

**B. Payment for Outlier Cases****1. General**

Section 1886(d)(5)(A) of the Act provides for Medicare payments to Medicare-participating hospitals in addition to the basic prospective payments for cases incurring extraordinarily high costs. To qualify for outlier payments, a case must have costs above a fixed-loss cost threshold amount (a dollar amount by which the costs of a case must exceed payments in order to qualify for outliers).

Hospital-specific cost-to-charge ratios are applied to the covered charges for a case to determine whether the costs of the case exceed the fixed-loss outlier threshold. Payments for eligible cases are then made based on a marginal cost factor, which is a percentage of the costs above the threshold. For Federal fiscal year (FY) 2003, the existing fixed-loss outlier threshold is \$33,560.

The actual determination of whether a case qualifies for outlier payments takes into account both operating and capital costs and DRG payments. That is, the combined operating and capital costs of a case must exceed the fixed-loss outlier threshold to qualify for an outlier payment. The operating and capital costs are computed separately by multiplying the total covered charges by the operating and capital cost-to-charge ratios. The estimated operating and capital costs are compared with the fixed-loss threshold after dividing that threshold into an operating portion and a capital portion (by first summing the operating and capital ratios and then determining the proportion of that total comprised by the operating and capital ratios and applying these percentages to the fixed-loss threshold). The thresholds are also adjusted by the area wage index (and capital geographic adjustment factor) before being compared to the operating and capital costs of the case. Finally, the outlier payment is based on a marginal cost factor equal to 80 percent of the combined operating and capital costs in excess of the fixed-loss threshold (90 percent for burn DRGs).

The following example simulates the IPPS outlier payment for a case at a generic hospital that receives IME and DSH payments in San Francisco, California (a large urban area). In the example, the patient was discharged after October 1, 2002, and the hospital incurred Medicare-covered charges of \$150,000. The DRG assigned to the case was DRG 286 (Adrenal and Pituitary Procedures), which has a FY 2003 relative weight of 2.0937. There is no new technology add-on payment for the case.

*Step 1:* Determine the Federal operating and capital payment with IME and DSH adjustment based on the following values:

**OPERATING PORTION**

National Large Urban Standardized Amounts:	
Labor-Related .....	\$3,022.60
Nonlabor-Related .....	\$1,228.60
San Francisco MSA Wage Index .....	1.4142
IME Operating Adjustment Factor .....	0.0744
DSH Operating Adjustment Factor .....	0.1413
DRG 286 Relative Weight .....	2.0937
Labor-Related Portion .....	0.711
Nonlabor-Related Portion .....	0.289

Federal Payment for Operating Costs = DRG Relative Weight  $\times$  [(Labor-Related Large Urban Standardized Amount  $\times$  San Francisco MSA Wage Index) + Nonlabor-Related National Large Urban Standardized Amount]  $\times$  (1 + IME + DSH):  $2.0937 \times [(\$3,022.60 \times 1.4142) + \$1,228.60] \times (1 + 0.0744 + 0.1413) = \$14,007.26$

**CAPITAL PORTION**

Federal Capital Rate .....	\$407.01
Large Urban Add-On .....	1.03
San Francisco MSA Geographic Adjustment Factor ..	1.2679
IME Capital Adjustment Factor .....	0.0243
DSH Capital Adjustment Factor .....	0.0631

Federal Payment for Capital Costs = DRG Relative Weight  $\times$  Federal Capital Rate  $\times$  Large Urban Add-On  $\times$  Geographic Adjustment Factor  $\times$  (1 + IME + DSH):  $2.0937 \times \$407.01 \times 1.03 \times 1.2679 \times (1 + 0.0243 + 0.0631) = \$1,210.12$

*Step 2:* Determine operating and capital costs from billed charges by applying the respective cost-to-charge ratios.

Billed Charges .....	\$150,000
Operating Cost-to-Charge Ratio .....	0.50
Operating Costs = (Billed Charges $\times$ Operating Cost-to-Charge Ratio) (\$150,000 $\times$ .50) .....	\$75,000
Capital Cost-to-Charge Ratio .....	0.06
Capital Costs = (Billed Charges $\times$ Capital Cost-to-Charge Ratio) (\$150,000 $\times$ .06) .....	\$9,000

*Step 3:* Determine outlier threshold.

Fixed Loss Threshold .....	\$33,560
Operating Cost-to-Charge Ratio to Total Cost-to-Charge Ratio:..	

(Operating Cost-to-Charge Ratio) / (Operating Cost-to-Charge Ratio + Capital Cost-to-Charge Ratio) (.50)/(.50 + .06) .....	0.8929
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Operating Outlier Threshold = {[Fixed Loss Threshold  $\times$  ((Labor-Related portion  $\times$  San Francisco MSA Wage Index) + Nonlabor-Related portion)]  $\times$  Operating Cost-to-Charge Ratio to Total Cost-to-Charge Ratio} + Federal Payment with IME and DSH:  $\{ \$33,560 \times [(0.711 \times 1.4142) + 0.289] \times 0.8929 \} + \$14,007.26 = \$52,797.78$   
Capital Cost-to-Charge Ratio to Total Cost-to-Charge Ratio = [(Capital Cost-to-Charge Ratio)/(Operating Cost-to-Charge Ratio + Capital Cost-to-Charge Ratio)]:  $\{ (.06)/(.50 + .06) \} = 0.1071$

Capital Outlier Threshold = (Fixed Loss Threshold  $\times$  Geographic Adjustment Factor  $\times$  Large Urban Add-On  $\times$  Capital CCR to Total CCR) + Federal Payment with IME and DSH:  $(\$33,560 \times 1.2679 \times 1.03 \times 0.1071) + \$1,210.12 = \$5,904.02$

*Step 4:* Determine outlier payment.

Marginal Cost Factor = 0.80

Outlier Payment = (Costs—Outlier Threshold)  $\times$  Marginal Cost Factor  
Operating Outlier Payment =  $(\$75,000 - \$52,797.78) \times 0.80 = \$17,761.78$

Capital Outlier Payment =  $(\$9,000 - \$5,904.02) \times 0.80 = \$2,476.78$

**2. Cost-to-Charge Ratios**

Under our existing regulation at § 412.84(h), the operating cost-to-charge ratio and, effective with cost reporting periods beginning on or after October 1, 1991, the capital cost-to-charge ratio used to adjust covered charges are computed annually by the intermediary for each hospital based on the latest available settled cost report for that hospital and charge data for the same time period as that covered by the cost report.

In the September 30, 1988 final rule with comment period published in the **Federal Register** (53 FR 38503), we initiated the use of hospital-specific cost-to-charge ratios to determine hospitals' costs for assessing whether a case qualified for payment as a cost outlier. Prior to that change, we determined the cost of discharges based on a nationwide cost-to-charge ratio of 60 percent. We indicated at the time that the use of hospital-specific cost-to-charge ratios is essential to ensure that outlier payments are made only for cases that have extraordinarily high costs, and not merely high charges.

Currently, cost-to-charge ratios are determined using the most recent settled cost report for each hospital. At