

ratios, the payment system remains vulnerable to overpayments to individual hospitals. Therefore, we believe the only way to eliminate the potential for such overpayments is to provide a mechanism for final settlement of outlier payments using actual cost-to-charge ratios from final settled cost reports.

However, the fixed-loss outlier threshold is an important aspect of the prospective nature of the IPPS. The outlier payment policy is designed to alleviate any financial disincentive hospitals may have against providing any medically necessary care their patients may require, even those patients who become very sick and require extraordinary resources. The preestablished threshold allows hospitals to approximate their Medicare payment for an individual patient while that patient is still in the hospital. Even though we proposed to make outlier payments susceptible to a reconciliation based on the hospital's actual cost-to-charge ratios during the contemporaneous cost reporting period, the hospital should still be in a position to make this approximation. Hospitals have immediate access to the information needed to determine what their cost-to-charge ratio will be when their cost reports are settled. Even if the final cost-to-charge ratio is likely to be different from the ratio used initially to process and pay the claim, as noted above, hospitals not only have the information available to estimate their cost-to-charge ratios, but also have the ability to control them, through the structure and levels of their charges.

If we were to make retroactive adjustments to outlier payments to ensure total payments are 5.1 percent of DRG payments (by retroactively adjusting outlier payments), we would be removing this important aspect of the prospective nature of the IPPS. Because such an across-the-board adjustment would either lead to more or less outlier payments for all hospitals, hospitals would no longer be able to reliably approximate their payment for a patient while the patient is still hospitalized. We believe it would be neither necessary nor appropriate to make such an aggregate retroactive adjustment.

Furthermore, we believe it is consistent with the intent of the language at section 1886(d)(5)(A)(iv) of the Act not to do so. This section calls for the Secretary to ensure that outlier payments are equal to or greater than 5 percent and less than or equal to 6 percent of projected or estimated (not actual) DRG payments. We believe this language reflects the intent of Congress regarding the prospectivity of the IPPS.

However, we do not believe it prevents settling outlier payments based on hospitals' actual cost-to-charge ratios during the period when the discharge occurs.

B. Summary of Public Comments and Departmental Responses

Comment: Many commenters argued that it is inappropriate to reconcile outlier payments through settled cost reports because IPPS payments are prospective and any type of reconciliation would make outlier payments retrospective.

In addition, some commenters claimed that cost report reconciliation for outliers is inconsistent with the government's position in prior litigation involving the Medicare outlier payment methodology. The commenters cited *County of Los Angeles v. Shalala*, 192 F.3d 1005 (D.C. Cir. 1999), and stated that in this case the Secretary succeeded in arguing to the United States Court of Appeals for the District of Columbia that the Act does not require retroactive adjustments to outlier payments in order to ensure that the actual amount of outlier reimbursement furnished to hospitals is between 5 and 6 percent of the total payments made under IPPS, notwithstanding the language in section 1886(d)(5)(A)(iii) of the Act (42 U.S.C. 1395ww(d)(5)(A)(iii)) mandating that outlier payments may not be less than 5 percent nor more than 6 percent of the total payments projected or estimated to be made based on DRG prospective payment rates. The commenters further asserted that any reconciliation of outlier payments would be inconsistent with the government's policy of refusing to make retroactive adjustments to outlier payments when estimates and projections prove inaccurate.

Response: As an initial matter, our position in the court cases is more accurately presented as stating that the language of the statute does not clearly mandate that the actual amount of outlier payments must be between 5 and 6 percent of total payments and that our policy of not making retroactive adjustments to ensure that actual payments fall between that range is consistent with the intent of Congress. However, the commenter is correct that we have scrupulously guarded the prospective nature of the IPPS over the years. The IPPS has continued and served as a model for prospective payment systems for other provider types under Medicare because it is fair and predictable. We believe any change to the system, especially one as significant as making outlier payments subject to retroactive adjustments, must

be evaluated in terms of its impact on those key characteristics of the IPPS.

As noted above and in the proposed rule, in light of the gross abuses of the current methodology by some hospitals and the negative impact such overpayments ultimately have on other hospitals due to their effect on the threshold, we believe the option of reconciling outlier payments based on the settled cost report for hospitals that have been initially paid using a significantly inaccurate cost-to-charge ratio compared to the actual ratio from the cost reporting period is now appropriate. In our view, reconciling outlier payments because they were originally paid on the basis of a significantly inaccurate cost-to-charge ratio is similar to recovering outlier payments when adjustments are made to covered charges for any services that are not found to be medically necessary or appropriate Medicare services upon medical or other review. This review is explicitly provided for at § 412.84(d). This provision was established when the IPPS was first implemented for FY 1984 (48 FR 39785).

The court cases referenced by the commenters all addressed the issue of whether outlier payments must be retroactively adjusted when the level of the threshold determined in advance of the fiscal year to which it applies ultimately results in actual outlier payments that are a smaller percentage of total DRG payments than was originally projected. We believe that an important goal of a PPS is predictability. Therefore, we believe that the fixed-loss outlier threshold should be projected based on the best available historical data and should not be adjusted retroactively. A retroactive change to the fixed-loss outlier threshold would affect all hospitals subject to the IPPS, thereby undercutting the predictability of the system as a whole.

However, if we deem it necessary as a result of a hospital-specific data variance to reconcile outlier payments of an individual hospital, such action on our part would not affect the predictability of the entire system. Rather, because each hospital is on notice as to our revised methodology for determining cost-to-charge ratios and that outlier payments are subject to possible reconciliation, and because each hospital has the necessary data regarding its own costs and charges to predict its actual cost-to-charge ratio, we are able to maintain the predictability of the system as a whole. Further, because reconciliation of outlier payments will affect only certain hospitals, the administrative burden of implementing such a policy is minimized.