, payments are adjusted by the same DRG for the case as they are under the operating IPPS. Similar adjustments are also made for IME and DSH as under the operating IPPS. Hospitals also may receive a capital outlier payment for those cases that qualify.