

believe that if hospitals' charges are not sufficiently comparable in magnitude to their costs, the legislative purpose underlying payment for outliers is thwarted. Thus, on June 9, 2003, we published a final rule in the **Federal Register** (68 FR 34494) to ensure that outlier payments are paid for truly high-cost cases under the hospital inpatient prospective payment system.

We believe the use of parameters is appropriate for determining cost-to-charge ratios to ensure these values are reasonable and that outlier payments can be made in the most equitable manner possible. Further, we believe the proposed methodology of computing IPF outlier payments is susceptible to the same payment enhancement practices identified under the hospital inpatient prospective payment system because it depends on the cost-to-charge ratio to determine the IPF's cost. Accordingly, as discussed below, we are proposing provisions for implementing the outlier policy to ensure the statistical accuracy of cost-to-charge ratios and appropriate adjustment of IPF outlier payments.

#### 1. 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 IPF'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 IPFs to under serve patients who require more costly care. Further, using a statistical measure of accuracy to address aberrant cost-to-charge ratios would also allow us to be consistent with the outlier policy under the hospital inpatient prospective payment system. Therefore, we are making the following two proposals:

- We will calculate two national ceilings, one for IPFs located in rural areas and one for facilities located in urban areas. We propose to compute this ceiling by first calculating the national average and the standard deviation of the cost-to-charge ratios for both urban and rural IPFs.

To determine the rural and urban ceilings, we propose to multiply each of the standard deviations by 3 and add the result to the appropriate national cost-to-charge ratio average (either rural or urban). We believe that the method explained above results in statistically valid ceilings. If an IPF's cost-to-charge ratio is above the applicable ceiling, the ratio is considered to be statistically inaccurate. Therefore, we are proposing

to assign the national (either rural or urban) median cost-to-charge ratio to the IPF. Due to the small number of IPFs compared to the number of acute care hospitals, we believe that statewide averages used in the hospital inpatient prospective payment system, would not be statistically valid in the IPF context.

In addition, the distribution of cost-to-charge ratios for IPFs is not normally distributed and there is no limit to the upper ceiling of the ratio. For these reasons, the average value tends to be overstated due to the higher values on the upper tail of the distribution of cost-to-charge ratios. Therefore, we are proposing to use the national median by urban and rural type as the substitution value when the facility's actual cost-to-charge ratio is outside the trim values. 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 these data are clearly erroneous and should not be relied upon. In addition, we propose to update and announce the ceiling and averages using this methodology every year.

- We will not apply the applicable national median cost-to-charge ratio when an IPF's cost-to-charge ratio falls below a floor. We are proposing this policy because we believe IPFs 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 propose a floor on cost-to-charge ratios, we would apply the applicable national median for the IPFs actual cost-to-charge ratio. Using the national median cost-to-charge ratio in place of the provider's actual cost-to-charge ratio would estimate the IPF's costs higher than they actually are and may allow the IPF to inappropriately qualify for outlier payments.

Accordingly, we are proposing to apply the IPF's actual cost-to-charge ratio to determine the cost of the case rather than creating and applying a floor. In such cases as described above, applying an IPF's actual cost-to-charge ratio to charges in the future to determine the cost of the case will result in more appropriate outlier payments.

Consistent with the policy change under the hospital inpatient prospective payment system, we are proposing that IPFs would receive their actual cost-to-charge ratios no matter how low their ratios fall. We are still assessing the procedural changes that would be necessary to implement this change.

#### 2. Adjustment of IPF Outlier Payments

As discussed in the hospital inpatient prospective payment system final rule for outliers, we have implemented changes to the outlier policy used to determine cost-to-charge ratios for acute care hospitals, because we became aware that payment vulnerabilities exist in the current outlier policy. Because we believe the IPF outlier payment methodology is likewise susceptible to the same payment vulnerabilities, we are proposing the following:

- Include in proposed § 412.424(c)(2)(v) a cross-reference to § 412.84(i) that was included in the final rule published in the **Federal Register** on June 9, 2003 (68 FR 34515). Through this cross-reference, we are proposing that fiscal intermediaries would use more recent data when determining an IPF's cost-to-charge ratio. Specifically, as provided in § 412.84(i), we are proposing that fiscal intermediaries would use either the most recent settled IPF cost report or the most recent tentatively settled IPF cost report, whichever is later to obtain the applicable IPF cost-to-charge ratio. In addition, as provided under § 412.84(i), any reconciliation of outlier payments will 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.

- Include in proposed § 412.424(c)(2)(v) a cross reference to § 412.84(m) (that was included in the final rule published in the **Federal Register** on June 9, 2003 (68 FR 34415) to revise the outlier policy under the hospital inpatient prospective payment system). Through this cross-reference, we are proposing that IPF outlier payments may be adjusted to account for the time value of money during the time period it was inappropriately held by the IPF as an "overpayment." We also may adjust outlier payments for the time value of money for cases that are "underpaid" to the IPF. In these cases, the adjustment will result in additional payments to the IPF. We are proposing that any adjustment will be based upon a widely available index to be established in advance by the Secretary, and will be applied from the midpoint of the cost reporting period to the date of reconciliation. We are still assessing the procedural changes that would be necessary to implement this change.

#### d. Computation of Proposed Outlier Payments

In order to illustrate the proposed outlier payment mechanism, we present