

cross-referencing proposed § 412.84(m), that IRF outlier payments may be adjusted to account for the time value of money which is the value of money during the time period it was inappropriately held by the IRF as an "overpayment." We also proposed to adjust outlier payments for the time value of money for cases that are "underpaid" to the IRF. In these cases, the adjustment would result in additional payments to the IRF. We proposed that any adjustment would be based upon a widely available index to be established in advance by the Secretary, and would be applied from the midpoint of the cost reporting period to the date of reconciliation.

Comment: A few commenters disagreed with the proposed policy to adjust outlier payments to account for the time value of money.

Response: Outlier payments are extremely susceptible to manipulation because hospitals set their own level of charges and are able to change their charges without notification to, or review by, their fiscal intermediary. Such changes by a hospital directly affect its level of outlier payments. Therefore, even though money may be recouped if the outlier payments are reconciled, the hospital would essentially be able to unilaterally increase its charges and acquire an interest-free loan in the meantime. For that reason, we believe it is appropriate and we are finalizing our policy to apply an adjustment for the time value of "overpayments" or "underpayments" identified at the cost report reconciliation.

Comment: Some commenters believe that the adjustment for the time value of money should be set at a point other than the midpoint of the cost reporting period.

Response: We believe using the midpoint of the cost reporting year is an appropriate point to base an adjustment, as proposed, and results in an average "overpayment" or "underpayment" that would be fair to use as part of the adjustment calculation. Specifically, using the midpoint of the cost reporting period as the point to base an adjustment for all discharges that occur during a given cost reporting period is appropriate given that the midpoint is the median of the time period for all discharges. As we stated in the proposed rule, we proposed that IRF outlier payments may be adjusted to account for the time value of money which is the value of money during the time period it was inappropriately held by the IRF as an "overpayment." We also stated that we may adjust outlier payments for the time value of money

for cases that are "underpaid" to the IRF. In these "underpayment" cases, the adjustment will result in additional payments to the IRF. Because this adjustment will be applicable to IRFs that were "overpaid," as well as those IRFs that were "underpaid," we believe applying adjustments from the midpoint of the cost reporting period to the date of reconciliation is reasonable. Further, this policy is consistent with the final outlier policy stated in the June 9, 2003 IPPS outlier final rule.

We proposed to add a provision to our regulations to provide that outlier payments would become subject to reconciliation when hospitals' cost reports are settled. Under this policy, outlier payments would be processed throughout the year using facility cost-to-charge ratios based on the best information available at that time. We proposed that when the cost report is settled, any reconciliation of outlier payments by fiscal intermediaries would be based on facility cost-to-charge ratios calculated on a ratio of costs to charges computed from the cost report and charge data determined at the time the cost report coinciding with the discharge is settled.

This process would require some degree of recalculating outlier payments for individual claims. It is not possible to distinguish, on an aggregate basis, how much a hospital's outlier payments would change due to a change in its cost-to-charge ratios. This is because, in the event of a decline in a cost-to-charge ratio, some cases may no longer qualify for any outlier payments while other cases may qualify for lower outlier payments. Therefore, the only way to determine accurately the net effect of a decrease in cost-to-charge ratios on a hospital's total outlier payments is to assess the impact on a claim-by-claim basis. Because under our proposal, outlier payments would be based on the relationship between the hospital's costs and charges at the time a discharge occurred, the proposed methodology would ensure that when the final outlier payments were made, they would reflect an accurate assessment of the actual costs the hospital incurred. Therefore, we are adopting this proposal as final.

4. Change to the Methodology for Calculating the Federal Prospective Payment Outlier Payment

Under § 412.624(e)(4), we provide for an additional payment to a facility if its estimated costs for a patient exceeds a fixed dollar amount (adjusted for area wage levels and factors to account for treating low-income patients and for rural locations) as specified by CMS. The additional payment equals 80

percent of the difference between the estimated cost of the patient and the sum of the adjusted Federal prospective payment computed under this section and the adjusted fixed dollar amount. Effective for discharges on or after October 1, 2003, additional payments made under this section will be subject to the adjustments at § 412.84(i) except that national averages will be used instead of statewide averages. Also effective for discharges on or after October 1, 2003, additional payments made under this section will also be subject to adjustments at § 412.84(m).

Comment: A commenter was concerned about the discretion given to the fiscal intermediaries that would allow them to reconcile a provider's outlier payments if they believe the outlier payments are significantly inaccurate.

Response: Although CMS understands the commenter's concerns about discretion given to the fiscal intermediaries, we believe that it is important for CMS to have the flexibility to respond appropriately in the future if unforeseen evidence of manipulation of other prospective payments similar to that of IPPS comes to light. Therefore, we will provide guidance to the fiscal intermediaries with respect to their scope of discretion, as well as, provide them with instructions to implement all revisions to the outlier policy contained in this final rule.

I. Miscellaneous Comment

Comment: We received a comment expressing a concern that some providers believe that recreational therapy services are not covered by Medicare and that the costs of providing recreational therapy services are not included in the IRF PPS rates.

Response: This comment is not specifically related to our proposed changes to the IRF PPS. We responded to similar comments in the IPPS January 3, 1984 final rule (49 FR 242) by stating that "Neither the implementation of the prospective payment system nor the criteria for excluding certain hospitals and units from it will prohibit the provision of recreational therapy services to hospital inpatients. In particular, the absence of these services from the list of rehabilitative services in rehabilitation hospitals and units does not indicate that Medicare will no longer pay for them in those hospitals and units that provide them. On the contrary, these services will continue to be covered to the same extent they always have been under the existing Medicare policies." Since the publication of the January 3, 1984 final