

by increasing their charges at extremely high rates, knowing that there would be a time lag before their cost-to-charge ratios would be adjusted to reflect the higher charges. The steps we proposed in the March 5, 2003 proposed rule, and are implementing here, to direct fiscal intermediaries to update cost-to-charge ratios using the most recent tentative settled cost reports (and in some cases, even later data) and using actual rather than statewide average ratios for hospitals that have cost-to-charge ratios higher than 3.0 standard deviations below the geometric mean cost-to-charge ratio, would greatly reduce the opportunity for hospitals to manipulate the system to maximize outlier payments. However, these steps would not completely eliminate all such opportunity. A hospital would still be able to dramatically increase its charges by far above the rate-of-increase in costs during any given year. This possibility is of great concern, given the recent findings that some hospitals have been able to receive large outlier payments by doing just that.

Therefore, we proposed to add a provision to our regulations to provide that outlier payments would become subject to reconciliation when hospitals' cost reports are settled. Under this policy, payments would be processed throughout the year using operating and capital cost-to-charge ratios based on the best information available at that time. We proposed that when the cost report is settled, any reconciliation of outlier payments by fiscal intermediaries would be based on operating and capital cost-to-charge ratios calculated based on a ratio of costs to charges computed from the cost report and charge data determined at the time the cost report coinciding with the discharge is settled.

This process would require some degree of recalculating outlier payments for individual claims. It is not possible to distinguish, on an aggregate basis, how much a hospital's outlier payments would change due to a change in its cost-to-charge ratios. This is because, in the event of a decline in a ratio, some cases may no longer qualify for any outlier payments while other cases may qualify for lower outlier payments. Therefore, the only way to determine accurately the net effect of a decrease in cost-to-charge ratios on a hospital's total outlier payments is to assess the impact on a claim-by-claim basis. We indicated in the proposed rule that we were still assessing the procedural modifications that would be necessary to implement this change.

Because, under our proposal, outlier payments would be based on the relationship between the hospital's costs

and charges at the time a discharge occurred, the proposed methodology would ensure that when final outlier payments are made, they would reflect an accurate assessment of the actual costs the hospital incurred. Nevertheless, a final vulnerability remains. Even though the final payment would reflect a hospital's true cost experience, there would still be the opportunity for a hospital to manipulate its outlier payments by dramatically increasing charges during the year in which the discharge occurs. In this situation, the hospital would receive excessive outlier payments, which, although the hospital would incur an overpayment and have to refund the money when the cost report is settled, would allow the hospital to obtain excess payments from the Medicare Trust Fund on a short-term basis.

Under section 1886(d)(5)(A)(iii) of the Act, the amount of any outlier payment should "approximate the marginal cost of care" in excess of the DRG payment and the fixed-loss threshold. Accordingly, because a hospital would have had access to any excess outlier payments until they are repaid to the Trust Fund (or, in the case of an underpayment, would not have had access to the appropriate amount during the same period), it may be necessary to adjust the amount of the final outlier payment to reflect the time value of the funds for that time period. Therefore, we proposed to add § 412.84(m) to provide that when the cost report is settled, outlier payments would be subject to an adjustment to account for the value of the money during the time period it was inappropriately held by the hospital. This adjustment would also apply in cases where outlier payments were underpaid to the hospital. In those cases, the adjustment would result in additional payments to hospitals. Any adjustment would be based upon a widely available index to be established in advance by the Secretary, and would be applied from the midpoint of the cost reporting period to the date of reconciliation (or when additional payments are issued, in the case of underpayments). This adjustment to reflect the time value of a hospital's outlier payments would ensure that the outlier payment received by the hospital at the time its cost report is settled appropriately reflects the hospital's approximate marginal costs, in excess of the DRG payment and fixed-loss threshold, of providing the care.

This proposed adjustment was also intended to account for the unique susceptibility of outlier payments to manipulation. Hospitals set their own level of charges and are able to change

their charges, without review by their fiscal intermediaries. As outlined above, changes in charges directly affect the level of outlier payments. This lack of fiscal intermediary review of a factor affecting a hospital's payments is in contrast to other IPPS adjustments, such as the IME adjustment or the DSH adjustment, where the fiscal intermediary must agree to a change to the determining factor (the resident-to-bed ratio or the share of low-income patients, respectively).

Under section 1886(d)(5)(A)(iv) of the Act, outlier payments for any year must be projected to be not less than 5 percent nor more than 6 percent of the total estimated operating DRG payments plus outlier payments. Section 1886(d)(3)(B) of the Act requires the Secretary to reduce the average standardized amounts by a factor to account for the estimated proportion of total DRG payments made to outlier cases. Despite the fact that each individual hospital's outlier payments may be subject to adjustment when the cost report is settled, we continue to believe that the fixed-loss outlier threshold (discussed in section VI. of this final rule) should be based on projected payments using the latest available historical data without retroactive adjustments, either midyear or at the end of the year, to ensure that actual outlier payments are equal to 5.1 percent of total DRG payments. That is, our proposed change was intended only to allow for use of the actual cost-to-charge ratio from the cost reporting period that corresponds to the discharges for which the outlier payments are made to adjust outlier payments to reflect the hospital's true costs of providing care. This adjustment would be made irrespective of whether the nationwide percentage of outlier payments relative to total operating DRG payments is equal to the outlier offset that is applied to the average standardized amounts (generally, 5.1 percent).

Outlier payments are intended to recognize the fact that hospitals occasionally treat cases that are extraordinarily costly and otherwise not adequately compensated under an average-based payment system. However, we can only estimate actual costs based on the charges for a case because charges are the only data available that indicate the resource usage for an individual case. Therefore, our ability to identify true outlier cases is dependent on the accuracy of the cost-to-charge ratios. To the extent some hospitals may be motivated to maximize outlier payments by taking advantage of the lag in updating the cost-to-charge