

guidelines for the review of outlier payments be established, specifying what changes to the cost-to-charge ratios would trigger a review and what entity is responsible for determining whether a review is necessary. The commenter added that CMS should ensure that outlier thresholds are estimated to reflect 8 percent of total payments. Another commenter stated that the proposed reconciliation to cost-to-charge ratios should be limited only to those hospitals that meet certain criteria, such as hospitals that cross a defined threshold of charge increases combined with a high level of outlier payments compared to the norm. The commenter requested that the final rule include specific criteria to be used for the determination of hospitals that will be subject to such an adjustment.

*Response:* As we stated earlier in this final rule, we intend to issue a program instruction to the fiscal intermediaries in the near future that will provide specific criteria to be used in the reconciliation of outlier payments for the remainder of the LTCH PPS rate year.

For cost reporting periods beginning on or after October 1, 2003, we are considering instructing fiscal intermediaries to conduct reconciliation for those LTCHs 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 (high-cost and short stay outlier payments combined) that exceed \$500,000. We believe these thresholds would appropriately capture those LTCHs whose outlier payments will be substantially inaccurate when using the ratio from the contemporaneous cost reporting period compared to the ratio from the latest cost reporting period. LTCHs 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 LTCHs' cost reports based on analysis that indicates the outlier payments made to those hospitals are significantly inaccurate.

In addition, we will continue to ensure that outlier payments are projected to be equal to 8 percent of total LTCH PPS payments by using the best and most recent available data in computing the fixed-loss amount.

*Comment:* One commenter strongly supported and recommended approval

of the proposals to use the most recent settled or tentatively settled cost report or other latest available data from the provider or the fiscal intermediary, and the reconciliation for outlier payments upon cost report settlement. The commenter was in favor of these proposals because the commenter believed that they correct the "inappropriately harmful impact" that the current rules have on those hospitals that hold charge increases to a level lower than their cost increases. The commenter recommended that these proposed policies should be applied retroactively to the beginning of the LTCH PPS. However, the commenter did not agree that an adjustment for the time value of overpayments or underpayments should be applied to outlier payments received in a cost reporting period, since the issue has already been addressed in the regulations at 42 CFR 405.378, and no other aspect of a final settlement reflects payment of interest.

Another commenter asserted that interest should not be assessed after the cost report is settled and before the provider has a chance to review and appeal potentially erroneous claims. Instead, the commenter recommended that CMS should allow a 180-day appeal period to give providers an opportunity to review the settlement and file appeals without interest.

*Response:* As we stated earlier, we are adopting as final the proposals to eliminate the use of statewide averages for hospitals with cost-to-charge ratios below the minimum floor cost-to-charge ratio, the use of the cost-to-charge ratio from a tentatively settled cost report or alternative best available data, and finalizing the reconciliation policy for outlier payments upon cost report settlement. We understand the commenters' concerns and acknowledge that a change in policy is needed, but under our rulemaking authority, there is a serious question as to whether we could apply these policies retroactively. Therefore, consistent with the rationale explained under the IPPS section of this final rule, the effective date of the policies concerning elimination of the floor, and using alternative data from the fiscal intermediary or the provider, is for discharges occurring on or after August 8, 2003. The use of the later of either the most recent tentatively settled cost report or the most recent settled cost report is effective for discharges occurring on or after October 1, 2003. The effective date of reconciliation of outlier payments is for discharges occurring on or after August 8, 2003.

As noted previously, 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. 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.

We are implementing these effective dates under §§ 412.84(i) and (m), as referenced under the LTCH PPS outlier regulations at §§ 412.525(a)(4) and 412.529(c)(5).

In regard to the commenter's objection to the policy concerning the time value of money, outlier payments are uniquely susceptible to manipulation because hospitals set their own level of charges without review by the fiscal intermediary. Therefore, despite the recovery of the overpayment by CMS, a hospital would essentially benefit from an interest-free loan simply by increasing its charges in the interim. In order to ensure that hospitals are reimbursed fairly for extremely costly cases, it is necessary to establish a mechanism whereby an adjustment can be made to help guarantee that payments appropriately reflect the marginal costs of care for outlier cases. Under the LTCH PPS, it is also important to ensure that hospitals are paid correctly for short-stay outlier cases. We believe an adjustment for the time value of money is the appropriate mechanism to use to ensure equity and accuracy of payments.

*Comment:* Several commenters noted the potential implications a retroactive adjustment to high-cost outlier payments may have on a beneficiary's use of lifetime reserve days. Medicare beneficiaries in a LTCH are much more likely to exceed their 90 days of available inpatient care during a LTCH stay than during a short-term acute hospital stay. A Medicare beneficiary's lifetime reserve days (days 91 through 150) are not used as long as coinsurance days are available or as long as a stay is covered under the LTC-DRG. However, as soon as a day of care moves the beneficiary into the high-cost outlier category, this day and subsequent days are counted against the beneficiary's lifetime reserve days, and the stay is paid by Medicare as a high-cost outlier, with beneficiary coinsurance equal to half of the inpatient deductible amount. The commenters stated that the proposed policy would result in retroactive adjustments to the day on which a patient's stay moves into the