

relative weights, wage index, and new technology add-on payments to aggregate payments using the FY 2004 relative weights and wage index, plus the add-on payments for new technology. The same methodology was used for the FY 2003 budget neutrality adjustment.

Based on this comparison, we computed a budget neutrality adjustment factor equal to 1.005522. We also adjust the Puerto Rico-specific standardized amounts for the effect of DRG reclassification and recalibration. We computed a budget neutrality adjustment factor for Puerto Rico-specific standardized amounts equal to 1.001661. These budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the FY 2003 budget neutrality adjustments.

In addition, we are applying these same adjustment factors to the hospital-specific rates that are effective for cost reporting periods beginning on or after October 1, 2003. (See the discussion in the September 4, 1990 final rule (55 FR 36073).)

b. *Reclassified Hospitals—Budget Neutrality Adjustment.*—Section 1886(d)(8)(B) of the Act provides that, effective with discharges occurring on or after October 1, 1988, certain rural hospitals are deemed urban. In addition, section 1886(d)(10) of the Act provides for the reclassification of hospitals based on determinations by the MGCRB. Under section 1886(d)(10) of the Act, a hospital may be reclassified for purposes of the standardized amount or the wage index, or both.

Under section 1886(d)(8)(D) of the Act, the Secretary is required to adjust the standardized amounts so as to ensure that aggregate payments under the IPPS after implementation of the provisions of sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act are equal to the aggregate prospective payments that would have been made absent these provisions. To calculate this budget neutrality factor, we used FY 2002 discharge data to simulate payments, and compared total IPPS payments prior to any reclassifications to total IPPS payments after reclassifications. Based on these simulations, we are applying an adjustment factor of 0.992026 to ensure that the effects of reclassification are budget neutral.

The adjustment factor is applied to the standardized amounts after removing the effects of the FY 2003 budget neutrality adjustment factor. We note that the FY 2004 adjustment reflects FY 2004 wage index and standardized amount reclassifications approved by the MGCRB or the Administrator, and the effects of section 1886(d)(10)(D)(v) of the Act to extend wage index reclassifications for 3 years.

c. *Outliers.*—Section 1886(d)(5)(A) of the Act provides for payments in addition to the basic prospective payments, for “outlier” cases involving extraordinarily high costs. To qualify for outlier payments, a case must have costs above a fixed-loss cost threshold amount (a dollar amount by which the costs of a case must exceed payments in order to qualify for outlier payment). To determine whether the costs of a case exceed the fixed-loss threshold, a hospital’s cost-to-charge ratio is applied to the total covered charges

for the case to convert the charges to costs. Payments for eligible cases are then made based on a marginal cost factor, which is a percentage of the costs above the threshold.

Under section 1886(d)(5)(A)(iv) of the Act, outlier payments for any year must be projected to be not less than 5 percent nor more than 6 percent of total operating DRG payments plus outlier payments. Section 1886(d)(3)(B) of the Act requires the Secretary to reduce the average standardized amounts by a factor to account for the estimated proportion of total DRG payments made to outlier cases. Similarly, section 1886(d)(9)(B)(iv) of the Act requires the Secretary to reduce the average standardized amounts applicable to hospitals in Puerto Rico to account for the estimated proportion of total DRG payments made to outlier cases.

i. *FY 2004 outlier fixed-loss cost threshold.* In the August 1, 2002 IPPS final rule (67 FR 50124), we established a threshold for FY 2003 that was equal to the prospective payment rate for the DRG, plus any IME and DSH payments and any additional payments for new technology, plus \$33,560. The marginal cost factor (the percent of costs paid after costs for the case exceed the threshold) was 80 percent.

In the May 19, 2003 proposed rule, we proposed to establish a fixed-loss cost outlier threshold equal to the prospective payment rate for the DRG plus any IME and DSH payments, and any add-on payments for new technology, plus \$50,645. However, we also stated that the final FY 2004 threshold was likely to be different from that proposed threshold, as a result of any changes to outlier policy subsequent to a proposed rule published on March 5, 2003. Subsequently, we published three central changes to our outlier policy in a final rule on June 9, 2003.

The first of the changes was that fiscal intermediaries will use more up-to-date data when determining the cost-to-charge ratio for each hospital. Currently, fiscal intermediaries use the hospital’s most recent settled cost report. We revised our regulations to specify that fiscal intermediaries will use either the most recent settled or the most recent tentative settled cost report, whichever is from the latest reporting period.

The second change removed the requirement in our regulations specifying that a fiscal intermediary will assign a hospital the statewide average cost-to-charge ratio when the hospital has a cost-to-charge ratio that falls below an established threshold (3 standard deviations below the national geometric mean cost-to-charge ratio). We specified that hospitals will receive their actual cost-to-charge ratios no matter how low their ratios actually fall.

The third change added a provision to our regulations to provide that the outlier payments for some hospitals will become subject to reconciliation when the hospitals’ cost reports are settled. In addition, outlier payments will be subject to an adjustment to account for the time value of any outlier overpayments or underpayments that are ultimately reconciled.

To calculate the FY 2004 outlier thresholds, we simulated payments by applying FY 2004 rates and policies using cases from the FY 2002 MedPAR file.

Therefore, in order to determine the appropriate FY 2004 threshold, it was necessary to inflate the charges on the MedPAR claims by 2 years, from FY 2002 to FY 2004.

As discussed in the August 1, 2002 IPPS final rule (67 FR 50124), rather than use the rate-of-cost increase from hospitals’ FY 1998 and FY 1999 cost reports to project the rate-of-increase from FY 2001 to FY 2003, as had been done in prior years, we used a 2-year average annual rate of change in charges per case to calculate the FY 2003 outlier threshold.

We are continuing to use the 2-year average annual rate of change in charges per case to establish the FY 2004 threshold. The 2-year average annual rate of change in charges per case from FY 2000 to FY 2001, and from FY 2001 to FY 2002, was 12.5978 percent annually, or 26.8 percent over 2 years.

In the past, we used cost-to-charge ratios from the Provider Specific File, and multiplied these ratios by the charges for each case to estimate costs. After the changes in policy enacted by the final outlier rule this year, it is necessary to calculate more recent cost-to-charge ratios because fiscal intermediaries will now use the latest tentatively settled cost report instead of the latest settled cost report to determine a hospital’s cost-to-charge ratio. Therefore, to approximate using the latest tentative settled cost reports in our estimate of the FY 2004 outlier threshold, we calculated updated cost-to-charge ratios using the following three steps: for each hospital, we matched charges-per-case to costs-per-case from the most recent cost reporting year; we then divided each hospital’s costs by its charges to calculate the cost-to-charge ratio for each hospital; and we multiplied charges from each case in the FY 2002 MedPAR (inflated to FY 2004) by this cost-to-charge ratio to calculate the cost per case. The final outlier rule also established the policy that fiscal intermediaries are to reconcile outlier payments at the time of cost report final settlement if a hospital’s actual operating or capital cost-to-charge ratios are found to be substantially different from the cost-to-charge ratios used during that time period to make outlier payments.

However, it is difficult to project which hospitals will be subject to reconciliation of their outlier payments using available data. For example, for most hospitals, the latest available cost data are from FY 2000. In addition, the amount of fiscal intermediary resources necessary to undertake reconciliation will ultimately influence the number of hospitals reconciled. Without actual experience with the reconciliation process, it is difficult to predict the number of hospitals that will be reconciled. However, as later data become available, particularly data reflecting hospital’s latest tentative settled cost-to-charge ratios, we will be better able to assess the appropriate number of hospitals to be reconciled.

Based on our analysis of hospitals that have been consistently overpaid recently for outliers, we have identified approximately 50 hospitals we believe will be reconciled. Therefore, for these hospitals, to account for the fact that the reconciliation will result in