

outlier payments. Even though this arbitrary increase in charges should result in a lower cost-to-charge ratio in the future (due to the lag time in cost report settlement), currently when a LTCH's actual cost-to-charge ratio falls below the floor, the LTCH's cost-to-charge ratio would be raised to the applicable statewide average. This application of the statewide average would result in inappropriately higher outlier payments. Accordingly, we proposed to apply the LTCH's actual cost-to-charge ratio to determine the cost of the case, even where the LTCH's actual cost-to-charge ratio falls below the floor. No longer applying the applicable statewide average cost-to-charge ratio when a LTCH's actual cost-to-charge ratio falls below the floor would result in a lower future cost-to-charge ratio. Applying this lower cost-to-charge ratio to charges in the future to determine the cost of the case would result in more appropriate outlier payments. Therefore, consistent with the proposed policy change for acute care hospitals under the IPPS, we proposed that LTCHs would receive their actual cost-to-charge ratios no matter how low their ratios fall. Also, consistent with the proposed policy change for acute care hospitals under the IPPS, we proposed under § 412.525(a)(4), by cross-referencing proposed § 412.84(i), to continue to apply the applicable statewide average cost-to-charge ratio when a LTCH's cost-to-charge ratio exceeds the ceiling by proposing to adopt the proposed policy at proposed § 412.84(i)(1)(ii). Cost-to-charge ratios above this range are probably due to faulty data reporting or entry, and, therefore, should not be used to identify and make payments for outlier cases because such data are clearly errors and should not be relied upon.

In addition, we proposed to make a similar change to § 412.529(c), by cross-referencing proposed § 412.84(i), for determining short-stay outlier payments to indicate that the applicable statewide average cost-to-charge ratio would be applied when a LTCH's cost-to-charge ratio exceeds the ceiling, but not when a LTCH's cost-to-charge ratio falls below the floor. Since cost-to-charge ratios are also used in determining short-stay outlier payments, the rationale for the proposed change mirrored that for high-cost outliers.

Therefore, consistent with IPPS outlier policy, in determining the proposed fixed-loss amount for the 2004 LTCH PPS rate year in the March 7, 2003, LTCH PPS proposed rule, we proposed to use only the current combined operating and capital cost-to-

charge ratio ceiling under the IPPS of 1.421 (as explained in the IPPS final rule (67 FR 50125, August 1, 2002)). We believe that using the current combined IPPS operating and capital cost-to-charge ratio ceiling for LTCHs is appropriate since, as we explained in the August 30, 2002, LTCH PPS final rule (67 FR 55960), LTCHs are certified as acute care hospitals that meet the criteria set forth in section 1861(e) of the Act in order to participate in the Medicare program. As we also discussed in the August 30, 2002, LTCH PPS final rule (67 FR 55956), in general, hospitals are paid as a LTCH only because their average length of stay is greater than 25 days in accordance with § 412.23(e). Furthermore, prior to qualifying as a LTCH under § 412.23(e)(2)(i), the hospitals generally are paid as acute care hospitals under the IPPS during the period in which they demonstrate that they have an average length of stay of greater than 25 days. Accordingly, if a LTCH's cost-to-charge ratio is above this ceiling, we proposed to assign the applicable IPPS statewide average cost-to-charge ratio. (Currently, the applicable IPPS statewide averages can be found in Tables 8A and 8B of the August 1, 2002, IPPS final rule (67 FR 50263).) We also would assign the applicable statewide average for LTCHs for which we are unable to compute a cost-to-charge ratio. Accordingly, in the March 7, 2003, LTCH PPS proposed rule, for the proposed 2004 LTCH PPS rate year, we proposed a fixed-loss amount of \$19,978. Thus, we proposed to pay an outlier case 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted Federal LTCH payment for the LTC-DRG and the proposed fixed-loss amount of \$19,978).

#### *C. Reconciliation of Outlier Payments Upon Cost Report Settlement*

Under existing regulations at § 412.525(a), we specify that no retroactive adjustment will be made to the outlier payments upon cost report settlement to account for differences between the estimated cost-to-charge ratios and the actual cost-to-charge ratios for outlier cases. This policy is consistent with the existing outlier payment policy for short-term acute care hospitals under the IPPS. However, as discussed earlier, in the March 5, 2003 IPPS proposed rule (68 FR 10420), we proposed to revise the methodology for determining cost-to-charge ratios for acute care hospitals under the IPPS because we became aware that payment vulnerabilities exist in the current IPPS outlier policy. Because the LTCH PPS high-cost outlier and short-stay policies

are modeled after the IPPS outlier policy, we believe they are susceptible to the same payment vulnerabilities and, therefore, merit revision.

As proposed for acute care hospitals under the IPPS at proposed § 412.84(m) in the March 5, 2003, proposed rule, we proposed in the March 7, 2003, LTCH PPS proposed rule under § 412.525(a)(4)(ii), by cross-referencing proposed § 412.84(m), that, for LTCHs, any reconciliation of outlier payments would be made upon cost report settlement to account for differences between the actual cost-to-charge ratio and the estimated cost-to-charge ratio for the period during which the discharge occurs. As was the case with the proposed changes to the outlier policy for acute care hospitals under the IPPS, we indicated that we were still assessing the procedural changes that would be necessary to implement this change for LTCHs under the LTCH PPS. In addition, we proposed to make a similar change in § 412.529(c)(4)(ii), by cross-referencing proposed § 412.84(m), to indicate that any reconciliation of payments for short-stay outliers would be made upon cost report settlement to account for differences between the estimated cost-to-charge ratio and the actual cost-to-charge ratio for the period during which the discharge occurs.

In addition, because we currently use cost-to-charge ratios based on the latest settled cost report, again consistent with the policy for acute care hospitals under the IPPS, any dramatic increases in charges by LTCHs during the payment year are not reflected in the cost-to-charge ratios when making outlier payments under the LTCH PPS. Consistent with the proposed policy change for acute care hospitals under the IPPS at proposed § 412.84(i) discussed in the March 5, 2003 IPPS proposed rule, because a LTCH has the ability to increase its outlier payments through a dramatic increase in charges and because of the lag time in the data used to calculate cost-to-charge ratios, in the March 7, 2003 LTCH PPS proposed rule, we proposed that fiscal intermediaries would use more recent data when determining a LTCH's cost-to-charge ratio. Therefore, under § 412.525(a)(4)(ii), by cross-referencing proposed § 412.84(i), we proposed that fiscal intermediaries would use either the most recent settled cost report or the most recent tentative settled cost report, whichever is later. In addition, we proposed to make a similar change to the short-stay outlier policy at § 412.529(c)(4)(ii), by cross-referencing proposed § 412.84(i), to indicate that subject to the proposed provisions in the regulations at § 412.84(i), fiscal