

Further, we believe the methodology of computing IRF outlier payments is susceptible to the same payment enhancement practices identified under the IPPS and, therefore, merit similar revisions. Accordingly, as discussed below, in this final rule we are making revisions as proposed in the May 16, 2003 proposed rule, to the IRF outlier payment methodology to be effective for discharges on or after October 1, 2003.

1. Current Outlier Payment Provision Under the IRF PPS

Section 1886(j)(4) of the Act provides the Secretary with the authority to make payments in addition to the basic IRF prospective payments for cases incurring extraordinarily high costs. In the August 7, 2001 IRF PPS final rule, we codified at § 412.624(e)(4) of the regulations the provision to make an adjustment for additional payments for outlier cases that have extraordinarily high costs relative to the costs of most discharges. Providing additional payments for outliers strongly improves the accuracy of the IRF PPS in determining resource costs at the patient and facility level. These additional payments reduce the financial losses that would otherwise be caused by treating patients who require more costly care and, therefore, reduce the incentives to underserve these patients.

Under § 412.624(e)(4), we make outlier payments for any discharges if the estimated cost of a case exceeds the adjusted IRF PPS payment for the CMG plus the adjusted threshold amount (\$11,211 which is then adjusted for each IRF by the facilities wage adjustment, its low-income patient adjustment, and its rural adjustment, if applicable). We calculate the estimated cost of a case by multiplying the IRF's overall cost-to-charge ratio by the Medicare allowable covered charge. In accordance with § 412.624(e)(4), we pay outlier cases 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted IRF PPS payment for the CMG and the adjusted threshold amount).

On November 1, 2001, we published a Program Memorandum (Transmittal A-01-131) with detailed intermediary instructions for calculating the cost-to-charge ratios for the purposes of determining outlier payments under the IRF PPS. We stated the following:

"Intermediaries will use the latest available settled cost report and associated data in determining a facility's overall Medicare cost-to-charge ratio specific to freestanding IRFs and for IRFs that are distinct part units of acute care hospitals. Intermediaries will calculate updated ratios each time a

subsequent cost report settlement is made. Further, retrospective adjustments to the data used in determining outlier payments will not be made. If the overall Medicare cost-to-charge ratio appears to be substantially out-of-line with similar facilities, the intermediary should ensure that the underlying costs and charges are properly reported. We are evaluating the use of upper and lower cost-to-charge ratio thresholds (similar with the outlier policy for acute care hospitals) in the future to ensure that the distribution of outlier payments remains equitable."

In the May 16, 2003 proposed rule, we proposed to continue to use the \$11,211 threshold amount.

Comment: A commenter asserted that CMS should consider dropping the outlier threshold similar to the IPPS.

Response: As we stated in the May 16, 2003 proposed rule, the threshold amount was used in the FY 2003 IRF PPS payment rates and we believe that the threshold amount of \$11,211 that was used remains appropriate because the data that was used to calculate this amount was not comprised of data that were inappropriately influenced by the incentives the current IRF PPS may create.

Specifically we used the IRF cost and charge data from the previous cost-based reimbursement system to establish the outlier threshold. These data were not inappropriately influenced by incentives to inflate charges that are created with the existence of an outlier policy. There is no need to inflate charges under cost-based reimbursement because a provider is paid their costs subject to certain applicable limits. This is unlike the outlier situation in IPPS, which used post-PPS data to update its annual threshold amount. The IPPS data reflected the practices that we believe erroneously created inappropriate outlier payments. Namely, that hospitals take advantage of the time lag between current charges on a submitted bill and the cost-to-charge ratio taken from the most recent settled cost report.

Specifically, using historical cost-to-charge ratios may not reflect actual charges in the cost reporting period when the discharge occurred. This can result in an over-estimation of costs that in turn may result in inappropriate outlier payments. In addition to the time lag vulnerability, some hospitals increase their charges so far above costs that their cost-to-charge ratios fall below a floor resulting in an over-estimation of a hospital's cost per case. Again, this over-estimation of costs can possibly result in inappropriate outlier payments. As discussed in the

November 3, 2000 proposed rule, the outlier threshold amount of \$11,211 was calculated by simulating aggregate payments with and without an outlier policy, and applying an iterative process to determine a threshold that would result in outlier payments being projected to equal 3 percent of total payments under the simulation. Once we have adequate post-IRF PPS data, we will be able to examine whether the threshold amount needs to be updated. Specifically, we will assess the extent to which total estimated outlier payment approximates 3 percent of total payments and whether the threshold amount needs to be updated. As we previously stated, the data used to develop the IRF PPS outlier threshold amount were not inappropriately influenced by these incentives, therefore, we are adopting as final the continued use of the \$11,211 threshold amount.

We will also continue to make outlier payments for any discharges if the estimated cost of a case exceeds the adjusted IRF PPS payment for the CMG plus the adjusted threshold amount (\$11,211 which is then adjusted for each IRF by the facility's wage adjustment, its low-income patient adjustment, and its rural adjustment, if applicable). We will calculate the estimated cost of a case by multiplying an IRF's overall cost-to-charge ratio by the Medicare allowable covered charge. However, we are applying a ceiling to an IRF's cost-to-charge ratios, which is discussed below. In accordance with § 412.624(e)(4), we will continue to pay outlier cases at 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted IRF PPS payment for the CMG and the adjusted threshold amount). In addition, under the existing methodology described in the preamble to the August 7, 2001 IRF PPS final rule (66 FR 41363), we will continue to assign the applicable national average for new IRFs.

2. Changes to the IRF Outlier Payment Methodology

Statistical accuracy of cost-to-charge ratios. We believe that there is a need to ensure that the cost-to-charge ratio used to compute an IRF's estimated costs should be subject to a statistical measure of accuracy. Removing aberrant data from the calculation of outlier payments will allow us to enhance the extent to which outlier payments are equitably distributed and continue to reduce incentives for IRFs to underserve patients who require more costly care. Further, we stated in the May 16, 2003 IRF proposed rule that using a statistical