

Accordingly, we continue to believe that the fixed-loss outlier threshold should be based on projected payments using the latest available historical data without retroactive adjustments. This was our position in the court cases cited by the commenter, and it has been our consistent and often stated position, including above in this final rule and the March 5, 2003 proposed rule.

Comment: Some commenters suggested that we clarify how reconciliation will be implemented and only reconcile outlier payments to those providers whose cost-to-charge ratios increased or decreased outside of certain parameters. The commenters suggested that we reconcile outlier payments only for those hospitals that would otherwise receive substantial outlier overpayments or underpayments (for example, where the cost-to-charge ratio increased or decreased by 15 percent). Limiting any reconciliation to those hospitals would have the desired impact of focusing the attention of CMS on those hospitals that deserve additional scrutiny without placing such a burden on all hospitals. Another commenter believed the savings of reconciliation would be offset by the additional workload for fiscal intermediaries and hospitals.

One commenter suggested that we eliminate the proposal of reconciliation and use a quarterly or semiannual review similar to periodic interim payment reviews. The commenter explained that these reviews would be performed by a joint effort of the provider and the fiscal intermediary, resulting in interim cost-to-charge ratio adjustments throughout the fiscal year (with no lump-sum adjustment or individual claims adjustment), based on cost and charge data available from hospital records.

Response: In the proposed rule, we proposed to establish the authority for CMS to reconcile outlier payments, but we did not propose to require that all hospitals' outlier payments be reconciled. We acknowledge the commenters' concerns about the administrative costs associated with reprocessing and reconciling all inpatient claims and the desirability of limiting which hospitals' outlier payments will be reconciled. Therefore, we agree that any reconciliation of outlier payments should be done on a limited basis.

Moreover, although this provision is effective 60 days after the date of publication of this final rule, given the large workload and limited resources of our fiscal intermediaries, attempting to implement this provision for all hospitals receiving outlier payments at

the same time would create an administrative burden. In addition, most of the changes in this regulation will apply for approximately the last 2 months of FY 2003. We intend to limit the impact of this provision during FY 2003 to ensure that the limited resources of fiscal intermediaries are focused upon those hospitals that appear to have disproportionately benefited from the time lag in updating their cost-to-charge ratios and to maintain the overall predictability of FY 2003 payments for most hospitals. Accordingly, we intend to issue a program instruction in the near future to assist fiscal intermediaries in implementing this provision during the remainder of FY 2003.

In the same program instruction, we will issue thresholds for fiscal intermediaries to reconcile outlier payments for other hospitals during FY 2003.

For cost reporting periods beginning during FY 2004, we are considering instructing fiscal intermediaries to conduct reconciliation for hospitals whose actual cost-to-charge ratios are found to be plus or minus 10 percentage points from the cost-to-charge ratio used during that time period to make outlier payments, and that have total FY 2004 outlier payments that exceed \$500,000. We believe these thresholds would appropriately capture those hospitals whose outlier payments will be substantially inaccurate when using the ratio from the contemporaneous cost reporting period. Hospitals exceeding these thresholds during their applicable cost reporting periods would become subject to reconciliation of their outlier payments. These thresholds would be reevaluated annually and, if necessary, modified each year. However, fiscal intermediaries would also have the administrative discretion to reconcile additional hospitals' cost reports based on analysis that indicates the outlier payments made to those hospitals are significantly inaccurate.

We continue to believe that cost report reconciliation is the most appropriate way to ensure that outlier payments are made only for truly costly cases. We believe the type of ongoing reviews suggested by the commenter referenced above would be an inefficient approach to addressing this problem, because it would require extensive ongoing reviews of every hospital's cost and charge data. However, we believe the problems leading to this final rule actually occur among a limited number of hospitals.

Comment: Some commenters believed that reconciliation is unnecessary because the proposed changes that

would eliminate the use of statewide averages and mandate use of the most recent tentative cost report would suffice to keep hospitals from gaming outliers. Therefore, they believed CMS should abandon its proposal to reconcile outlier payments.

Response: The steps we are taking in this final rule to direct fiscal intermediaries to update cost-to-charge ratios using the most recent tentative settled cost reports and using actual cost-to-charge ratios rather than statewide average ratios will greatly reduce the opportunity for hospitals to manipulate the system to maximize outlier payments. However, these steps will not completely eliminate all such opportunity. A hospital would still be able to dramatically increase its charges far above its rate-of-increase in costs during any given year in order to obtain excessive outlier payments. Therefore, we believe reconciliation is necessary to ensure that outlier payments are appropriately paid in the future.

Comment: One commenter suggested the use of a rolling 3-year average instead of reconciliation. The commenter explained that if a hospital is found to have a cost-to-charge ratio that significantly decreased over a short period of time, the cost-to-charge ratio that would be used to pay outliers would be projected by applying the 3-year average rate of change in cost-to-charge ratios over a rolling 3-year period. Cost reports used from that 3-year period would include the most recent audited or tentatively settled cost report for each year. The commenter provided an example where the cost-to-charge ratio from the most recent tentatively settled cost report is trended down to reflect the fact that over a longer period of time, charge increases have exceeded cost increases. This rolling 3-year average would be applied to hospitals that trigger this mechanism for a period of several years, until the period where the charge increases that gave rise to the use of the projection has worked its way through the method.

Response: The changes in this final rule are designed to take away any incentive for hospitals to seek outlier payments that are excessive. We believe the method recommended by the commenter still leaves the potential to game the system. For example, a hospital with a high cost-to-charge ratio can lower its charges substantially in any given year and receive extra outlier payments until the 3-year average is applied. Also, even after the 3-year moving average is applied, the hospital can continue to raise its charges in any given year and continue to receive outlier payments that do not reflect its