

measure of accuracy to address aberrant cost-to-charge ratios would also allow us to be consistent with the proposed outlier policy changes for the acute care hospital IPPS discussed in the March 4, 2003 Cost Outlier proposed rule, (68 FR 10420). In the May 16, 2003 proposed rule, we proposed the following:

(1) To apply a ceiling to IRF's cost-to-charge ratio if a facility's cost-to-charge ratio is above a ceiling. We would calculate two national ceilings, one for IRFs located in rural areas and one for facilities located in urban areas. We proposed to compute this ceiling by first calculating the national average and the standard deviation of the cost-to-charge ratio for both urban and rural IRFs. (Because of the small number of IRF's compared to the number of acute care hospitals, we believe that statewide averages for IRFs, as proposed and adopted as final under the IPPS, would not be statistically valid. Thus, we proposed to use national average cost-to-charge ratios in place of statewide averages.)

However, we believe that using only a national average may not adequately address the differences among the various types of IRFs, like the use of statewide averages would under the IPPS. Therefore, we believe using two national ceilings, one for IRFs in urban areas and one for IRFs in rural areas would be more appropriate than just using one national ceiling for IRFs. In the August 7, 2001 final rule, we discussed our policy to adjust IRF PPS payments to IRFs located in rural areas, in large part, because IRFs in rural areas have significantly higher costs than other facilities. Similarly, we believe using an average cost-to-charge ratio specifically targeted for rural facilities will allow us to more accurately estimate costs that are used to determine outlier payments for IRFs in rural areas. Therefore, we are adopting as final the use of two national ceilings, one for IRFs in urban areas and one for IRFs in rural areas.

To determine the rural and urban ceiling, we proposed to multiply each of the standard deviations by 3 and add the result to the appropriate national cost-to-charge ratio average (rural and urban). We believe this method results in statistically valid ceilings. If an IRF's cost-to-charge ratio is above the applicable ceiling it would be considered to be statistically inaccurate and we would assign the national (either rural or urban) average cost-to-charge ratio to the IRF. Cost-to-charge ratios above this ceiling are probably due to faulty data reporting or entry, and, therefore, should not be used to identify and make payments for outlier

cases because such data are most likely erroneous and therefore should not be relied upon. We proposed to update the ceiling and averages using this methodology every year and indicated that we would publish these amounts in future program memoranda.

*Comment:* We received no comments on this proposal.

*Response:* We are adopting this proposed policy as final.

(2) Not assign the applicable national average cost-to-charge ratio when an IRF's cost-to-charge ratio falls below a floor. We proposed this policy because, as is the case for acute care hospitals, we believe IRFs could arbitrarily increase their charges in order to maximize outlier payments. Even though this arbitrary increase in charges should result in a lower cost-to-charge ratio in the future (due to the lag time in cost report settlement), if we use a floor, the IRF's cost-to-charge ratio would be raised to the applicable national average. This application of the national average could result in inappropriately higher outlier payments. Accordingly, we proposed to apply the IRF's actual cost-to-charge ratio to determine the cost of the case rather than creating and applying a floor. Applying an IRF's actual cost-to-charge ratio to charges in the future to determine the cost of a case will result in more appropriate outlier payments because it does not overstate the actual cost-to-charge ratio.

*Comment:* Some commenters disagreed with the proposal to assign a national ceiling and not a national floor when an IRF's own ratio falls below the floor. A commenter asserted that this did not seem equitable.

*Response:* We disagree with the commenters and believe the elimination of a floor while maintaining a ceiling is fair and appropriate. The proposed policy not to use a floor under the IRF PPS is appropriate because use of a floor results in cost-to-charge ratios being set too high relative to an IRF's own cost-to-charge ratio, which in turn results in an over-estimation of an IRF's current costs per case. We also note that not using a floor is consistent with the IPPS finalized outlier policies as discussed in the June 9, 2003 final rule. This policy was established in response to a specific problem associated with hospitals under the IPPS, with some hospitals intentionally taking advantage of our policy to assign cost-to-charge ratios when a hospital's own ratio fell below the floor. We are finalizing our decision not to use a floor in our outlier policy as it would aid in appropriately identifying those cases that warrant outlier payments. In addition, the

proposed policy to maintain a ceiling under IRF PPS is fair because we believe that if an IRF has a cost-to-charge ratio above 3 standard deviations from the mean, then the cost-to-charge ratio is probably due to faulty data reporting or entry and should not be used to identify and pay for outliers.

### 3. Adjustment of IRF Outlier Payments

Under the existing methodology for computing IRF outlier payments as described in the preamble of the August 7, 2001 IRF PPS final rule (66 FR 41363) and in the November 1, 2001 Program Memorandum discussed above, we specify that the cost-to-charge ratio used to compute estimated costs are obtained from the most recent settled Medicare cost report. Further, we provided for no retroactive adjustment to the outlier payments to account for differences between the cost-to-charge ratio from the latest settled cost report and the actual cost-to-charge ratio for the cost reporting period in which the outlier payment is made. This policy is consistent with the existing outlier payment policy for acute care hospitals under the IPPS. However, as discussed in the IPPS March 4, 2003 Cost Outlier proposed rule (68 FR 10423), we proposed to revise the methodology for determining cost-to-charge ratios for acute care hospitals under the IPPS because we became aware that payment vulnerabilities exist in the current IPPS outlier policy. Because we believe the IRF outlier payment methodology is likewise susceptible to the same payment vulnerabilities, we proposed the following:

(1) As proposed for acute care hospitals under the IPPS at proposed § 412.84(i) in the March 4, 2003 proposed rule (68 FR 10420), we proposed under § 412.624(e)(4), by cross-referencing proposed § 412.84(i), that fiscal intermediaries would use more recent data when determining an IRF's cost-to-charge ratio. Specifically, under § 412.84(i), we proposed that fiscal intermediaries would use either the most recent settled IRF cost report or the most recent tentative settled IRF cost report (whichever is later) to obtain the applicable IRF cost-to-charge ratio. In addition, as proposed under § 412.84(i), any reconciliation of outlier payments would be based on a ratio of costs to charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled.

(2) As proposed for acute care hospitals under the IPPS at proposed § 412.84(m) in the March 4, 2003 proposed rule (68 FR 10420), we proposed under § 412.624(e)(4), by