

different outlier payments than predicted using the cost-to-charge ratios calculated as described above, we attempted to project each hospital's cost-to-charge ratio based on its rate of increase in charges per case based on FY 2002 charges, compared to costs (inflated to FY 2002 using actual market basket increases).

Using this methodology, we are establishing 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 \$31,000.

This single threshold will be applicable to qualify for both operating and capital outlier payments. We also are maintaining the marginal cost factor for cost outliers at 80 percent.

Comment: One commenter supported our changes to the outlier payment methodology but asked that we reconsider and revise the outlier threshold to at least a level of increase consistent with prior years. Other commenters asked that we lower the threshold to reflect the financial impact of the new outlier policies, to allow deserving hospitals to qualify for outlier payments and to ensure that hospitals receive the statutory mandated level of 5 to 6 percent of total DRG payments set aside for outliers. Another commenter reasoned that hospitals that have had their outlier payments dwindle to record low amounts will have no incentive to treat high-cost cases; therefore, the outlier threshold must be lowered. Another commenter noted that the current proposed threshold makes it almost impossible for hospitals to qualify for outlier payments and will cause hospitals to lose an extraordinary amount of money before additional outlier payments become available.

Other commenters indicated that they had conducted research, using the 2001 MedPAR file, which showed that the threshold required to spend 5.1 percent of total DRG payments decreased by 45 percent when the cost-to-charge ratios used to estimate costs were updated from the latest final settled to the latest tentatively settled cost report. Based on this finding, the commenters recommended a 45-percent reduction to the proposed outlier threshold, which would yield a threshold less than \$28,000.

Some commenters believed that, in light of the changes adopted this year, it is appropriate that CMS revert to using changes in hospital costs to set the charge inflation factor rather than changes in hospital charges. The commenters explained that the combination of the changes made to the outlier policy and a return to using a cost inflation factor would lead to a more accurate and lower threshold. Another commenter noted the previous problems using changes in costs and recommended that CMS use a blend of the rates-of-increases for costs and charges to establish the charge inflation factor.

One commenter recommended that CMS keep the outlier threshold at \$33,560 until CMS can determine the impact of using the most current cost-to-charge ratio during a full fiscal year. Other commenters also recommended that CMS eliminate any increase in the outlier threshold because the

new outlier regulations will have a significant impact on Medicare outlier payments for FY 2004.

One commenter requested that CMS factor in the calculation of the threshold the fact that certain hospitals have distorted their charges significantly.

One commenter submitted a model of the outlier threshold for FY 2004 that incorporated the changes from the June 9, 2003 final rule. The commenter estimated the fixed-loss threshold to be \$25,375 under these assumptions. The commenter also noted that the reconciliation process will reduce outlier payments and, accordingly, CMS should model a reduction in the outlier threshold to account for reconciliation, which would further lower the outlier threshold.

One commenter suggested that CMS lower the outlier threshold because independent studies strongly suggest that final FY 2003 outlier payments will fall short of the legislative mandate of 5 to 6 percent. Another commenter suggested that the outlier threshold remain at its current level because outlier payments for the first 3 months of FY 2003 represent 5.5 percent of total payments and, as a result, there does not seem to be any justification for such an increase. Another commenter explained that the transfer policy already reduces the payment to hospitals for short-stay cases and any increase in the outlier threshold will further penalize hospitals for treating high cost, medically complex cases.

Response: As described above, we are reflecting the changes made to outliers from the June 9, 2003 final rule. These changes have resulted in a substantial reduction in the outlier threshold from the proposed level. We estimate the outlier threshold would be approximately \$50,200 without accounting for the effects of these changes. Therefore, the final threshold is 37 percent lower due to the changes described above. This reduction in the outlier threshold will allow hospitals that have been negatively impacted by the increase in the FY 2003 threshold due to those hospitals that maximized their outlier payments by dramatically increasing charges to qualify for higher outlier payments due to the lower threshold.

We are concerned that the outlier policy maintains its original intent to ensure hospitals are not significantly disadvantaged by unpredictable extraordinarily costly cases, and, therefore, we acted to close the loopholes in our prior policy through the final outlier rule. As a result of those changes, the threshold has fallen significantly from the proposed threshold.

Comment: Another commenter asked that any final outlier threshold included in the final rule be subject to a 60-day review and comment period.

Response: In the proposed rule, we noted that we would incorporate any final outlier policy changes in this final rule. We received many comments in response to the proposed rule, and we have considered them thoroughly in undertaking our analysis. Therefore, we do not believe there is any need for an additional public comment period on the changes. Accordingly, a fixed-loss threshold of \$31,000 will be applied to

calculate outlier payments for discharges occurring on or after October 1, 2003.

Comment: One commenter asked that CMS implement a transition period to protect those hospitals harmed by the significant changes in the June 9, 2003 final outlier rule. The commenter explained that a transition period is justified and would be consistent with previous transition methodologies employed for CMS changes, such as those proposed.

One commenter stated that any reconciliation would be inconsistent with the prospective nature of the IPPS.

Response: We responded to similar comments in the June 9, 2003 final rule on outliers (68 FR 34494). Therefore, we refer the commenters to that final rule.

Comment: Two commenters stated that the criterion in the final rule on outliers that specifically addressed our policy on reconciliation (that if a hospital's cost-to-charge ratio changed by 10 or more percentage points, a hospital would be subject to reconciliation) is flawed. The commenters believed that the criterion would tolerate vastly different rates of charge growth among hospitals, and hospitals with the lowest charges in relation to cost would be inappropriately subject to the greatest restriction in charge growth. The commenters provided an example where a hospital with a cost-to-charge ratio of .30 could mark up its charges by 50 percent in a 2-year period without triggering reconciliation, while another hospital with a cost-to-charge ratio of .80 would trigger reconciliation if charges grew by only 14 percent. The commenters recommended that, because of this inequity in this criterion, CMS modify the trigger for outlier reconciliation by promulgating a scale of cost-to-charge ratios rather than a constant amount. The scale could be based upon a rate of tolerable charge growth, which CMS would choose.

Response: We appreciate the suggestion by the commenters and will carefully evaluate the information provided by them. We note that fiscal intermediaries have discretion under the reconciliation policy to reconcile additional hospitals' cost reports based on analysis that indicates the outlier payments made to those hospitals are significantly inaccurate.

Comment: One commenter explained that one health care system agreed to accept reduced outlier payments during FY 2003. The commenter asked that this reduction be accounted for in the calculation of the threshold.

Response: Our calculation of the outlier threshold reflects the application of the outlier policies implemented by the June 9, 2003 final rule. The agreement referred to by the commenter was based upon the application of policies prior to that final rule. Therefore, it has no bearing on the calculation of the FY 2004 threshold described in this final rule.

Comment: One commenter noted that outlier payments are increasing because DRG payments are not keeping pace with the high cost of treatment. The commenter added that adjusting the outlier threshold will only add to the problem of underfunded health care and, because health care is not a priority,