However, we will continue to monitor the experience and evaluate whether further requirements to our methodology are warranted.

Using this methodology, we are establishing a fixed-loss cost outlier threshold equal to the prospective payment rate for the DRG, plus any IME and DSH payments, and any add-on payments for new technology, plus $25,800.

We are not including in the calculation of the outlier threshold the possibility that hospitals' cost-to-charge ratios and outlier payments may be reconciled upon cost report settlement. Reconciliation occurs when hospitals' cost-to-charge-ratios at the time of cost report settlement are different than the tentatively settled cost-to-charge-ratio used to make outlier payments during the fiscal year. However, we believe that due to changes in hospital charging practices following implementation of the new outlier regulations in the June 9, 2003 final rule, the majority of hospitals' cost-to-charge ratios will not fluctuate significantly enough between the tentatively settled cost report and the final settled cost report to meet the criteria to trigger reconciliation of their outlier payments. Furthermore, it is difficult to predict which specific hospitals may be subject to reconciliation in any given year. As a result, we believe it is appropriate to omit reconciliation from the outlier threshold calculation.

ii. Other changes concerning outliers. As stated in the September 1, 1993 final rule (58 FR 46348), we establish outlier thresholds that are applicable to both hospital inpatient operating costs and hospital inpatient capital-related costs. When we modeled the combined operating and capital outlier payments, we found that using a common set of thresholds resulted in a lower percentage of outlier payments for capital-related costs than for operating costs. We project that the thresholds for FY 2005 will result in outlier payments equal to 5.10 percent of operating DRG payments and 4.9385 percent of capital payments based on the Federal rate.

In accordance with section 1886(d)(3)(B) of the Act, we reduced the FY 2005 standardized amount by the same percentage to account for the projected proportion of payments paid to outliers.

The outlier adjustment factors that are applied to the standardized amount for FY 2005 are as follows:

	Operating standardized amounts	Capital federal rate
National	0.949005	0.950615
Puerto Rico	0.973192	0.973757

We apply the outlier adjustment factors after removing the effects of the FY 2004 outlier adjustment factors on the standardized amount.

To determine whether a case qualifies for outlier payments, we apply hospital-specific cost-to-charge ratios to the total covered charges for the case. Operating and capital costs for the case are calculated separately by applying separate operating and capital cost-to-charge ratios. These costs are then combined and compared with the fixed-loss outlier threshold.

The June 9, 2003 outlier final rule (68 FR 34494) eliminated the application of the statewide average for hospitals whose cost-to-charge ratios fall below 3 standard deviations from the national mean cost-to-charge ratio. However, for those hospitals for which the fiscal intermediary computes operating cost-to-charge ratios greater than 1.240 or capital cost-to-charge ratios greater than 0.169, or hospitals for whom the fiscal intermediary is unable to calculate a cost-to-charge ratio (as described at § 412.84(i)(3) of our regulations), we are still using statewide average ratios to calculate costs to determine whether a hospital qualifies for outlier payments.[11] Table 8A in section VI. of this Addendum contains the statewide average operating cost-to-charge ratios for urban hospitals and for rural hospitals for which the fiscal intermediary is unable to compute a hospital-specific cost-to-charge ratio within the above range. These statewide average ratios replace the ratios published in the August 1, 2003 IPPS final rule (68 FR 45637). Table 8B in section VI. of this Addendum contains the comparable statewide average capital cost-to-charge ratios. Again, the cost-to-charge ratios in Tables 8A and 8B will be used during FY 2005 when hospital-specific cost-to-charge ratios based on the latest settled cost report are either not available or are outside the range noted above.

iii. FY 2003 and FY 2004 outlier payments. In the August 1, 2003 IPPS final rule (68 FR 45478), we stated that, based on available data, we estimated that actual FY 2003 outlier payments would be approximately 6.5 percent of actual total DRG payments. This estimate was computed based on simulations using the FY 2002 MedPAR file (discharge data for FY 2002 bills). That is, the estimate of actual outlier payments did not reflect actual FY 2003 bills, but instead reflected the application of FY 2003 rates and policies to available FY 2002 bills.

Our current estimate, using available FY 2003 bills, is that actual outlier payments for FY 2003 were approximately 5.7 percent of actual total DRG payments. Thus, the data indicate that, for FY 2003, the percentage of actual outlier payments relative to actual total payments is higher than we projected before FY 2003 (and, thus, exceeds the percentage by which we reduced the standardized amounts for FY 2003). Nevertheless, consistent with the policy and statutory interpretation we have maintained since the inception of the IPPS, we do not plan to make retroactive adjustments to outlier payments to ensure that total outlier payments for FY 2003 are equal to 5.1 percent of total DRG payments.

We currently estimate that actual outlier payments for FY 2004 will be approximately 3.5 percent of actual total DRG payments, 1.6 percentage points lower than the 5.1 percent we projected in setting outlier policies for FY 2004. This estimate is based on simulations using the FY 2003 MedPAR file (discharge data for FY 2003 bills). We used these data to calculate an estimate of the actual outlier percentage for FY 2004 by applying FY 2004 rates and policies, including an outlier threshold of $31,000 to available FY 2003 bills.

d. Section 410A of Public Law 108–173 Rural Community Hospital Demonstration Program Adjustment

Section 410A of Public Law 108–173 requires the Secretary to establish a demonstration that will modify reimbursement for inpatient services for up to fifteen small rural hospitals. Section 410A(c)(2) of Public Law 108–173 requires that ''in conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the

[11] These figures represent 3.0 standard deviations from the mean of the log distribution of cost-to-charge ratios for all hospitals.

Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.'' As discussed in section IV.P. of this final rule, we are satisfying this requirement by adjusting national IPPS rates by a factor that is sufficient to account for the added costs of this demonstration. We estimate that the average additional annual payment that will be made to each participating hospital under the demonstration will be approximately $855,893. We based this estimate on the recent historical experience of the difference between inpatient cost and payment for hospitals that would be eligible for the demonstration. For 15 participating hospitals, the total annual impact of the demonstration program is estimated to be $12,838,390. The required adjustment to the Federal rate used in calculating Medicare inpatient prospective payments as a result of the demonstration is 0.999855.

In order to achieve budget neutrality, we are adjusting national IPPS rates by an amount sufficient to account for the added costs of this demonstration. In other words, we are applying budget neutrality across the payment system as a whole rather than merely across the participants of this demonstration. We believe that the language of the statutory budget neutrality requirement permits the agency to implement the budget neutrality provision in this manner. This is because the statutory language requires that ''aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration * * * was not implemented,'' but does not identify the range across which aggregate payments must be held equal.

In the May 18, 2004 proposed rule, we invited public comments on how we were proposing to implement this statutory provision.

Comment: One commenter observed that we have historically implemented demonstration projects on a budget neutral basis within the context of the given demonstration. The commenter opposed our proposal to fund the Rural Community Hospital demonstration by reducing the payment rate to all hospitals paid on the basis of DRGs, saying that requiring nonparticipating hospitals to fund hospitals participating in a demonstration project is a poor policy precedent to set.

Response: The Rural Community Hospital Demonstration Program is mandated by section 410A of Public Law 108–173. It is aimed at testing the feasibility and advisability of payment for covered inpatient services based on reasonable cost for rural hospitals as defined by the legislation. The commenter is correct in stating that we usually implement demonstrations in which savings occurring among participants guarantee budget neutrality. However, in this case it is not realistic to expect hospitals chosen for the demonstration to generate an offsetting reduction in costs. Furthermore, we believe that the statutory authority allows us to define budget neutrality across the payment system. We believe that the method that we proposed to assure budget neutrality is the only feasible way to implement the demonstration, which is mandated by law.

5. FY 2005 Standardized Amount

The adjusted standardized amount is divided into labor and nonlabor portions. Tables 1A and 1B in section VI. of this Addendum contain the national standardized amount that we are applying to all hospitals, except hospitals in Puerto Rico. The amounts shown in the two tables differ only in that the labor-related share applied to the standardized amounts in Table 1A is 71.1 percent, and the labor-related share applied to the standardized amounts in Table 1B is 62 percent. As described in section II.A.1. of this Addendum, we are implementing section 403 of Pub. L. 108–173, which provides that the labor-related share is 62 percent, unless the application of that percentage would result in lower payments to a hospital than would otherwise be made. The effect of this provision is that the labor-related share of the standardized amount is 62 percent for all hospitals whose wage indexes are less than or equal to 1.0000.

However, the labor-related share of the standardized amount remains 71.1 percent (reflecting the Secretary's current estimate of the proportion of costs that are wages and wage-related costs) for hospitals whose wage indexes are greater than 1.0000. In addition, both tables include standardized amounts reflecting the full 3.3 percent update for FY 2005, and standardized amounts reflecting the 0.4 percentage point reduction to the update applicable for hospitals that fail to submit quality data consistent with section 501(b) of Public Law 108–173. (Tables 1C and 1D show the new standardized amounts for Puerto Rico, reflecting the different labor shares that apply, that is, 71.3 percent or 62 percent.)

The following table illustrates the changes from the FY 2004 national average standardized amount. The first column shows the changes from the 2004 standardized amounts for hospitals that satisfy the quality data submission requirement for receiving the full update (3.3 percent). The second column shows the proposed changes for hospitals receiving the reduced update (2.9 percent). The first row in the table shows the updated (through FY 2003) average standardized amount after restoring the FY 2004 offsets for outlier payments and geographic reclassification budget neutrality. The DRG reclassification and recalibration and wage index budget neutrality factor is cumulative. Therefore, the FY 2004 factor is not removed from the amount in the table. We have added separate rows to this table to reflect the different labor-related shares that apply to hospitals.

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