

expanded over the course of the entire stay provides a fuller picture of the actual resources needed to provide care for the complete episode of care. After assessing the entire stay, one can determine if a "loss" was actually incurred by the IPF.

Therefore, we are proposing to define the outlier threshold amount as the total IPF prospective payment for an IPF stay, plus a fixed dollar loss amount. As explained below, the fixed dollar amount is determined to be the dollar amount per stay that achieves a total outlier percentage of 2 percent of the proposed prospective payments. The proposed outlier payment would be defined as a proportion of the estimated cost beyond the outlier threshold. The proportion of additional costs paid as outlier payments is referred to as the loss-sharing ratio. We chose to propose the fixed dollar loss amount and the loss-sharing ratios to allow the estimated total outlier payments to be 2 percent of the total estimated proposed IPF prospective payments.

In order to determine the most appropriate outlier policy, our goal was to analyze the extent to which the various outlier percentages reduce financial risk, reduce incentives to under serve costly beneficiaries, and improve the overall fairness of the payment system. Our analysis showed that the higher the outlier percentage, the more cases qualified for outlier payments, and the less payment was made per case. Conversely, a low outlier percentage resulted in a higher fixed dollar loss threshold and although fewer cases exceeded the threshold, the amount paid was more substantial.

We began our analysis by determining that if approximately 10 percent of IPF cases received an outlier payment, we would be maintaining the basic premise behind establishing an outlier policy, that is, to compensate IPFs for their truly high cost cases. Also, this percentage of cases, that is 10 percent, is not inconsistent with the percentage of total outlier cases paid in other prospective payment systems.

Initially, we believed that a 5 percent outlier policy would result in outlier payments for approximately 10 percent of total IPF cases. However, our analysis showed that a 5 percent outlier policy resulted in outlier payments for approximately 20 percent of IPF cases, paying an average of \$1,975 per case. Since 20 percent of IPF cases would receive an outlier payment, we do not believe that a 5 percent outlier policy limits outlier payments to only the truly high cost cases. We then reduced the outlier policy to 3 percent and found that 12 percent of IPF cases received

outlier payments, with an average payment of \$2,125 per case. Although a 3 percent outlier policy reduced the number of cases that would qualify for outlier payments, 12 percent of cases still exceeded our target of 10 percent of total IPF cases.

However, we have determined that an outlier policy of 2 percent of the total proposed IPF payments would allow us to achieve a balance of the above stated goals. A 2 percent outlier policy would appropriately compensate for the truly high cost cases with a much more appropriate level of payment and reduced financial risk without causing a significant reduction in the per diem base rate. Under a 2 percent outlier policy, approximately 7 percent of IPF cases qualify for outlier payments with an average payment of \$2,350 per case. Providing outlier payments to 7 percent of cases meets the 10 percent target and would provide outlier payment for only the high cost IPF cases. Accordingly, we are proposing the outlier policy to be 2 percent of the total proposed IPF payments. The amount of outlier payments would be funded by prospectively reducing the non-outlier payment rates in a budget-neutral manner.

Under our proposed outlier policy, we would make outlier payments for discharges in which estimated costs exceed an adjusted threshold amount (\$4,200 multiplied by the IPF's facility adjustments, that is wages, rural location, and teaching status) plus the total IPF prospective payment system adjusted payment amount for the discharge. The estimated cost for a case would be calculated by multiplying the overall facility-specific cost-to-charge ratio by the total charges for the inpatient stay.

In establishing the loss-sharing ratio, we considered establishing a single ratio consistent with the hospital inpatient prospective payment system, which is set at a marginal cost of 80 percent of the difference between the cost for the discharge and the adjusted threshold amount. However, the proposed IPF prospective payment system unlike the hospital inpatient prospective payment system is a per diem payment system, we are concerned that a single loss-sharing ratio at 80 percent might provide an incentive to increase length of stay in order to receive additional outlier payments. Therefore, we are proposing to reduce the loss-sharing ratio when the length of the stay increases beyond the median length of stay. We believe that a reduction to the outlier loss-sharing ratio should occur in a similar manner to the declining per diem payment. The per diem payment

amount under the proposed IPF prospective payment system is highest on days 1 through 4, declines on days 5 through 8, and declines further for all days beyond 8. Similarly, we are proposing to establish an 80-percent loss-sharing ratio for days 1 through 8 in order to reflect higher costs early in an IPF stay and reduce the ratio by 20 percent for days 9 and thereafter. This is consistent with the median length of stay for IPFs. Reducing the amount Medicare would share in the loss of high cost cases would provide an incentive for an IPF to contain costs once a case qualifies for outlier payments. We solicit comments on this approach.

c. Proposed Implementation of the Outlier Policy

The intent of proposing an outlier policy is to adequately pay for truly high-cost cases. However, we have become aware that under the hospital inpatient prospective payment system, some hospitals have taken advantage of two system features in the outlier policy to maximize their outlier payments. The first is the time lag between the current charges on a submitted claim and the cost-to-charge ratio taken from the most recent settled cost report. Second, statewide average cost-to-charge ratios are used in those instances in which an acute care hospital's operating or capital cost-to-charge ratios fall outside reasonable parameters. We set forth these parameters and the statewide cost-to-charge ratios for acute care hospitals in the annual publication of prospective payment rates that are published by August 1 of each year in accordance with § 412.8(b)(2). Currently, these parameters represent 3.0 standard deviations (plus or minus) from the geometric mean of cost-to-charge ratios for all hospitals. Hospitals could arbitrarily increase their charges so far above costs that their cost-to-charge ratios would fall below 3 standard deviations from the geometric mean of the cost-to-charge ratio. Thus, a higher statewide average cost-to-charge ratio would be applied to determine if the hospital should receive an outlier payment. This disparity results in their cost-to-charge ratios being set too high, which in turn results in an overestimation of their current costs per case.

The intention of the outlier policy under both the hospital inpatient prospective payment system and the proposed IPF prospective payment system is to make payments only when the cost of care is extraordinarily high in relation to the average cost of treating comparable conditions or illnesses. We