

the end of the cost reporting period, Medicare charges from all claims are accumulated through the Provider Statistical and Reimbursement Report (PS&R). The PS&R contains data such as the number of discharges and the actual charges from each hospital. The hospital also submits a cost report to its fiscal intermediary, which is used to determine total allowable inpatient Medicare costs. Once all these data are available, the fiscal intermediary then determines the cost-to-charge ratio for the hospital by using charges from the PS&R and costs from the cost report.

The Congress intended that outlier payments 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 our existing outlier methodology, if hospitals' charges are not sufficiently comparable in magnitude to their costs, the legislative purpose underlying the outlier regulations is thwarted.

Recent analysis indicates that some hospitals have taken advantage of two vulnerabilities in our methodology to

maximize their outlier payments. One vulnerability 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. The second vulnerability, in some cases, is that 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 cost-to-charge ratios and a higher statewide average cost-to-charge ratio is applied. In a March 5, 2003 IPPS proposed rule (68 FR 10420) and a March 7, 2003 LTCH PPS proposed rule (68 FR 11234) that are discussed in sections II., III., IV., V., and VI., and section VII., respectively, of this final rule, we proposed to implement new regulations to correct these vulnerabilities and to ensure outlier payments are paid only for truly high-cost cases.

Because the fixed-loss threshold is determined based on hospitals' historical charge data, hospitals that have been inappropriately maximizing their outlier payments have caused the threshold to increase dramatically for

FY 2003, and even more dramatically for the proposed IPPS FY 2004 outlier threshold of \$50,645 (68 FR 27235, May 19, 2003). As illustrated by the table below, the IPPS cost outlier threshold increased by 80 percent from \$9,700 in FY 1997 to \$17,550 in FY 2001. In addition, the cost outlier threshold increased by 91 percent from \$17,550 in FY 2001 to \$33,560 in FY 2003. The proposed FY 2004 threshold would be a 51-percent increase over the FY 2003 threshold. The table also demonstrates, for FYs 2000 and 2001, the level at which the threshold would have to have been set in order to result in outlier payments equal to 5.1 percent of total DRG payments (absent further behavioral responses by hospitals).¹ We are required by section 1886(d)(2)(E) of the Act to apply an offset to the average standardized amounts equal to the projected outlier payments as a percentage of total DRG payments. We have historically projected outlier payments to be 5.1 percent of total DRG payments.

Fiscal year	Outlier percentage	Payments in excess of target of 5.1 percent ¹ (in billions of dollars)	Outlier threshold	Threshold that would have paid out 5.1 percent
1997	5.5	\$0.3	\$9,700
1998	6.5	1.0	11,050
1999	7.6	1.8	11,100
2000	7.6	1.8	14,050	21,825
2001	7.7	1.9	17,550	26,200
2002	7.9	2.5	21,025	(²)
2003	6.1	(²)	33,560

¹ All payments are estimated and reflect operating payments only (not capital payments).

² Not available.

II. Issuance of Proposed Rules

On March 5, 2003, we published in the **Federal Register** (68 FR 10420) a proposed rule that would change the methodology for establishing how extraordinarily high-cost cases (cost-outliers) qualify for an outlier payment. On March 7, 2003, as part of the proposed rule published in the **Federal Register** (68 FR 11234) to update the payment rates and policies under the LTCH PPS, we included a proposal to apply a similar change in the methodology for establishing outlier payments for LTCHs. We proposed these changes in the payment methodology for both systems in order to correct situations in which rapid increases in charges by certain hospitals

have resulted in their cost-to-charge ratios being set too high. Use of these cost-to-charge ratios has resulted in excessive outlier payments to these hospitals.

We received approximately 582 timely pieces of correspondence on the provisions of the March 5, 2003 IPPS outlier proposed rule. We received approximately 22 timely pieces of correspondence on the provisions of the March 7, 2003 LTCH PPS proposed rule that related to payment for outlier cases. In this section of this final rule, we discuss comments we received that are not related to the specific changes we proposed, but are instead more general comments related to outlier payment policies. We also discuss in this section the general issue of allowing a transition

period for the changes we are implementing.

Comments directly related to specific proposals to revise the IPPS outlier payment policy and our responses to those comments are addressed in sections III., IV., V., and VI. of this final rule. Comments directly related to the specific proposed LTCH PPS outlier payment policy changes and our responses to those comments are addressed in section VII. of this final rule.

We received a number of comments that, while directly or indirectly related to outlier policy, were unrelated to the policies discussed in the proposed rule. We have not responded to comments that are unrelated to the changes that were proposed in the March 5, 2003

¹ We estimate the FY 2003 percent of outlier payments compared to total DRG payments is 6.1

percent. Although in the May 19, 2003 FY 2004 IPPS proposed rule, we estimated this percentage to

be 5.5 percent, we have now determined that this percentage was underestimated.