DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

SEP - 9 2005

TO: Herb Kuhn
Director, Center for Medicare Management
Centers for Medicare & Medicaid Services

FROM: Joseph E. Vengrin
Deputy Inspector General for Audit Services

SUBJECT: Audit of the Effectiveness of the Revised Medicare Outlier Payment Regulations for Inpatient Acute Care Hospitals (A-07-04-04032)

Attached are two copies of our final report on the effectiveness of the revised Medicare outlier payment regulations for inpatient acute care hospitals. We previously raised concerns to the Centers for Medicare & Medicaid Services (CMS) about excessive outlier payments in an early alert memorandum dated December 23, 2002.

Under Medicare's prospective payment system for inpatient acute care hospitals, CMS reimburses hospitals a predetermined amount, known as a diagnosis-related group (DRG) payment, for their services. Generally speaking, Medicare pays a fixed DRG amount per discharge for each type of inpatient case. Under this system, hospitals have a financial incentive to avoid extremely costly patients. To counter this incentive and promote access to hospital care for such patients, the Social Security Act (the Act) requires that CMS make additional payments called outlier payments. The Act also mandates that CMS set a target threshold for outlier payments at 5 to 6 percent of total projected inpatient DRG payments. CMS set the target at 5.1 percent of total operating DRG payments.[1] However, CMS paid $9 billion in excess of its target from fiscal year (FY) 1998 through FY 2002.

After we issued our early alert memorandum, CMS revised the Medicare outlier payment regulations. The revised regulations, effective in 2003, required the use of the cost-to-charge ratio from the latest cost reporting period, either the most recent final or tentatively settled cost report. In addition, the regulations eliminated the use of the statewide average cost-to-charge ratio for hospitals with low cost-to-charge ratios and provided for a retroactive adjustment of outlier payments during final cost report settlements.

Our objective was to determine whether the 2003 revision of the Medicare outlier payment regulations reduced operating outlier payments for specific hospitals.

The revised regulations reduced collective operating outlier payments to 362 hospitals that had received high levels of such payments. For those hospitals, operating outlier payments decreased from 9.1 percent of Medicare operating DRG payments in December 2002 to 5.2 percent in

[1]DRG payments to hospitals consist of operating payments and capital payments. Operating payments cover costs such as labor and supplies. Capital payments cover capital-related costs such as the building. Although separate outlier payments are made for both operating and capital costs, this report addresses only operating outlier payments.

December 2003. The average operating outlier payment per claim decreased by 42.7 percent, from $834.30 to $478.17.

Outlier payments to the 362 hospitals decreased because the Medicare fiscal intermediaries reduced the cost-to-charge ratios by an average of 13.8 percent as a result of the revised regulations. The fiscal intermediaries computed lower cost-to-charge ratios for 80.1 percent of the 362 hospitals, higher cost-to-charge ratios for 18.5 percent, and the same cost-to-charge ratios for 1.4 percent. Further outlier payment adjustments may occur when the fiscal intermediaries conduct final settlements of the 362 hospitals' cost reports. As a result of the revised regulations, CMS estimated that the Medicare program would save at least $9 billion over 5 years.

We recommend that CMS continue to monitor Medicare outlier payments to all prospective payment system hospitals to ensure that the payments comply with Medicare regulations. In comments on our draft report, CMS agreed with the recommendation.

We would appreciate your views and the status of any further action taken or contemplated on our recommendations within the next 60 days. If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through e-mail at george.reeb@oig.hhs.gov. Please refer to report number A-07-04-04032 in all correspondence.

Attachment

cc:
Tim Hill
Director, Office of Financial Management

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

AUDIT OF THE EFFECTIVENESS OF THE REVISED MEDICARE OUTLIER PAYMENT REGULATIONS FOR INPATIENT ACUTE CARE HOSPITALS

Daniel R. Levinson
Inspector General

SEPTEMBER 2005
A-07-04-04032

Office of Inspector General

http://oig.hhs.gov

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EXECUTIVE SUMMARY

BACKGROUND

Outlier Payments

Under Medicare's prospective payment system for inpatient acute care hospitals, the Centers for Medicare & Medicaid Services (CMS) reimburses hospitals a predetermined amount, known as a diagnosis-related group (DRG) payment, for their services. Generally speaking, Medicare pays a fixed DRG amount per discharge for each type of inpatient case. Under this system, hospitals have a financial incentive to avoid extremely costly patients. To counter this incentive and promote access to hospital care for such patients, the Social Security Act (the Act) requires that CMS make additional payments called outlier payments. The Act also mandates that CMS set a target threshold for outlier payments at 5 to 6 percent of total projected inpatient DRG payments. CMS set the target at 5.1 percent of total operating DRG payments.[1]

Regulations To Address Excessive Outlier Payments

From fiscal year (FY) 1998 through FY 2002, rapid increases in charges by certain hospitals resulted in outlier payments in excess of CMS's 5.1 percent target. CMS paid hospitals $9 billion in operating outlier payments in excess of the target during this period.

To address these excessive payments, CMS implemented revised outlier regulations in 2003 that required the use of the cost-to-charge ratio from the latest cost reporting period, either the most recent final or tentatively settled cost report. In addition, the regulations eliminated the use of the statewide average cost-to-charge ratio for hospitals with low cost-to-charge ratios and provided for a retroactive adjustment of outlier payments during final cost report settlements.

OBJECTIVE

Our objective was to determine whether the 2003 revision of the Medicare outlier payment regulations reduced operating outlier payments for specific hospitals.

SUMMARY OF RESULTS

The revised outlier payment regulations reduced collective operating outlier payments to 362 hospitals that had received high levels of such payments. For those hospitals, operating outlier payments decreased from 9.1 percent of Medicare operating DRG payments in December 2002 to 5.2 percent in December 2003. The average operating outlier payment per claim decreased by 42.7 percent, from $834.30 to $478.17.

[1]DRG payments to hospitals consist of operating payments and capital payments. Operating payments cover costs such as labor and supplies. Capital payments cover capital-related costs such as the building. Although separate outlier payments are made for both operating and capital costs, this report addresses only operating outlier payments.

Outlier payments to the 362 hospitals decreased because the Medicare fiscal intermediaries reduced the cost-to-charge ratios by an average of 13.8 percent as a result of the revised regulations. The fiscal intermediaries computed lower cost-to-charge ratios for 80.1 percent of the 362 hospitals, higher cost-to-charge ratios for 18.5 percent, and the same cost-to-charge ratios for 1.4 percent. Further outlier payment adjustments may occur when the fiscal intermediaries conduct final settlements of the 362 hospitals' cost reports. As a result of the revised regulations, CMS estimated that the Medicare program would save at least $9 billion over 5 years.

RECOMMENDATION

We recommend that CMS continue to monitor Medicare outlier payments to all prospective payment system hospitals to ensure that the payments comply with Medicare regulations.

CMS'S COMMENTS

In comments dated July 5, 2005, CMS concurred with our recommendation. The comments are included in their entirety as Appendix B.

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INTRODUCTION

BACKGROUND

Under Medicare's prospective payment system for inpatient acute care hospitals, the Centers for Medicare & Medicaid Services (CMS) reimburses hospitals a predetermined amount, known as a diagnosis-related group (DRG) payment, for inpatient services furnished to beneficiaries. Generally speaking, Medicare pays a fixed DRG amount per discharge for each type of inpatient case. Under this system, hospitals have a financial incentive to avoid extremely costly cases because they would be reimbursed only the standard payment for the case type, not the cost of the individual case. To counter this incentive and promote access to hospital care for extremely costly patients, the Social Security Act (the Act) required that CMS make additional payments called outlier payments. Outlier payments can be viewed as insurance for hospitals against the large losses that could result from extremely expensive cases.

The Act mandates that CMS set a target threshold for outlier payments at 5 to 6 percent of total projected inpatient DRG payments. CMS set the target at 5.1 percent of total operating DRG payments.[1]

Outlier Payments in Excess of Target

From fiscal year (FY) 1998 through FY 2002, rapid increases in charges by certain hospitals resulted in outlier payments in excess of CMS's 5.1-percent target. CMS paid hospitals $9 billion in excess of the target, as shown in Table 1.[2]

Table 1: Historic Operating Outlier Payments

Fiscal Year	Outliers as Percentage of Actual DRG Payments	Payments in Excess of 5.1-Percent Target (in billions)
1998	6.5	$1.0
1999	7.6	1.8
2000	7.6	1.8
2001	7.7	1.9
2002	7.9	2.5
Total		**$9.0**

[1]DRG payments to hospitals consist of operating payments and capital payments. Operating payments cover costs such as labor and supplies. Capital payments cover capital-related costs such as the building. Although separate outlier payments are made for both operating and capital costs, this report addresses only operating outlier payments.

[2]Federal Register, vol. 68, No. 110, June 9, 2003, Rules and Regulations, page 34496.

Cost-to-Charge Ratio

Providers bill for Medicare claims on the basis of patient charges. To determine whether claims qualify for an outlier payment, Medicare fiscal intermediaries must convert billed charges to estimated costs using a cost-to-charge ratio. The use of provider-specific cost-to-charge ratios is essential to ensure that outlier payments are made only for cases that have extraordinarily high costs and not merely high charges. Medicare fiscal intermediaries calculate the cost-to-charge ratios by dividing patient-related costs by total charges, as shown on the Medicare cost reports.

The cost-to-charge ratio is based on a historic relationship between charges and costs. If a hospital increases its charges, the fiscal intermediary will eventually calculate a revised cost-to-charge ratio that will capture the charge increases. Until the cost-to-charge ratio is revised, it will overstate the estimated cost of a claim for hospitals that rapidly increase charges. Without a provision for retroactively adjusting claims on the basis of final cost reports, hospitals can increase outlier payments by raising charges.

For example, if a hospital with an operating cost-to-charge ratio of 0.332 had doubled its billed charges for a cardiac procedure (DRG 107) in FY 2002, its operating outlier payment would have increased by more than $40,000 (Table 2). The increase would have occurred even without any change in the cost of providing the procedure.

Table 2: Impact of a Charge Increase on an Outlier Payment

Billed Charges	Outlier Payment
$150,000	$3,410
300,000	44,090

Program Vulnerabilities

Before 2003, some hospitals received higher operating outlier payments primarily by taking advantage of two vulnerabilities in the outlier calculation methodology:

- The first vulnerability was the significant timelag between billed charges on a submitted claim and the cost-to-charge ratio taken from the most recent final cost report. Although billed charges were current, there was an inherent timelag (up to 2 or more years) in the cost report filing and approval process. Because the outlier methodology had no provision for retroactively adjusting operating outlier payments upon approval of a final cost report, some hospitals were able to take advantage of the timelag. Specifically, for hospitals that raised charges significantly without a commensurate increase in costs, the use of an outdated cost-to-charge ratio to convert currently billed charges to costs overestimated the hospitals' costs and yielded higher operating outlier payments.

- The second vulnerability pertained to hospitals that increased their charges so far above costs that their cost-to-charge ratio fell below a percentage rate that CMS set. Pursuant to CMS outlier regulations (42 CFR § 412.84), this triggered the use of the higher statewide average cost-to-charge ratio instead of the hospital's specific cost-to-charge ratio. The

use of the statewide average ratio in these instances also overestimated the hospitals' costs and yielded higher operating outlier payments.

Revised Regulations To Address Outlier Payments

In 2003, CMS adopted revised regulations (42 CFR § 412.84) to address the two program vulnerabilities. To address the timelag problem, the regulations require the Medicare fiscal intermediary to use a hospital's most recent tentatively settled or final cost report in establishing a cost-to-charge ratio to compute outlier payments. However, even the more current ratios calculated from a tentatively settled cost report could overestimate costs for hospitals that continue to increase charges much faster than costs. Therefore, the regulations permit the fiscal intermediary to retroactively adjust outlier payments using a lower cost-to-charge ratio during final cost report settlement. To address the issue of the statewide average cost-to-charge ratio, the regulations require the use of a hospital's actual cost-to-charge ratio rather than the statewide average ratio for hospitals that have cost-to-charge ratios below the percentage rate that CMS sets.

Final Adjustments Yet To Occur

The fiscal intermediaries do not perform retroactive adjustments until final cost report settlements, which usually occur several years after the end of the cost report period. Because the revised regulations applied to most hospitals for discharges that occurred on or after October 1, 2003, any outlier payment adjustments under this provision will not occur for several years.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the 2003 revision of the Medicare outlier payment regulations reduced operating outlier payments for specific hospitals.

Scope

Our review focused on acute care inpatient operating outlier payments that 362 hospitals received during December 2002 and December 2003. We limited our review to a nonstatistical sample of Medicare hospitals selected from a list of nine fiscal intermediaries with providers that received high levels of operating outlier payments. We did not review the internal controls of the hospitals or the fiscal intermediaries because the audit objective did not require us to do so.

For claims paid in December 2002, the hospitals received $156.9 million in operating outlier payments. For claims paid in December 2003, the hospitals received $97.4 million in operating outlier payments.

Because the retroactive adjustments required by the revised outlier regulations will not occur for several years, this report addresses only the reimbursement impact of the use of tentatively

settled cost reports and the elimination of the statewide average cost-to-charge ratio for hospitals with low cost-to-charge ratios.

Methodology

We selected the 362 hospitals in 2 stages. First, we selected nine fiscal intermediaries from a CMS-produced list of intermediaries that had providers with high operating outlier payments. From each of these 9 intermediaries, we then requested all Medicare inpatient paid claims for December 2002 and December 2003 for the 50 hospitals with the highest operating outlier payments in December 2002. Because some of the fiscal intermediaries had fewer than 50 hospitals with operating outlier payments, our sample included 362 (rather than 450) hospitals. Appendix A lists the fiscal intermediaries and the number of hospitals selected from each intermediary.

We identified the total operating outlier payments that the 362 hospitals received during December 2002 and December 2003. To determine the impact of the revised outlier regulations, we calculated the ratio of total operating outlier payments to total DRG payments that the 362 hospitals received during December 2002 and December 2003. In addition, we computed the average operating outlier payment per claim for each of the 2 months and obtained the cost-to-charge ratio data for each hospital.

Finally, to compare the reduction in outlier payments among various categories of hospitals, we obtained the following information from the cost reports:

- hospital location (urban or rural);
- hospital education status (teaching or nonteaching);
- disproportionate share status (disproportionate share or nondisproportionate share); and
- ownership (proprietary, nonproprietary, or governmental).

We performed our audit in accordance with generally accepted government auditing standards.

RESULTS OF REVIEW AND RECOMMENDATION

The revised outlier payment regulations reduced collective operating outlier payments to 362 hospitals that had received high levels of such payments. For those hospitals, operating outlier payments decreased from 9.1 percent of Medicare operating DRG payments in December 2002 to 5.2 percent in December 2003. The average operating outlier payment per claim decreased by 42.7 percent, from $834.30 to $478.17.

Outlier payments to the 362 hospitals decreased because the Medicare fiscal intermediaries reduced the cost-to-charge ratios by an average of 13.8 percent as a result of the revised regulations. The fiscal intermediaries computed lower cost-to-charge ratios for 80.1 percent of the 362 hospitals, higher cost-to-charge ratios for 18.5 percent, and the same cost-to-charge

ratios for 1.4 percent. Further outlier payment adjustments may occur when the fiscal intermediaries conduct final settlements of the 362 hospitals' cost reports. As a result of the revised regulations, CMS estimated that the Medicare program would save at least $9 billion over 5 years.

OUTLIER PAYMENT REQUIREMENTS

Federal Law

Section 1886(d)(5)(A)(ii) of the Act requires that Medicare pay hospitals an amount in addition to the basic DRG amount for hospital inpatient cases for which the charges adjusted to cost exceed the sum of the applicable DRG prospective payment rate plus a fixed dollar threshold established by CMS. Section 1886(d)(5)(A)(iv) requires that the total inpatient outlier payments in a fiscal year not be less than 5 percent or more than 6 percent of the total payments projected or estimated to be made based on DRG prospective payment rates for inpatient discharges that year.

Federal Regulations and CMS Instructions

Pursuant to 42 CFR § 412.84, Medicare must pay an additional amount beyond the basic DRG amount for a hospital inpatient case with extraordinarily high costs compared with other cases in the same DRG.

In 2003, CMS revised 42 CFR § 412.84. The significant revisions follow:

- For discharges occurring on or after October 1, 2003, the operating and capital cost-to-charge ratios applied when a claim is processed are based on either the most recent final or tentatively settled cost report, whichever is from the latest cost reporting period.

- For discharges occurring on or after August 8, 2003, the fiscal intermediary may use a statewide average cost-to-charge ratio if it is unable to determine an accurate operating or capital cost-to-charge ratio for a hospital in one of the following circumstances:[3]

    - A new hospital has not yet submitted its first Medicare cost report.

    - A hospital's operating or capital cost-to-charge ratio is in excess of 3 standard deviations above the corresponding national geometric mean.

    - The fiscal intermediary cannot obtain accurate data to calculate an operating or capital cost-to-charge ratio.

- For discharges occurring on or after August 8, 2003, any reconciliation of outlier payments will be based on operating and capital cost-to-charge ratios calculated based on

[3]This provision effectively eliminated the use of the statewide average cost-to-charge ratio for hospitals with a cost-to-charge ratio that falls below the percentage that CMS sets.

a ratio of costs and charges from the relevant cost report and from charge data determined when the cost report coinciding with the discharge is settled.

In 2003, CMS issued Program Memorandum A-03-058 to implement 42 CFR § 412.84. The program memorandum states that for discharges occurring in cost reporting periods beginning on or after October 1, 2003, fiscal intermediaries are to adjust outlier payments at the time of final cost report settlement for inpatient prospective payment system hospitals if the following criteria apply:

- Actual operating or capital cost-to-charge ratios are at least plus or minus 10 percentage points from the cost-to-charge ratios used during that time period to make outlier payments.

- Total outlier payments in the cost reporting period exceed $500,000.

REDUCED OPERATING OUTLIER PAYMENTS

For 362 hospitals that had received high levels of operating outlier payments, operating outlier payments decreased from 9.1 percent of Medicare operating DRG payments in December 2002 to 5.2 percent in December 2003. The average operating outlier payment per claim to the 362 hospitals decreased by 42.7 percent, from $834.30 to $478.17. Further reductions may occur when the fiscal intermediaries conduct final cost report settlements and consider outlier payments received in December 2003 for retroactive adjustment.

Table 3 on the following page shows the reduction in operating outlier payments to various types of hospitals in our nonstatistical sample. As noted, proprietary hospitals experienced the greatest reduction (68.6 percent).

Table 3: Outlier Payment Reductions by Type of Hospital

Hospital Type	Number of Hospitals	Per Claim Average Outlier Payment Dec. 2002	Per Claim Average Outlier Payment Dec. 2003	Reduction Amount	Reduction Percentage
All Types	**362**	**$834.30**	**$478.17**	**$356.13**	**42.7%**[4]
Urban	324	864.81	494.85	369.96	42.8%
Rural	38	182.16	131.42	50.74	27.9%
Teaching	233	857.17	502.29	354.88	41.4%
Nonteaching	129	753.72	394.18	359.54	47.7%
Disproportionate Share	283	922.78	526.33	396.45	43.0%
Nondisproportionate Share	79	549.51	326.07	223.44	40.7%
Proprietary	61	2,380.49	748.54	1,631.95	68.6%
Nonproprietary	253	543.27	432.77	110.50	20.3%
Governmental	48	897.43	467.33	430.10	47.9%

We used the following definitions to categorize hospitals:

Urban/Rural: An urban hospital is located in a metropolitan statistical area or a New England county metropolitan area as defined by the Office of Management and Budget. A rural hospital is located outside an urban area.

Teaching: A teaching hospital is affiliated with a medical school and provides medical education to students, interns, residents, and sometimes postgraduates. In addition, a teaching hospital has a graduate education program, approved by the appropriate accrediting body, in the field of medicine, osteopathy, dentistry, or podiatry.

Disproportionate Share Hospital (DSH): Pursuant to section 1886(d)(5)(F) of the Act, there are two ways in which a hospital can qualify for the Medicare DSH adjustment. The primary method is based on a complex statutory formula that produces a DSH patient percentage. The DSH patient percentage is equal to the sum of the percentage of Medicare inpatient days attributable to patients eligible for both Medicare Part A and Supplemental Security Income and the percentage of total inpatient days attributable to patients eligible for Medicaid but not Medicare Part A. Under the alternative special-exception method, large urban hospitals can qualify for DSH payments if they demonstrate that more than 30 percent of their total net inpatient care revenues come from State and local governments for indigent care (other than Medicare or Medicaid revenues).

[4]Combined group averages will not equal the overall average because of the weighted average of the larger group.

Proprietary/Nonproprietary: A proprietary hospital is operated as a profit-making business and is owned by a corporation, an investment group, or physicians who use it primarily for their own patients. A nonproprietary hospital is an incorporated organization that exists for educational or charitable reasons and from which its shareholders or trustees do not benefit financially. It can also be called a nonprofit or not-for-profit hospital.

Governmental: A governmental hospital is under the jurisdiction of a city, county, or State.

REVISED COST-TO-CHARGE RATIOS

Outlier payments to the 362 hospitals decreased because the Medicare fiscal intermediaries reduced the cost-to-charge ratios by an average of 13.8 percent as a result of the revised regulations. The fiscal intermediaries computed lower cost-to-charge ratios for 80.1 percent of the 362 hospitals, higher cost-to-charge ratios for 18.5 percent, and the same cost-to-charge ratios for 1.4 percent. The ratio reductions resulted from the use of the cost-to-charge ratio from the latest cost reporting period, either the most recent final or tentatively settled cost report, and the elimination of the statewide average cost-to-charge ratio for hospitals with low cost-to-charge ratios.

ESTIMATED PROGRAM SAVINGS

As a result of the revised regulations, CMS estimated that the Medicare program would save at least $9 billion over 5 years (2004 through 2008). This cost savings is based on CMS's estimate of excess outlier payments for FYs 1998 through 2002.

CONCLUSION

The revised outlier payment regulations reduced collective operating outlier payments to the 362 hospitals reviewed. Because these hospitals represented a nonstatistical sample of providers with high outlier payments, our results cannot be generalized to all hospitals. Measuring the financial effect of the revised regulations on all prospective payment system hospitals would require examining their cost reports after the final cost report settlements. Such a review cannot be done for several years.

RECOMMENDATION

We recommend that CMS continue to monitor Medicare outlier payments to all prospective payment system hospitals to ensure that the payments comply with Medicare regulations.

CMS'S COMMENTS

In written comments dated July 5, 2005, CMS concurred with our recommendation and said that it would continue to monitor outlier payments as a share of total inpatient prospective payment system payments. In addition, CMS stated that it planned to analyze:

- fluctuations in hospital cost-to-charge ratios from the time claims were paid to cost report settlement,

- trends in hospital-specific outlier payments, and

- hospitals' current cost-to-charge ratios to determine whether alternative ratios could be assigned to more accurately reflect the hospitals' actual costs and charges.

CMS's comments are included in their entirety as Appendix B.

APPENDIXES

APPENDIX A

FISCAL INTERMEDIARIES AND NUMBER OF HOSPITALS REVIEWED

	Number of Hospitals
AdminaStar Federal	50
Associated Hospital Services	35
Chisholm Blue Cross Blue Shield of Oklahoma	20
Mutual of Omaha	50
Premera Blue Cross of Washington	13
TrailBlazer Health	50
Trispan Blue Cross Blue Shield of Mississippi	49
United Government Services	45
Veritus	50
Total	**362**

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: JUL - 5 2005

TO: Daniel R. Levinson
Inspector General

FROM: Mark B. McClellan, M. D., Ph.D. MM
Administrator

SUBJECT: Office of Inspector General's Draft Report: "Audit of the Effectiveness of the Revised Medicare Outlier Payment Regulations for Inpatient Acute Care Hospitals" (A-07-04-04032)

Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report on the effectiveness of the Centers for Medicare & Medicaid Services (CMS) revision of the Medicare outlier payment regulations for inpatient acute care hospitals. The subject report recommends that CMS continue to monitor Medicare outlier payments to all prospective payment system hospitals to ensure that the payments are in accordance with Medicare regulations.

The CMS agrees with the OIG that it is necessary to monitor and ensure that outlier payments are in accordance with Medicare regulations. As a result, for inpatient prospective payment system (IPPS) hospitals, we have already begun to analyze and monitor hospital specific outlier payments. Some of the items we plan to closely analyze are the fluctuations in hospital cost-to-charge ratios (CCRs) from the time claims are paid to the CCR at the time of cost report settlement. We also plan on analyzing trends in hospital specific outlier payments and to continue our long standing practice of monitoring outlier payments as a share of total IPPS payments. Finally, because there is still a slight time lag in using the tentatively settled cost reports for determining a hospital's CCR, we plan on analyzing hospitals' current CCRs and determining if an alternative one can be assigned that better reflects a hospital's actual costs and charges.

We appreciate the efforts that the OIG has made on this issue.