

made to the cost-to-charge ratio in the fiscal intermediary's system will cause the provider to make multiple unnecessary adjustments to properly account for the difference in payment for high-cost outliers and short-stay outlier cases. The commenter proposed that the fiscal intermediary should be required to send the provider notification each time the cost-to-charge ratio will be changed in its system.

*Response:* As explained in response to comments on the IPPS outlier proposed rule, although the provision concerning reconciliation is effective 60 days after the date of publication of this final rule, we understand that, 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. Accordingly, we intend to issue a program instruction in the near future to assist fiscal intermediaries in implementing this provision during the remainder of the LTCH rate year.

Notably, however, for LTCHs, particularly because the universe of LTCHs is relatively small, we do not believe it will be overly burdensome for the fiscal intermediaries to rerun a LTCH's claims to determine the accurate outlier payment amount. We also do not believe that the reconciliation of outlier payments for LTCHs will be overly burdensome because LTCHs are on notice of the revised methodology.

We also are not adopting the commenter's recommendation to establish a system for monitoring PS&R data or for quarterly reporting. While those procedures might aid in detecting aberrant charge increases, we believe that the reconciliation process is preferable because it allows for outlier payments to be ultimately determined based on actual cost-to-charge ratios, rather than on estimates. Finally, we agree with the commenter that the fiscal intermediaries should notify the hospitals whenever a change is made to the cost-to-charge ratio. We plan to provide more details on this procedure in program instructions to be issued after the publication of this final rule.

*Comment:* Several commenters questioned whether CMS has the authority to retroactively adjust outlier payments, stating that it is "completely contrary to the entire concept of a prospective payment system," and would generate budgeting uncertainty and administrative burden for hospitals and CMS.

One commenter claimed that the Secretary of the Department of Health and Human Services has argued in court

that the Medicare statute does not allow retroactive adjustments to outlier payments. (See *County of Los Angeles v. Shalala*, 192 F.3d 1005 (D.C. Cir. 1999).)

Another commenter argued that since the LTCH PPS is uniquely different from the IPPS in that a much greater percentage of overall payment under the LTCH PPS is dependent upon cost-to-charge ratios (high-cost outliers and short-stay outliers combined), subjecting such a large portion of payments to a cost-based settlement approach defeats the purpose and benefits of a PPS. Specifically, the commenter noted that since the cost-to-charge ratio is used to determine payment for both high-cost outliers and for short-stay outliers, which combined, can represent a significant percentage of all discharges from a LTCH, both the classification of a case as a short-stay or high-cost outlier and the resulting payment amount would have to be reassessed and possible retroactive adjustments would have to be made following an audit of more recent cost report data. Therefore, the commenter believed that a policy that allows for retroactive adjustments to prior payment amounts introduces a large amount of uncertainty and complexity that the PPS was intended to eliminate.

*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 outlier payments under the IPPS, 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 commenters are correct in pointing out that a basic premise of a PPS is predictability of payment, the prospectivity of the system is undermined when it is manipulated and abused in order to maximize reimbursement. Under the IPPS, 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 impact on the fixed-loss amount, 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. We believe that at this time it is appropriate to adopt this policy for the LTCH PPS because it will contribute to the overall accuracy and fairness of

the fixed-loss amount under the prospective payment system.

As we stated above, 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 under Medicare upon medical or other review. This review is explicitly provided for under the IPPS policy 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 fixed-loss amount under the IPPS determined in advance of the fiscal year to which it applies ultimately results in actual IPPS outlier payments that are a smaller percentage of total IPPS 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, whether under the IPPS or the LTCH PPS, should be projected based on the best available historical data and should not be adjusted retroactively. We believe that a retroactive change to the fixed-loss outlier threshold would affect all hospitals subject to a PPS, 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 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, 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. Accordingly, we continue to believe that the fixed-loss amount 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 earlier in this final rule and in the March 5, 2003, IPPS outlier proposed rule.

*Comment:* One commenter recommended that subregulatory