DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412

[CMS–1243–F]

RIN 0938–AM41

Medicare Program; Change in Methodology for Determining Payment for Extraordinarily High-Cost Cases (Cost Outliers) Under the Acute Care Hospital Inpatient and Long-Term Care Hospital Prospective Payment Systems

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: In this final rule, we are revising the methodology for determining payments for extraordinarily high-cost cases (cost outliers) made to Medicare-participating hospitals under the acute care hospital inpatient prospective payment system (IPPS).

Under the existing outlier methodology, the cost-to-charge ratios from hospitals' latest settled cost reports are used in determining a fixed-loss amount cost outlier threshold. We have become aware that, in some cases, hospitals' recent rate-of-charge increases greatly exceed their rate-of-cost increases. Because there is a time lag between the cost-to-charge ratios from the latest settled cost report and current charges, this disparity in the rate-of-increases for charges and costs results in cost-to-charge ratios that are too high, which in turn results in an overestimation of hospitals' current costs per case. Therefore, we are revising our outlier payment methodology to ensure that outlier payments are made only for truly expensive cases.

We also are revising the methodology used to determine payment for high-cost outlier and short-stay outlier cases that are made to Medicare-participating long-term care hospitals (LTCHs) under the long-term care hospital prospective payment system (LTCH PPS). The policies for determining outlier payment under the LTCH PPS are modeled after the outlier payment policies under the IPPS.

EFFECTIVE DATE: The provisions of this final rule are effective on August 8, 2003.

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SUPPLEMENTARY INFORMATION:

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I. Background

A. Description of the Acute Care Hospital Inpatient Prospective Payment System (IPPS)

Section 1886(d) of the Social Security Act (the Act) sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively set rates. This payment system is referred to as the acute care hospital inpatient prospective payment system (IPPS). Under the IPPS, each case is categorized into a diagnosis-related group (DRG). Each DRG has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that DRG.

The IPPS base payment rate (also referred to as the average standardized amount) is divided into a labor-related share and a nonlabor-related share. The labor-related share is adjusted by the wage index applicable to the area where the hospital is located, and if the hospital is located in Alaska or Hawaii, the nonlabor-related share is adjusted by a cost-of-living adjustment factor. This base payment rate is multiplied by the DRG relative weight.

If a hospital treats a high percentage of low-income patients, it receives a percentage add-on payment applied to the DRG-adjusted base payment rate. This add-on payment, known as the disproportionate share hospital (DSH) adjustment, provides for a percentage increase in Medicare payments to hospitals that qualify under either of two statutory formulas that are designed to identify hospitals that serve a disproportionate share of low-income patients. For qualifying hospitals, the amount of the DSH adjustment may vary based on the outcome of the statutory calculation.

Also, if a hospital is an approved teaching hospital it receives a percentage add-on payment for each case paid under the IPPS. This add-on payment, known as the indirect medical education (IME) adjustment, varies depending on the ratio of residents-to-beds for operating costs and according to the ratio of residents-to-average daily census for capital costs under the IPPS.

Additional payments may be made for cases that involve new technologies that have been approved for special add-on payments. In order to qualify, a new technology must demonstrate that it is a substantial clinical improvement over technologies otherwise available, and that, absent an add-on payment, it would be inadequately paid under the regular DRG payment.

For particular cases that are unusually costly, known as outlier cases (discussed below), the IPPS payment is increased. This additional payment is designed to protect a Medicare-participating hospital from large financial losses due to unusually expensive cases. Any outlier payment due to the hospital is added to the DRG-adjusted base payment rate, plus any DSH, IME, and new technology add-on adjustments.

The regulations governing payments for operating costs under the IPPS are located in 42 CFR Part 412. The specific regulations governing payments for outlier cases are located at 42 CFR 412.80 through 412.86.

Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of inpatient hospital services ''in accordance with a prospective payment system established by the Secretary.'' The basic methodology for determining capital prospective payments is set forth in our regulations at §§ 412.308 and 412.312. Under the capital prospective payment system, payments are adjusted by the same DRG for the case as they are under the operating IPPS. Similar adjustments are also made for IME and DSH as under the operating IPPS. Hospitals also may receive a capital outlier payment for those cases that qualify.

B. Payment for Outlier Cases

1. General

Section 1886(d)(5)(A) of the Act provides for Medicare payments to Medicare-participating hospitals in addition to the basic prospective payments for cases incurring extraordinarily high costs. To qualify for outlier payments, a case must have costs above a fixed-loss cost threshold amount (a dollar amount by which the costs of a case must exceed payments in order to qualify for outliers).

Hospital-specific cost-to-charge ratios are applied to the covered charges for a case to determine whether the costs of the case exceed the fixed-loss outlier threshold. Payments for eligible cases are then made based on a marginal cost factor, which is a percentage of the costs above the threshold. For Federal fiscal year (FY) 2003, the existing fixed-loss outlier threshold is $33,560.

The actual determination of whether a case qualifies for outlier payments takes into account both operating and capital costs and DRG payments. That is, the combined operating and capital costs of a case must exceed the fixed-loss outlier threshold to qualify for an outlier payment. The operating and capital costs are computed separately by multiplying the total covered charges by the operating and capital cost-to-charge ratios. The estimated operating and capital costs are compared with the fixed-loss threshold after dividing that threshold into an operating portion and a capital portion (by first summing the operating and capital ratios and then determining the proportion of that total comprised by the operating and capital ratios and applying these percentages to the fixed-loss threshold). The thresholds are also adjusted by the area wage index (and capital geographic adjustment factor) before being compared to the operating and capital costs of the case. Finally, the outlier payment is based on a marginal cost factor equal to 80 percent of the combined operating and capital costs in excess of the fixed-loss threshold (90 percent for burn DRGs).

The following example simulates the IPPS outlier payment for a case at a generic hospital that receives IME and DSH payments in San Francisco, California (a large urban area). In the example, the patient was discharged after October 1, 2002, and the hospital incurred Medicare-covered charges of $150,000. The DRG assigned to the case was DRG 286 (Adrenal and Pituitary Procedures), which has a FY 2003 relative weight of 2.0937. There is no new technology add-on payment for the case.

Step 1: Determine the Federal operating and capital payment with IME and DSH adjustment based on the following values:

OPERATING PORTION

National Large Urban Standardized Amounts:	
Labor-Related	$3,022.60
Nonlabor-Related	$1,228.60
San Francisco MSA Wage Index	1.4142
IME Operating Adjustment Factor	0.0744
DSH Operating Adjustment Factor	0.1413
DRG 286 Relative Weight	2.0937
Labor-Related Portion	0.711
Nonlabor-Related Portion	0.289

Federal Payment for Operating Costs = DRG Relative Weight × [(Labor-Related Large Urban Standardized Amount × San Francisco MSA Wage Index) + Nonlabor-Related National Large Urban Standardized Amount] × (1 + IME + DSH): 2.0937 × [($3,022.60 × 1.4142) + $1,228.60] × (1 + 0.0744 + 0.1413) = $14,007.26

CAPITAL PORTION

Federal Capital Rate	$407.01
Large Urban Add-On	1.03
San Francisco MSA Geographic Adjustment Factor	1.2679
IME Capital Adjustment Factor	0.0243
DSH Capital Adjustment Factor	0.0631

Federal Payment for Capital Costs = DRG Relative Weight × Federal Capital Rate × Large Urban Add-On × Geographic Adjustment Factor × (1 + IME + DSH): 2.0937 × $407.01 × 1.03 × 1.2679 × (1 + 0.0243 + 0.0631) = $1,210.12

Step 2: Determine operating and capital costs from billed charges by applying the respective cost-to-charge ratios.

Billed Charges	$150,000
Operating Cost-to-Charge Ratio	0.50
Operating Costs = (Billed Charges × Operating Cost-to-Charge Ratio) ($150,000 × .50)	$75,000
Capital Cost-to-Charge Ratio	0.06
Capital Costs = (Billed Charges × Capital Cost-to-Charge Ratio) ($150,000 × .06)	$9,000

Step 3: Determine outlier threshold.

Fixed Loss Threshold	$33,560
Operating Cost-to-Charge Ratio to Total Cost-to-Charge Ratio:.	
(Operating Cost-to-Charge Ratio) / (Operating Cost-to-Charge Ratio + Capital Cost-to-Charge Ratio) (.50)/(.50 + .06)	0.8929

Operating Outlier Threshold = {[Fixed Loss Threshold × ((Labor-Related portion × San Francisco MSA Wage Index) + Nonlabor-Related portion)] × Operating Cost-to-Charge Ratio to Total Cost-to-Charge Ratio} + Federal Payment with IME and DSH: {$33,560 × [(0.711×1.4142) + 0.289] × 0.8929} + $14,007.26=$52,797.78

Capital Cost-to-Charge-Ratio to Total Cost-to-Charge Ratio = [(Capital Cost-to-Charge Ratio)/(Operating Cost-to-Charge Ratio + Capital Cost-to-Charge Ratio)]: {(.06)/(.50+.06)} = 0.1071

Capital Outlier Threshold = (Fixed Loss Threshold × Geographic Adjustment Factor × Large Urban Add-On × Capital CCR to Total CCR) + Federal Payment with IME and DSH: ($33,560×1.2679×1.03×0.1071) + $1,210.12=$5,904.02

Step 4: Determine outlier payment.

Marginal Cost Factor = 0.80

Outlier Payment = (Costs—Outlier Threshold) × Marginal Cost Factor

Operating Outlier Payment = ($75,000 − $52,797.78) × 0.80=$17,761.78

Capital Outlier Payment = ($9,000 − $5,904.02) × 0.80=$2,476.78

2. Cost-to-Charge Ratios

Under our existing regulation at § 412.84(h), the operating cost-to-charge ratio and, effective with cost reporting periods beginning on or after October 1, 1991, the capital cost-to-charge ratio used to adjust covered charges are computed annually by the intermediary for each hospital based on the latest available settled cost report for that hospital and charge data for the same time period as that covered by the cost report.

In the September 30, 1988 final rule with comment period published in the **Federal Register** (53 FR 38503), we initiated the use of hospital-specific cost-to-charge ratios to determine hospitals' costs for assessing whether a case qualified for payment as a cost outlier. Prior to that change, we determined the cost of discharges based on a nationwide cost-to-charge ratio of 60 percent. We indicated at the time that the use of hospital-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.

Currently, cost-to-charge ratios are determined using the most recent settled cost report for each hospital. At

the end of the cost reporting period, Medicare charges from all claims are accumulated through the Provider Statistical and Reimbursement Report (PS&R). The PS&R contains data such as the number of discharges and the actual charges from each hospital. The hospital also submits a cost report to its fiscal intermediary, which is used to determine total allowable inpatient Medicare costs. Once all these data are available, the fiscal intermediary then determines the cost-to-charge ratio for the hospital by using charges from the PS&R and costs from the cost report.

The Congress intended that outlier payments would be made only in situations where the cost of care is extraordinarily high in relation to the average cost of treating comparable conditions or illnesses. Under our existing outlier methodology, if hospitals' charges are not sufficiently comparable in magnitude to their costs, the legislative purpose underlying the outlier regulations is thwarted.

Recent analysis indicates that some hospitals have taken advantage of two vulnerabilities in our methodology to maximize their outlier payments. One vulnerability is the time lag between the current charges on a submitted bill and the cost-to-charge ratio taken from the most recent settled cost report. The second vulnerability, in some cases, is that hospitals may increase their charges so far above costs that their cost-to-charge ratios fall below 3 standard deviations from the geometric mean of cost-to-charge ratios and a higher statewide average cost-to-charge ratio is applied. In a March 5, 2003 IPPS proposed rule (68 FR 10420) and a March 7, 2003 LTCH PPS proposed rule (68 FR 11234) that are discussed in sections II., III., IV., V., and VI., and section VII., respectively, of this final rule, we proposed to implement new regulations to correct these vulnerabilities and to ensure outlier payments are paid only for truly high-cost cases.

Because the fixed-loss threshold is determined based on hospitals' historical charge data, hospitals that have been inappropriately maximizing their outlier payments have caused the threshold to increase dramatically for FY 2003, and even more dramatically for the proposed IPPS FY 2004 outlier threshold of $50,645 (68 FR 27235, May 19, 2003). As illustrated by the table below, the IPPS cost outlier threshold increased by 80 percent from $9,700 in FY 1997 to $17,550 in FY 2001. In addition, the cost outlier threshold increased by 91 percent from $17,550 in FY 2001 to $33,560 in FY 2003. The proposed FY 2004 threshold would be a 51-percent increase over the FY 2003 threshold. The table also demonstrates, for FYs 2000 and 2001, the level at which the threshold would have to have been set in order to result in outlier payments equal to 5.1 percent of total DRG payments (absent further behavioral responses by hospitals).[1] We are required by section 1886(d)(2)(E) of the Act to apply an offset to the average standardized amounts equal to the projected outlier payments as a percentage of total DRG payments. We have historically projected outlier payments to be 5.1 percent of total DRG payments.

Fiscal year	Outlier percentage	Payments in excess of target of 5.1 percent[1] (in billions of dollars)	Outlier threshold	Threshold that would have paid out 5.1 percent
1997	5.5	$0.3	$9,700	.....
1998	6.5	1.0	11,050	.....
1999	7.6	1.8	11,100	.....
2000	7.6	1.8	14,050	21,825
2001	7.7	1.9	17,550	26,200
2002	7.9	2.5	21,025	([2])
2003	6.1	([2])	33,560	.....

[1] All payments are estimated and reflect operating payments only (not capital payments).
[2] Not available.

II. Issuance of Proposed Rules

On March 5, 2003, we published in the **Federal Register** (68 FR 10420) a proposed rule that would change the methodology for establishing how extraordinarily high-cost cases (cost-outliers) qualify for an outlier payment. On March 7, 2003, as part of the proposed rule published in the **Federal Register** (68 FR 11234) to update the payment rates and policies under the LTCH PPS, we included a proposal to apply a similar change in the methodology for establishing outlier payments for LTCHs. We proposed these changes in the payment methodology for both systems in order to correct situations in which rapid increases in charges by certain hospitals have resulted in their cost-to-charge ratios being set too high. Use of these cost-to-charge ratios has resulted in excessive outlier payments to these hospitals.

We received approximately 582 timely pieces of correspondence on the provisions of the March 5, 2003 IPPS outlier proposed rule. We received approximately 22 timely pieces of correspondence on the provisions of the March 7, 2003 LTCH PPS proposed rule that related to payment for outlier cases. In this section of this final rule, we discuss comments we received that are not related to the specific changes we proposed, but are instead more general comments related to outlier payment policies. We also discuss in this section the general issue of allowing a transition period for the changes we are implementing.

Comments directly related to specific proposals to revise the IPPS outlier payment policy and our responses to those comments are addressed in sections III., IV., V., and VI. of this final rule. Comments directly related to the specific proposed LTCH PPS outlier payment policy changes and our responses to those comments are addressed in section VII. of this final rule.

We received a number of comments that, while directly or indirectly related to outlier policy, were unrelated to the policies discussed in the proposed rule. We have not responded to comments that are unrelated to the changes that were proposed in the March 5, 2003

[1] We estimate the FY 2003 percent of outlier payments compared to total DRG payments is 6.1 percent. Although in the May 19, 2003 FY 2004 IPPS proposed rule, we estimated this percentage to be 5.5 percent, we have now determined that this percentage was underestimated.

proposed rule and that are implemented in this final rule. We also received many detailed comments pertaining to specific implementation issues associated with these changes. We also are not addressing them in this final rule, but intend to issue implementation instructions separately and will respond to these comments at that time.

Comment: One commenter suggested that we reinstitute day outliers as an alternative to the current case methodology for outlier payments. The commenter reasoned that day outliers would more fairly and equitably pay hospitals for treating high-cost cases and would allow for payment of an outlier based on the length of stay of a particular Medicare beneficiary.

Response: Section 1886(d)(5)(A)(i) of the Act eliminates day outlier payments for discharges occurring on or after October 1, 1997. This provision was enacted in recognition of the fact that the high costs of a case are a preferable indicator of whether a case merits additional payments as an outlier than a long length stay. Furthermore, although we recognize that the issues with our current methodology for making outlier payments that are discussed in this final rule indicate the need for changes to that methodology, we believe that, after implementation of these changes, it will still be preferable to continue to use high costs to identify outlier cases.

Comment: Several commenters argued that, in the past, CMS has provided a transition period for the introduction of the capital PPS and for the removal of graduate medical education salaries from the calculation of the IPPS wage index. Therefore, the commenters recommended that a similar transition period be applied for any changes to outliers as well.

MedPAC recommended no transition period because, in recent years, some hospitals have received extra payments as a result of substantial outlier revenues. MedPAC further noted that this issue has been prominent in the news media for many months and hospitals have had sufficient opportunity to anticipate the end of these revenues and plan accordingly.

Another commenter also suggested that a transition period was unnecessary and recommended an immediate implementation date because most of the proposed changes will benefit those hospitals that did not try to game the system. In addition, the commenter believed that the proposed changes are designed to correct program abuses and any transition period would serve no legitimate public purpose and would only delay the phaseout of an otherwise overstated threshold.

Some commenters asked that CMS implement the proposals beginning on or after October 1, 2003, in order to allow fiscal intermediaries and hospitals adequate time to update their processing systems. The commenters added that if the proposals are implemented effective October 1, 2003, no disruption would be made mid-year to the cost report; that is, only entire cost reports would be reconciled once the cost report is final settled.

Response: As discussed above, the current outlier payment methodology includes two distinct vulnerabilities that some hospitals have exploited to dramatically increase their outlier payments over a brief period of time by raising their charges in excess of increases in their costs. As these increases in outlier payments to those hospitals are reflected in the data used to calculate the outlier thresholds, they force the outlier threshold to rise so that the projected outlier payout is equal to the outlier offset to the standardized amounts. The result is that hospitals that do not aggressively increase their charges do not receive outlier payments or receive reduced outlier payments for truly costly cases.

An extended transition period would allow the effects of this inappropriate redistribution of outlier payments to continue into the future. We believe it is essential to eliminate those effects as soon as possible in order to ensure that outlier payments are made only for truly high-cost cases. Although, for reasons discussed below, we are delaying implementation of some aspects of the changes we are making until October 1, 2003, we are not transitioning any of these changes beyond that date.

III. Updating Cost-to-Charge Ratios for IPPS Hospitals

A. Background and Provisions of the May 5, 2003 Proposed Rule

Currently, we use the most recent settled cost report when determining cost-to-charge ratios for IPPS hospitals. Generally, the covered charges on bills submitted for payment during FY 2003 are converted to costs by applying a cost-to-charge ratio from cost reports that began in FY 2000 or, in some cases, FY 1999 or even earlier. These covered charges reflect all of a hospital's charge increases to date, in particular those that have occurred since FY 2000 and are not reflected in the FY 2000 cost-to-charge ratios. If a hospital's rate-of-charge increases since FY 2000 exceeds the rate of the hospital's cost increases during that time, the hospital's cost-to-charge ratio based on its FY 2000 cost report will be too high, and applying it to current charges will overestimate the hospital's costs per case during FY 2003. Overestimating costs may result in some cases receiving outlier payments when these cases, in actuality, are not high-cost cases.

Because a hospital has the ability to increase its outlier payments during the time lag between the current charges and the cost-to-charge ratio from the settled cost report, through dramatic charge increases, in the March 5, 2003 IPPS outlier payment proposed rule, we proposed new regulations at § 412.84(i)(1) that would allow fiscal intermediaries to use more up-to-date data when determining the cost-to-charge ratio for each hospital. As mentioned above, currently, fiscal intermediaries use the hospital's most recent settled cost report. We proposed to revise our regulations to specify that fiscal intermediaries will use either the most recent settled cost report or the most recent tentative settled cost report, whichever is from the later cost reporting period.

Hospitals must submit their cost reports within 5 months after the end of their fiscal year. CMS makes a decision to accept a cost report within 30 days. Once the cost report is accepted, CMS makes a tentative settlement of the cost report within 60 days. The tentative settlement is a cursory review of the filed cost report to determine the amount of payment to be paid to the hospital if an amount is due on the as-filed cost report. After the cost report is tentatively settled, it can take 12 to 24 months, depending on the type of review or audit, before the cost report is final-settled. Thus, using cost-to-charge ratios from tentative settled cost reports, as we proposed in the March 5, 2003 proposed rule, reduces the time lag for updating cost-to-charge ratios by a year or more.

However, even the later ratios calculated from the tentative settled cost reports would overestimate costs for hospitals that have continued to increase charges much faster than costs during the time between the tentative settled cost report period and the time when the claim is processed. That is, even though we proposed to reduce the lag in time by revising the regulations to use the latest tentative settled cost report rather than the latest settled cost report, if the cost report is from a later cost reporting period, there would still be a lag of 1 to 2 years during which a hospital's charges may still increase faster than costs. Therefore, we proposed to add a new provision to the regulations that, in the event more

recent charge data indicate that a hospital's charges have been increasing at an excessive rate (relative to the rate-of-increase among other hospitals), CMS would have the authority to direct the fiscal intermediary to change the hospital's operating and capital cost-to-charge ratios to reflect the high charge increases evidenced by the later data. In addition, we proposed to allow a hospital to contact its fiscal intermediary to request that its cost-to-charge ratios, otherwise applicable, be changed if the hospital presents substantial evidence that the ratios are inaccurate. Any such requests would have to be approved by the CMS Regional Office with jurisdiction over that fiscal intermediary.

B. Summary of Public Comments and Departmental Responses

Comment: Several commenters were troubled by our proposal that CMS would have the authority to direct fiscal intermediaries to change a hospital's cost-to-charge ratio based on excessive charges, and the proposal that would allow a hospital to contact its fiscal intermediary to request its cost-to-charge ratio be changed if the hospital presents substantial evidence to support its request. Specifically, the commenters requested that CMS establish clear guidelines for both processes and define what constitutes ''excessive charges'' and ''substantial evidence.''

One commenter noted that some hospital cost reports from 1997 have still not been settled. The commenter asked that there be a graduated update of the cost-to-charge ratio data, updating the data by no more than 2 years in any payment period. For example, the commenter stated, a hospital currently paid using 1997 data would be updated to 1999 in the first payment period under the new methodology and to 2001 in the second period.

Response: Although we understand the commenters' desire that thresholds and parameters established in advance be used to determine when CMS will direct the fiscal intermediaries to apply a cost-to-charge ratio different than one calculated using the latest tentative settled cost report or the latest settled cost report, whichever is from the latest period, we also believe it is important for CMS to have the flexibility to respond appropriately in the future if unforeseen evidence of similar manipulation of outlier payments comes to light. We believe that establishing fixed thresholds in the regulations or in preamble language could limit our ability to respond quickly to stop such abuse. In addition, we believe that predetermined and public thresholds can serve as benchmarks for those hospitals intending to inappropriately maximize outlier payments in the future and would allow hospitals to operate just below the threshold to avoid detection.

With regard to the standards we would apply to determine whether we would direct the fiscal intermediaries to apply a different cost-to-charge ratio (for example, ''excessive charges''), we would compare hospitals' rate-of-increase in charges to the rate-of-increase among other hospitals. Hospitals with increases in charges that are far above the national average rate-of-increase, for example, would be likely to have an alternative ratio assigned. These hospitals would then have the opportunity to request that an alternative ratio be assigned by presenting substantial evidence in support of their request. Such evidence, for example, would be documentation that the hospitals' costs had increased, leading to the increase in charges. At this time, we are still developing the specific procedures involved and plan to issue further guidance through program memoranda.

However, we recognize that, for some hospitals, updating to the cost-to-charge ratio calculated using the latest tentative settled cost reports may represent a substantial leap forward in the data and a potentially large decrease in their cost-to-charge ratios. Although we believe it is appropriate that all hospitals' charges are adjusted by the most accurate cost-to-charge ratio when estimating costs, we recognize the potential negative impact that may occur for some hospitals solely due to the delay in settling their cost reports. Therefore, in this final rule, we are not mandating use of the latest settled or tentatively settled cost report for discharges occurring prior to October 1, 2003. This delay in the effective date from that proposed in the proposed rule should ease the burden of the change in cost-to-charge ratios for most hospitals.

Although we are implementing the change to require the use of the latest of the settled or tentative settled cost report to compute the cost-to-charge ratio for discharges occurring on or after October 1, 2003, we believe that it is necessary to implement the other proposed provision authorizing CMS to specify an alternative cost-to-charge ratio for some hospitals, to be effective for discharges occurring on or after August 8, 2003. Such an alternative would reflect available data, such as the most recent rate-of-increase in charges, to approximate the most accurate cost-to-charge ratio (which may include data in the latest tentatively settled cost report or other data that may be available).

Although this provision will be effective for all hospitals 60 days after the date of publication of this final rule, we understand that, given the large workload and limited resources of our fiscal intermediaries, attempting to implement this provision for all hospitals receiving outlier payments at the same time would create an administrative burden. In addition, given the effective date of this final rule, most of the changes in this regulation will apply only for approximately the last 2 months of FY 2003. We are aware that hospitals have projected their outlier payments for the current fiscal year based on the policies in effect as of October 1, 2002, and any change in the middle of the fiscal year could disrupt their budgets. As a result, we intend to limit the impact of this provision during FY 2003 to ensure that the limited resources of fiscal intermediaries are focused upon updating the cost-to-charge ratios for those hospitals that appear to have disproportionately benefited from the time lag in updating their cost-to-charge ratios and to maintain the overall predictability of FY 2003 payments for most hospitals. Accordingly, we intend to issue a program instruction in the near future to assist fiscal intermediaries in implementing this provision during the remainder of FY 2003. The criteria for FY 2004 will target a somewhat broader group of hospitals, but will still be limited to those hospitals that have benefited the most from the time lag in updating cost-to-charge ratios, and the majority of hospitals will not be affected.

Comment: Some commenters suggested a transition period for implementing the adoption of the latest tentative settled cost-to-charge ratios and gave a detailed recommendation of how the transition period would be implemented. The commenters recommended two different methods for how a transition period could be implemented:

One recommendation was that FY 2002 would be considered the base year amount. The commenter explained that, beginning with the effective date of the final rule, hospitals would receive a blended cost-to-charge ratio of its base year amount and the cost-to-charge ratio from the most recent tentative cost report. In the first year, hospitals' cost-to-charge ratios would consist of 66.7 percent from a base year and 33.3 percent from the most recent tentative settled cost report. In the second year the cost-to-charge ratio would consist of 33.3 percent from the base year and 66.7

percent from the most recent tentative settled cost report. In the third year, this gradual decrease from the base year could continue or CMS could cease from blending the cost-to-charge ratio.

The second recommendation was a 3-year transition period using blended cost-to-charge ratios as follows: The first year would be 75 percent of the old cost-to-charge ratio and 25 percent of the new. The second year would be 50 percent of the old cost-to-charge ratio and 50 percent of the new cost-to-charge ratio. The third year would be 25 percent of the old cost-to-charge ratio and 75 percent of the new cost-to-charge ratio. During the transition period, CMS would monitor outlier payments to ensure they remain in statutory limits. Only those hospitals that have not been identified by CMS as having excessive outlier payments would qualify for the transition period.

Response: As noted previously, we believe it is essential to eliminate the effects of the inappropriate redistribution of outlier payments as soon as possible; that is, by not allowing hospitals that have benefited from the time lag resulting from the use of the latest settled cost-to-charge ratios to continue to do so. We do not believe any transition period would be appropriate, as it would continue to lead to lower outlier payments to those hospitals that have already been harmed by the inappropriate redistribution of outliers described above. Therefore, although in this final rule we are delaying the effective date of this provision until discharges occurring on or after October 1, 2003, so that most hospitals that had relied on outlier payments based on existing policy may continue to do so for the remainder of the Federal fiscal year, we are not adopting the commenters' suggestions to further delay the effective date by allowing for a blended cost-to-charge ratio.

Comment: Several other commenters offered different recommendations on how CMS should administer updating of a hospital's cost-to-charge ratio. One commenter recommended that hospitals be notified in advance of any change to their cost-to-charge ratio and be given the opportunity to appeal the fiscal intermediary's decision of any change to their cost-to-charge ratio. Another commenter suggested that parameters be set, such as those in Program Memorandums A–02–122 (released December 3, 2002) and A–02–126 (released December 20, 2002), to determine when a cost-to-charge ratio should be updated. One commenter proposed that CMS use an expedited process when a hospital is requesting that its cost-to-charge ratio be decreased and not require the use of ''substantial evidence'' for a reduction. For increases in cost-to-charge ratios, the commenter suggested that CMS might want to reserve final approval and substantial evidence standards. Other commenters suggested that hospitals be provided with an expedited appeals process to resolve quickly any disputes with the fiscal intermediaries over the accuracy of their cost-to-charge ratios. Some commenters supported using a hospital's tentative settled cost report to update cost-to-charge ratios but believed that fiscal intermediaries should have discretion to change a hospital's cost-to-charge ratio.

Response: As we proposed, in this final rule we are implementing a new regulation that specifies that CMS may direct the fiscal intermediary to change a hospital's operating and capital cost-to-charge ratios to reflect the high-charge increases evidenced by the later data. Fiscal intermediaries will not have their own discretion to update a hospital's cost-to-charge ratio. Only CMS will have the authority to direct the fiscal intermediary that an update is necessary in the event more recent charge data indicates that a hospital's charges have been increasing at an excessive rate (relative to the rate-of-increase among other hospitals).

C. Provisions of the Final Rule Relating to Updating Cost-to-Charge Ratios

We are establishing a new § 412.84(i)(1), which specifies that, for discharges occurring on or after 60 calendar days after the date of publication of this final rule, in the event more recent charge data indicate that a hospital's charges have been increasing at an excessive rate (relative to the rate-of-increase among other hospitals), CMS may direct the fiscal intermediary to change the hospital's operating and capital cost-to-charge ratios to reflect the high-charge increases evidenced by the later data. A hospital may also request that its fiscal intermediary use a different (higher or lower) cost-to-charge ratio based on substantial evidence presented by the hospital. Before the change can go into effect, the CMS Regional Office must approve the request.

We also are establishing § 412.84(i)(2), which provides that, for discharges occurring on or after October 1, 2003, the operating and capital cost-to-charge ratios applied at the time a claim is processed are based on either the most recent settled cost report or the most recent tentative settled cost report, whichever is from the latest cost reporting period.

IV. Statewide Average Cost-to-Charge Ratios

A. Background and Provisions of the March 5, 2003 Proposed Rule

As hospitals raise their charges faster than their costs increase, over time their cost-to-charge ratios will decline. If hospitals continue to increase charges at a faster rate than their costs increase over a long period of time, or if they increase charges at extreme rates, their cost-to-charge ratios may fall below the range considered reasonable under the regulations (0.194 for operating cost-to-charge ratios and 0.012 for capital cost-to-charge ratios in FY 2003 (67 FR 50125)), and, under current regulations at § 412.84(h), their fiscal intermediaries will assign a statewide average cost-to-charge ratio. These statewide averages are generally considerably higher than the threshold. Therefore, under existing regulations, these hospitals benefit from an artificially high ratio being applied to their already high charges. Furthermore, hospitals can continue to increase charges faster than costs, without any further downward adjustment to their cost-to-charge ratios.

For example, in a 3-year span, one hospital was found to have an increase in charges of 60 percent from FY 1999 to FY 2000, 35 percent from FY 2000 to FY 2001, and 13 percent from FY 2001 to FY 2002. This hospital's actual operating cost-to-charge ratio for FY 2003 was 0.093. Because this number is below the threshold of 0.194, the fiscal intermediary assigned this hospital the statewide average cost-to-charge ratio of 0.328 (from Table 8A of the August 1, 2002 IPPS final rule (67 FR 50263)). In this case, the assignment of the statewide average cost-to-charge ratio to this hospital increased the hospital's estimated costs per case far above the estimate using the actual ratio, leading to substantially higher outlier payments to the hospital as a result of this policy.

In December 2002, we issued Program Memorandum A–02–122, which requested fiscal intermediaries to identify all hospitals receiving the statewide average operating or capital cost-to-charge ratio because their cost-to-charge ratios fell below the floor of reasonable parameters. We received a list of 43 hospitals that were assigned the statewide average operating cost-to-charge ratio and 14 hospitals that were receiving the statewide average capital cost-to-charge ratio. Three hospitals were found on both lists. Prior to application of the statewide average cost-to-charge ratios, the average actual operating cost-to-charge ratio for the 43 hospitals was 0.164, and the average actual capital cost-to-charge ratio for the

14 listed hospitals was 0.008. In contrast, the statewide average operating cost-to-charge ratio for the 43 hospitals was 0.3425 and the statewide average capital cost-to-charge ratio for the 14 hospitals was 0.035.

Because of hospitals' ability to increase their charges to lower their cost-to-charge ratios in order to be assigned the statewide average, in the March 5, 2003 proposed rule, we proposed to remove the requirement in our existing regulations that specified that a fiscal intermediary will assign a hospital the statewide average cost-to-charge ratio when the hospital has a cost-to-charge ratio that falls below the floor. We proposed that hospitals would receive their actual cost-to-charge ratios, no matter how low their ratios fall.

We proposed that statewide average cost-to-charge ratios would still apply in those instances in which a hospital's operating or capital cost-to-charge ratio exceeds the upper threshold. We indicated that cost-to-charge ratios above this range are probably due to faulty data reporting or entry and should not be used to identify and pay for outliers. In addition, we proposed that hospitals that have not yet filed their first Medicare cost reports with their fiscal intermediaries would still receive the statewide average cost-to-charge ratios.

B. Summary of Public Comments and Departmental Responses

Comment: Many commenters supported the proposal to remove the existing requirement that specified that a fiscal intermediary will assign a hospital the statewide average cost-to-charge ratio when the hospital has a cost-to-charge ratio that falls below the floor. However, they argued that the requirement to use the statewide average ratio for those hospitals that are above 3 standard deviations from the geometric mean should also be removed. The commenters reasoned that the policy should be consistent for the floor and the ceiling. As an alternative to using the statewide average (instead of ratios above the ceiling), some commenters suggested that we reduce the parameter of 3 standard deviations above the mean to a lower standard. Another commenter stated that CMS was acting in bad faith by eliminating the statewide average for the floor but not the ceiling.

Response: The changes we are making in this final rule are in response to a specific problem associated with hospitals intentionally taking advantage of our policy to assign the statewide cost-to-charge ratios when a hospital's own ratio fell below the floor. There is no similar incentive for hospitals to increase their ratios to the ceiling. Also, we believe it is unlikely a hospital would maintain a cost-to-charge ratio as high as 3 standard deviations of the geometric mean over a period of years. Therefore, we continue to believe the statewide average should be assigned for those hospitals with ratios above the ceiling.

Comment: One commenter argued that a transition period would be necessary because this change would have an immediate impact on affected hospitals' credit stability and patient service levels in certain regions. Another commenter suggested a transition period for those hospitals that did not engage in aggressive pricesetting. The commenter suggested a gradual phaseout of the statewide average. On the other hand, many commenters also supported the immediate elimination of the statewide average from the floor.

Response: We believe that, for hospitals receiving the statewide average cost-to-charge ratio because their actual ratio fell below 3 standard deviations below the geometric mean, their actual ratio is a more accurate reflection of the relationship between their costs and charges. Although it may not have been a specific objective of each hospital currently in this situation to increase charges until its ratio fell below the floor, we are not persuaded there is any justification to continue making outlier payments to these hospitals on the basis of a cost-to-charge ratio that clearly results in excessive outlier payments. Therefore, we are adopting as final the proposed change that eliminates the use of the statewide average for hospitals below 3 standard deviations from the geometric mean effective for discharges occurring on or after 60 calendar days after the date of publication of this final rule.

C. Provisions of the Final Rule Relating to Statewide Average Cost-to-Charge Ratios

We are implementing new regulations at §§ 412.84(h) and (i)(1) that are effective 60 calendar days after the date of publication of this final rule, that remove the existing requirement that a fiscal intermediary will assign a hospital the statewide average cost-to-charge ratio when the hospital has a cost-to-charge ratio that falls below the floor. Hospitals will receive their actual cost-to-charge ratios, no matter how low their ratios fall.

The statewide average cost-to-charge ratios will still apply in those instances in which a hospital's operating or capital cost-to-charge ratios fall outside of reasonable parameters (that is, exceed the upper threshold). In addition, hospitals that have not yet filed their first Medicare cost reports with their fiscal intermediaries would still receive the statewide average cost-to-charge ratios. CMS will continue to set forth the reasonable parameters and the statewide cost-to-charge ratios in each year's annual notice of prospective payment rates published in the **Federal Register** in accordance with § 412.8(b).

V. Reconciling Outlier Payments Through Settled Cost Reports

A. Background and Provisions of the March 5, 2003 Proposed Rule

Under the IPPS, hospitals submit a bill for each Medicare patient stay for which they expect a payment from Medicare. The bill includes information needed to: (1) Classify the case to a DRG; (2) determine whether the case was a transfer; (3) identify whether a new technology eligible for add-on payments was involved; and (4) calculate the costs of a case to determine whether it is eligible for an outlier payment or a new technology add-on payment. This latter calculation is based on the covered charges reported on the bill, which, as discussed above, are also used to estimate the covered costs of the case by applying the cost-to-charge ratio.

The information from the bill is processed through the fiscal intermediary's claims processing system to determine the payment amount for each case. Unless a hospital qualifies for periodic interim payments under § 412.116(b), or other interim payments, payment is made on the basis of the actual amount determined for each bill processed. For hospitals that qualify for periodic interim payments, the fiscal intermediary estimates a hospital's IPPS payments and makes biweekly payments equal to 1/26 of the total estimated amount of payment for the year. However, outlier payments are not made on an interim basis, but are made on a claim-by-claim basis (even for hospitals that qualify for interim payments under § 412.116(b)), and generally represent final payment (§ 412.116(e)). This policy is in contrast to payments under the IME adjustment and the DSH adjustment, both of which are routinely adjusted when hospitals' cost reports are settled to reflect updated data such as the number of residents or patient days during the actual cost reporting period.

However, as stated earlier in this preamble, we are increasingly aware that some hospitals have taken advantage of the existing outlier policy

by increasing their charges at extremely high rates, knowing that there would be a time lag before their cost-to-charge ratios would be adjusted to reflect the higher charges. The steps we proposed in the March 5, 2003 proposed rule, and are implementing here, to direct fiscal intermediaries to update cost-to-charge ratios using the most recent tentative settled cost reports (and in some cases, even later data) and using actual rather than statewide average ratios for hospitals that have cost-to-charge ratios higher than 3.0 standard deviations below the geometric mean cost-to-charge ratio, would greatly reduce the opportunity for hospitals to manipulate the system to maximize outlier payments. However, these steps would not completely eliminate all such opportunity. A hospital would still be able to dramatically increase its charges by far above the rate-of-increase in costs during any given year. This possibility is of great concern, given the recent findings that some hospitals have been able to receive large outlier payments by doing just that.

Therefore, 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, payments would be processed throughout the year using operating and capital 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 operating and capital cost-to-charge ratios calculated based 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 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. We indicated in the proposed rule that we were still assessing the procedural modifications that would be necessary to implement this change.

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 final outlier payments are made, they would reflect an accurate assessment of the actual costs the hospital incurred. Nevertheless, a final vulnerability remains. Even though the final payment would reflect a hospital's true cost experience, there would still be the opportunity for a hospital to manipulate its outlier payments by dramatically increasing charges during the year in which the discharge occurs. In this situation, the hospital would receive excessive outlier payments, which, although the hospital would incur an overpayment and have to refund the money when the cost report is settled, would allow the hospital to obtain excess payments from the Medicare Trust Fund on a short-term basis.

Under section 1886(d)(5)(A)(iii) of the Act, the amount of any outlier payment should ''approximate the marginal cost of care'' in excess of the DRG payment and the fixed-loss threshold. Accordingly, because a hospital would have had access to any excess outlier payments until they are repaid to the Trust Fund (or, in the case of an underpayment, would not have had access to the appropriate amount during the same period), it may be necessary to adjust the amount of the final outlier payment to reflect the time value of the funds for that time period. Therefore, we proposed to add § 412.84(m) to provide that when the cost report is settled, outlier payments would be subject to an adjustment to account for the value of the money during the time period it was inappropriately held by the hospital. This adjustment would also apply in cases where outlier payments were underpaid to the hospital. In those cases, the adjustment would result in additional payments to hospitals. 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 (or when additional payments are issued, in the case of underpayments). This adjustment to reflect the time value of a hospital's outlier payments would ensure that the outlier payment received by the hospital at the time its cost report is settled appropriately reflects the hospital's approximate marginal costs, in excess of the DRG payment and fixed-loss threshold, of providing the care.

This proposed adjustment was also intended to account for the unique susceptibility of outlier payments to manipulation. Hospitals set their own level of charges and are able to change their charges, without review by their fiscal intermediaries. As outlined above, changes in charges directly affect the level of outlier payments. This lack of fiscal intermediary review of a factor affecting a hospital's payments is in contrast to other IPPS adjustments, such as the IME adjustment or the DSH adjustment, where the fiscal intermediary must agree to a change to the determining factor (the resident-to-bed ratio or the share of low-income patients, respectively).

Under section 1886(d)(5)(A)(iv) of the Act, outlier payments for any year must be projected to be not less then 5 percent nor more than 6 percent of the total estimated operating DRG payments plus outlier payments. Section 1886(d)(3)(B) of the Act requires the Secretary to reduce the average standardized amounts by a factor to account for the estimated proportion of total DRG payments made to outlier cases. Despite the fact that each individual hospital's outlier payments may be subject to adjustment when the cost report is settled, we continue to believe that the fixed-loss outlier threshold (discussed in section VI. of this final rule) should be based on projected payments using the latest available historical data without retroactive adjustments, either midyear or at the end of the year, to ensure that actual outlier payments are equal to 5.1 percent of total DRG payments. That is, our proposed change was intended only to allow for use of the actual cost-to-charge ratio from the cost reporting period that corresponds to the discharges for which the outlier payments are made to adjust outlier payments to reflect the hospital's true costs of providing care. This adjustment would be made irrespective of whether the nationwide percentage of outlier payments relative to total operating DRG payments is equal to the outlier offset that is applied to the average standardized amounts (generally, 5.1 percent).

Outlier payments are intended to recognize the fact that hospitals occasionally treat cases that are extraordinarily costly and otherwise not adequately compensated under an average-based payment system. However, we can only estimate actual costs based on the charges for a case because charges are the only data available that indicate the resource usage for an individual case. Therefore, our ability to identify true outlier cases is dependent on the accuracy of the cost-to-charge ratios. To the extent some hospitals may be motivated to maximize outlier payments by taking advantage of the lag in updating the cost-to-charge

ratios, the payment system remains vulnerable to overpayments to individual hospitals. Therefore, we believe the only way to eliminate the potential for such overpayments is to provide a mechanism for final settlement of outlier payments using actual cost-to-charge ratios from final settled cost reports.

However, the fixed-loss outlier threshold is an important aspect of the prospective nature of the IPPS. The outlier payment policy is designed to alleviate any financial disincentive hospitals may have against providing any medically necessary care their patients may require, even those patients who become very sick and require extraordinary resources. The preestablished threshold allows hospitals to approximate their Medicare payment for an individual patient while that patient is still in the hospital. Even though we proposed to make outlier payments susceptible to a reconciliation based on the hospital's actual cost-to-charge ratios during the contemporaneous cost reporting period, the hospital should still be in a position to make this approximation. Hospitals have immediate access to the information needed to determine what their cost-to-charge ratio will be when their cost reports are settled. Even if the final cost-to-charge ratio is likely to be different from the ratio used initially to process and pay the claim, as noted above, hospitals not only have the information available to estimate their cost-to-charge ratios, but also have the ability to control them, through the structure and levels of their charges.

If we were to make retroactive adjustments to outlier payments to ensure total payments are 5.1 percent of DRG payments (by retroactively adjusting outlier payments), we would be removing this important aspect of the prospective nature of the IPPS. Because such an across-the-board adjustment would either lead to more or less outlier payments for all hospitals, hospitals would no longer be able to reliably approximate their payment for a patient while the patient is still hospitalized. We believe it would be neither necessary nor appropriate to make such an aggregate retroactive adjustment.

Furthermore, we believe it is consistent with the intent of the language at section 1886(d)(5)(A)(iv) of the Act not to do so. This section calls for the Secretary to ensure that outlier payments are equal to or greater than 5 percent and less than or equal to 6 percent of projected or estimated (not actual) DRG payments. We believe this language reflects the intent of Congress regarding the prospectivity of the IPPS. However, we do not believe it prevents settling outlier payments based on hospitals' actual cost-to-charge ratios during the period when the discharge occurs.

B. Summary of Public Comments and Departmental Responses

Comment: Many commenters argued that it is inappropriate to reconcile outlier payments through settled cost reports because IPPS payments are prospective and any type of reconciliation would make outlier payments retrospective.

In addition, some commenters claimed that cost report reconciliation for outliers is inconsistent with the government's position in prior litigation involving the Medicare outlier payment methodology. The commenters cited *County of Los Angeles* v. *Shalala,* 192 F.3d 1005 (D.C. Cir. 1999), and stated that in this case the Secretary succeeded in arguing to the United States Court of Appeals for the District of Columbia that the Act does not require retroactive adjustments to outlier payments in order to ensure that the actual amount of outlier reimbursement furnished to hospitals is between 5 and 6 percent of the total payments made under IPPS, notwithstanding the language in section 1886(d)(5)(A)(iii) of the Act (42 U.S.C. 1395ww(d)(5)(A)(iii)) mandating that outlier payments may not be less than 5 percent nor more than 6 percent of the total payments projected or estimated to be made based on DRG prospective payment rates. The commenters further asserted that any reconciliation of outlier payments would be inconsistent with the government's policy of refusing to make retroactive adjustments to outlier payments when estimates and projections prove inaccurate.

Response: As an initial matter, our position in the court cases is more accurately presented as stating that the language of the statute does not clearly mandate that the actual amount of outlier payments must be between 5 and 6 percent of total payments and that our policy of not making retroactive adjustments to ensure that actual payments fall between that range is consistent with the intent of Congress. However, the commenter is correct that we have scrupulously guarded the prospective nature of the IPPS over the years. The IPPS has continued and served as a model for prospective payment systems for other provider types under Medicare because it is fair and predictable. We believe any change to the system, especially one as significant as making outlier payments subject to retroactive adjustments, must be evaluated in terms of its impact on those key characteristics of the IPPS.

As noted above and in the proposed rule, in light of the gross abuses of the current methodology by some hospitals and the negative impact such overpayments ultimately have on other hospitals due to their effect on the threshold, we believe the option of reconciling outlier payments based on the settled cost report for hospitals that have been initially paid using a significantly inaccurate cost-to-charge ratio compared to the actual ratio from the cost reporting period is now appropriate. In our view, reconciling outlier payments because they were originally paid on the basis of a significantly inaccurate cost-to-charge ratio is similar to recovering outlier payments when adjustments are made to covered charges for any services that are not found to be medically necessary or appropriate Medicare services upon medical or other review. This review is explicitly provided for at § 412.84(d). This provision was established when the IPPS was first implemented for FY 1984 (48 FR 39785).

The court cases referenced by the commenters all addressed the issue of whether outlier payments must be retroactively adjusted when the level of the threshold determined in advance of the fiscal year to which it applies ultimately results in actual outlier payments that are a smaller percentage of total DRG payments than was originally projected. We believe that an important goal of a PPS is predictability. Therefore, we believe that the fixed-loss outlier threshold should be projected based on the best available historical data and should not be adjusted retroactively. A retroactive change to the fixed-loss outlier threshold would affect all hospitals subject to the IPPS, thereby undercutting the predictability of the system as a whole.

However, if we deem it necessary as a result of a hospital-specific data variance to reconcile outlier payments of an individual hospital, such action on our part would not affect the predictability of the entire system. Rather, because each hospital is on notice as to our revised methodology for determining cost-to-charge ratios and that outlier payments are subject to possible reconciliation, and because each hospital has the necessary data regarding its own costs and charges to predict its actual cost-to-charge ratio, we are able to maintain the predictability of the system as a whole. Further, because reconciliation of outlier payments will affect only certain hospitals, the administrative burden of implementing such a policy is minimized.

Accordingly, we continue to believe that the fixed-loss outlier threshold should be based on projected payments using the latest available historical data without retroactive adjustments. This was our position in the court cases cited by the commenter, and it has been our consistent and often stated position, including above in this final rule and the March 5, 2003 proposed rule.

Comment: Some commenters suggested that we clarify how reconciliation will be implemented and only reconcile outlier payments to those providers whose cost-to-charge ratios increased or decreased outside of certain parameters. The commenters suggested that we reconcile outlier payments only for those hospitals that would otherwise receive substantial outlier overpayments or underpayments (for example, where the cost-to-charge ratio increased or decreased by 15 percent). Limiting any reconciliation to those hospitals would have the desired impact of focusing the attention of CMS on those hospitals that deserve additional scrutiny without placing such a burden on all hospitals. Another commenter believed the savings of reconciliation would be offset by the additional workload for fiscal intermediaries and hospitals.

One commenter suggested that we eliminate the proposal of reconciliation and use a quarterly or semiannual review similar to periodic interim payment reviews. The commenter explained that these reviews would be performed by a joint effort of the provider and the fiscal intermediary, resulting in interim cost-to-charge ratio adjustments throughout the fiscal year (with no lump-sum adjustment or individual claims adjustment), based on cost and charge data available from hospital records.

Response: In the proposed rule, we proposed to establish the authority for CMS to reconcile outlier payments, but we did not propose to require that all hospitals' outlier payments be reconciled. We acknowledge the commenters' concerns about the administrative costs associated with reprocessing and reconciling all inpatient claims and the desirability of limiting which hospitals' outlier payments will be reconciled. Therefore, we agree that any reconciliation of outlier payments should be done on a limited basis.

Moreover, although this provision is effective 60 days after the date of publication of this final rule, given the large workload and limited resources of our fiscal intermediaries, attempting to implement this provision for all hospitals receiving outlier payments at the same time would create an administrative burden. In addition, most of the changes in this regulation will apply for approximately the last 2 months of FY 2003. We intend to limit the impact of this provision during FY 2003 to ensure that the limited resources of fiscal intermediaries are focused upon those hospitals that appear to have disproportionately benefited from the time lag in updating their cost-to-charge ratios and to maintain the overall predictability of FY 2003 payments for most hospitals. Accordingly, we intend to issue a program instruction in the near future to assist fiscal intermediaries in implementing this provision during the remainder of FY 2003.

In the same program instruction, we will issue thresholds for fiscal intermediaries to reconcile outlier payments for other hospitals during FY 2003.

For cost reporting periods beginning during FY 2004, we are considering instructing fiscal intermediaries to conduct reconciliation for hospitals whose actual cost-to-charge ratios are found to be plus or minus 10 percentage points from the cost-to-charge ratio used during that time period to make outlier payments, and that have total FY 2004 outlier payments that exceed $500,000. We believe these thresholds would appropriately capture those hospitals whose outlier payments will be substantially inaccurate when using the ratio from the contemporaneous cost reporting period. Hospitals exceeding these thresholds during their applicable cost reporting periods would become subject to reconciliation of their outlier payments. These thresholds would be reevaluated annually and, if necessary, modified each year. However, fiscal intermediaries would also have the administrative discretion to reconcile additional hospitals' cost reports based on analysis that indicates the outlier payments made to those hospitals are significantly inaccurate.

We continue to believe that cost report reconciliation is the most appropriate way to ensure that outlier payments are made only for truly costly cases. We believe the type of ongoing reviews suggested by the commenter referenced above would be an inefficient approach to addressing this problem, because it would require extensive ongoing reviews of every hospital's cost and charge data. However, we believe the problems leading to this final rule actually occur among a limited number of hospitals.

Comment: Some commenters believed that reconciliation is unnecessary because the proposed changes that would eliminate the use of statewide averages and mandate use of the most recent tentative cost report would suffice to keep hospitals from gaming outliers. Therefore, they believed CMS should abandon its proposal to reconcile outlier payments.

Response: The steps we are taking in this final rule to direct fiscal intermediaries to update cost-to-charge ratios using the most recent tentative settled cost reports and using actual cost-to-charge ratios rather than statewide average ratios will greatly reduce the opportunity for hospitals to manipulate the system to maximize outlier payments. However, these steps will not completely eliminate all such opportunity. A hospital would still be able to dramatically increase its charges far above its rate-of-increase in costs during any given year in order to obtain excessive outlier payments. Therefore, we believe reconciliation is necessary to ensure that outlier payments are appropriately paid in the future.

Comment: One commenter suggested the use of a rolling 3-year average instead of reconciliation. The commenter explained that if a hospital is found to have a cost-to-charge ratio that significantly decreased over a short period of time, the cost-to-charge ratio that would be used to pay outliers would be projected by applying the 3-year average rate of change in cost-to-charge ratios over a rolling 3-year period. Cost reports used from that 3-year period would include the most recent audited or tentatively settled cost report for each year. The commenter provided an example where the cost-to-charge ratio from the most recent tentatively settled cost report is trended down to reflect the fact that over a longer period of time, charge increases have exceeded cost increases. This rolling 3-year average would be applied to hospitals that trigger this mechanism for a period of several years, until the period where the charge increases that gave rise to the use of the projection has worked its way through the method.

Response: The changes in this final rule are designed to take away any incentive for hospitals to seek outlier payments that are excessive. We believe the method recommended by the commenter still leaves the potential to game the system. For example, a hospital with a high cost-to-charge ratio can lower its charges substantially in any given year and receive extra outlier payments until the 3-year average is applied. Also, even after the 3-year moving average is applied, the hospital can continue to raise its charges in any given year and continue to receive outlier payments that do not reflect its

actual cost-to-charge ratio. At the end of the fiscal year, the hospital would receive a new cost-to-charge ratio based on its 3-year rolling average when in reality its actual cost-to-charge ratio is much lower. A hospital could continue to stay ahead of the system every year and receive outlier payments that do not reflect its actual cost-to-charge ratio. This is the exact behavior we are trying to prevent and, therefore, we believe we need to implement the process of reconciliation to dissuade hospitals from gaming the system.

Comment: Other commenters believed reconciliation would lead to further unpredictability and volatility in the Medicare payment system and would have implications for cost report simplification. Another commenter expressed similar concerns that some hospitals' cost reports may not be settled for longer than 2 to 3 years and would be subject to large overpayments that would then be subject to an adjustment for the time value of money. Similarly, a hospital's cost report can be reopened at a later date even after final settlement, which would cause further uncertainty if reconciliation had been conducted in the past.

Response: We plan to issue further guidance through program memoranda detailing the specific operational aspects of reconciling outlier payments on the cost report. At this time, we are still developing the specific procedures involved, including the exact timing of any reconciliation in terms of the cost reporting settlement process and the appeals process.

Comment: Several commenters argued that it would be inappropriate, illogical, and inconsistent with current policies to single-out outliers for adjustments to account for the time value of money. The commenters pointed out that other IPPS payment adjustments, such as IME and DSH, are subject to reconciliation but hospitals are not charged for the time value of money when those overpayments or underpayments are reconciled. However, another commenter agreed that outlier payments are substantially different from IME and DSH payments and the premise for adjusting for the time value of money with respect to outlier payments (when it is limited to situations where the cost-to-charge ratio is substantially inaccurate, and does not involve policy disputes) is not applicable to other adjustments such as IME and DSH.

Response: As we noted above and in the proposed rule, outlier payments are uniquely 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, unlike IME or DSH where the fiscal intermediary must agree to a change to the underlying data. Therefore, even though the 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 to apply an adjustment for the time value of overpayments or underpayments identified at cost report reconciliation. Because the other changes we are making in this final rule will largely ensure the payments hospitals receive for outlier cases are accurate, we do not anticipate it will be necessary to apply this adjustment broadly. Therefore, the actual total impact of this adjustment should be relatively small.

Comment: One commenter argued that there is no statutory authorization for this adjustment. The commenter referenced section 1815(d) of the Act (42 U.S.C. 1395g(d)), which provides that interest is charged when a final determination is made and payment is not made within 30 days of the date of the determination. The commenter concluded there is no authority to impose interest in any fashion except in a manner consistent with this statutory authorization, and, thus, the proposed time value adjustment should be withdrawn.

Response: The reference cited by the commenter authorizes Medicare to charge and pay interest when an overpayment or underpayment is made. However, the referenced statutory authority is not the basis for the proposal to adjust outlier payments for the time value of money when reconciliation is made. Rather, this adjustment is consistent with the statutory requirement at section 1886(d)(5)(A)(iii) that outlier payments approximate the marginal cost of care beyond the threshold. That is, because hospitals are uniquely able to manipulate outlier payments by increasing charges, it is necessary to establish a mechanism whereby an adjustment can be made to ensure payments appropriately reflect the true marginal costs of care for outlier cases. As a result, the outlier adjustment can be distinguished from other IPPS payment adjustments where interest is applied, such as IME or DSH, because changes to these adjustments are subject to review by the fiscal intermediary before additional payments are made.

C. Provisions of the Final Rule Relating to Reconciliation of Outlier Payments Through Settled Cost Reports

We are adding § 412.84(i)(3) to provide that, effective 60 calendar days after the date of publication of this final rule, outlier payments will become subject to adjustment when hospitals' cost reports coinciding with the discharge are settled.

Payments will be processed throughout the year using the appropriate historical operating and capital cost-to-charge ratios, consistent with the regulations. When the cost report is settled, any reconciliation of outlier payments by fiscal intermediaries will be based on operating and capital cost-to-charge ratios calculated based 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. We intend to issue program instructions to the fiscal intermediaries that will provide specific criteria for identifying those hospitals subject to reconciliation for the remainder of FY 2003 and for FY 2004. These criteria for FY 2003 will allow the fiscal intermediaries to focus their limited resources on only those hospitals that appear to have disproportionately benefited from the time lag in updating their cost-to-charge ratios. The criteria for FY 2004 will target a somewhat broader group of hospitals, but will still be limited to those hospitals that have benefited the most from the time lag in updating cost-to-charge ratios, and the majority of hospitals will not be affected. Also, fiscal intermediaries will have the administrative discretion to reconcile additional hospitals' cost reports based on analysis that indicates the outlier payments made to those hospitals are significantly inaccurate.

In addition, effective for discharges occurring on or after 60 calendar days after the date of publication of this final rule, for those hospitals for which reconciliation is necessary, outlier payments will be adjusted to account for the time value of any underpayments or overpayments (§ 412.84(m)).

VI. Fixed-Loss Outlier Threshold for IPPS Hospitals

A. Background and Provisions of the March 5, 2003 Proposed Rule

As noted above, under section 1886(d)(5)(A)(iv) of the Act, outlier payments for any year must be projected to be not less than 5 percent nor more than 6 percent of total estimated operating DRG payments plus outlier payments. Section 1886(d)(3)(B) of the

Act requires the Secretary to reduce the average standardized amounts by a factor to account for the estimated proportion of total DRG payments made to outlier cases. Similarly, section 1886(d)(9)(B)(iv) of the Act requires the Secretary to reduce the average standardized amounts applicable to hospitals in Puerto Rico to account for the estimated proportion of total DRG payments made to outlier cases.

In the August 1, 2002, IPPS final rule, we established the FY 2003 outlier fixed-loss threshold at $33,560 (67 FR 50122). This was a nearly 60-percent increase over the FY 2002 threshold of $21,025. The primary reason for this dramatic increase was a change in our methodology to use the rate of increase in charges rather than the rate-of-increase in costs to determine the threshold. That is, because we use FY 2001 cases to project the threshold for FY 2003, it is necessary to inflate the charges on the FY 2001 bills to approximate the charges on a similar claim for FY 2003. Prior to the calculation of the FY 2003 outlier threshold, we used the rate-of-cost increase from the most recent cost reports available to inflate actual charges on the prior year's bills to estimate what the charges would be in the upcoming year.

Our analysis indicated hospitals' charges were increasing at a much faster rate than costs. Therefore, in the August 1, 2002, IPPS final rule, we changed our methodology to inflate charges (67 FR 50122). Rather than using the observed rate-of-increase in costs from the cost reports, we inflated the FY 2001 charges by a 2-year average annual rate of change in actual charges per case from FY 1999 to FY 2000, and from FY 2000 to FY 2001, to estimate what the charges would be in FY 2003 for a similar claim.

The provisions of this final rule make several changes to better target outlier payments to the most costly cases. As a result, outlier payments to the hospitals that have been most aggressively increasing their charges to maximize outlier payments will be dramatically reduced. However, we are concerned that unrestrained charge increases have continued to occur during FY 2003 prior to the implementation of these final changes, and will likely result in outlier payments in excess of the 5.1 percent offset established by the August 1, 2002, IPPS final rule. (We now estimate FY 2003 outlier payments are equal to 6.1 percent of total DRG payments.) For example, hospitals intending to maximize outlier payments during FY 2003 could continue to do so by increasing charges enough to outpace the increase in the threshold. In fact, given the public attention on this behavior over the past few months and the potential for other hospitals to begin to aggressively increase their charges, and consequently their outlier payments, it is possible this type of aggressive gaming of the outlier policy has become more widespread in recent months.

Because of the extreme uncertainty regarding the effects of aggressive hospital charging practices on FY 2003 outlier payments to date, we did not propose any change to the FY 2003 fixed-loss threshold ($33,560) in the March 5, 2003, proposed rule. However, we noted that data for the first quarter of FY 2003 inpatient claims would be available soon and these data would allow us to evaluate whether outlier payments to date appear to be approximately 5.1 percent of total DRG payments. We solicited comments and data from hospitals with respect to the recent trends in hospital charges and the implications for outlier payments if the fixed-loss threshold were to remain at $33,560. We indicated in the March 5, 2003, proposed rule that, based upon that analysis and the comments we received in response to the proposed rule, we would adjust the threshold accordingly in the final rule.

B. Summary of Public Comments and Departmental Responses

Comment: Many commenters recommended that we lower the outlier threshold to ensure that hospitals have access to these special payments to cover extremely high-cost Medicare patients. In addition, they argued that because the threshold was raised from $21,025 in FY 2002 to $33,650 in FY 2003 based on policies in place at the beginning of the year, the threshold should now be lowered to reflect these mid-year changes.

Some commenters suggested that if a new threshold cannot be calculated by the publication date of the final rule, we should apply the FY 2002 threshold until a new threshold could be calculated. They argued that use of this threshold would enable all legitimate claims to qualify for cost outlier status.

MedPAC noted that failing to adjust the threshold would continue to deny additional payments to hospitals that have extraordinarily costly cases, thwarting the legislative purpose of the policy. One commenter suggested we lower the threshold close to the FY 2002 amount because it was not the intent of the Congress to have such a high outlier threshold for those hospitals that did not try to manipulate the outlier system and have sustained high losses for true outlier cases.

One commenter argued that last year, for purposes of setting a FY 2003 outlier threshold, CMS inflated charges using a 2-year average annual rate of change in charges per case from FY 1999 to FY 2000, and from FY 2000 to FY 2001, because CMS analysis demonstrated that charges have been growing at a much faster rate than recent estimates of cost growth. The commenter argued that, based on the new proposals in the proposed rule, this methodology was now unnecessary because the assumption of a lag in cost reports no longer applies.

One commenter recommended that we lower the threshold to the FY 2002 amount and implement this threshold retroactively to October 1, 2002. The commenter explained that many hospitals did not game the system and have had their outlier payments reduced over the years because the threshold has increased dramatically over the last 3 years due to a limited number of hospitals who gamed the system.

Response: We reestimated the fixed-loss threshold reflecting the changes implemented in this final rule that will be in effect during a portion of FY 2003. To do that reestimation, we inflated charges from the FY 2002 Medicare Provider Analysis and Review (MedPAR) file by the 2-year average annual rate of change in charges per case to predict charges for FY 2004. We believe the use of charge inflation is more appropriate than our previous methodology of cost inflation because charges are increasing at a much faster rate than costs. Therefore, we disagree that we should return to using the previous methodology based on cost inflation. Originally, when the FY 2003 threshold of $33,560 was set, we used FY 2001 MedPAR records. Because more recent data are now available, we believe it would be appropriate to use FY 2002 data to reestimate the FY 2003 threshold, taking into account the changes implemented by this final rule.

As noted previously, we continued to pay substantially more than was projected for outlier payments in FY 2002. Our most recent estimate is that we paid approximately 7.9 percent of total DRG payments in outliers, well in excess of our original projection of 5.1 percent, and higher than the percentage of total DRG payments for outliers in FY 2001. That percentage was 7.7. Therefore, using FY 2002 cases to estimate the outlier threshold for FY 2003 would result in a threshold of $42,300. However, after accounting for the changes implemented in this final rule, we estimate the threshold would be only slightly higher than the current threshold (by approximately $600).

We believe it is appropriate not to change the FY 2003 outlier threshold at this time. Although our current empirical estimate of the threshold indicates it could be slightly higher, there are other considerations that lead us to conclude the threshold should remain at $33,560. Increasing the threshold would result in lower outlier payments for all hospitals, not just those that have been aggressively maximizing their outlier payments. Changing the threshold for the remaining few months of the fiscal year could disrupt hospitals' budgeting plans and would be contrary to the overall prospectivity of the IPPS. We do believe that we have the authority to revise the threshold, given the extraordinary circumstances that have occurred (in particular, the manipulation of the policy by some hospitals). However, in light of the relatively small difference between the current threshold and our revised estimate, and the limited amount of time remaining in the fiscal year, we have concluded it is more appropriate to maintain the threshold at $33,560.

We note that, in the May 19, 2003, IPPS proposed rule for FY 2004, we proposed an outlier threshold of $50,645 for FY 2004 (68 FR 27235). Because that proposed rule was published prior to the publication of this final rule, the FY 2004 outlier threshold was calculated without accounting for the changes implemented in this final rule. The changes implemented here will be reflected in the calculation of the final FY 2004 outlier threshold.

C. Provisions of the Final Rule Relating to the Fixed-Loss Outlier Threshold

We are maintaining the fixed-loss outlier threshold at $33,560 for the remainder of FY 2003. We also are maintaining the marginal cost factor, the percentage of costs above the threshold that is paid for outlier cases, at 80 percent.

VII. Adjustment for High-Cost Outliers and Short-Stay Outliers Under the LTCH PPS

A. Background

Under the LTCH PPS, as implemented in the regulations at § 412.525(a), we make an adjustment for additional payments for outlier cases that have extraordinarily high costs relative to the costs of most discharges. In the LTCH PPS final rule for the 2004 LTCH PPS rate year, we intend to summarize the proposals relating to outlier payments under the LTCH PPS that were made in the March 7, 2003, LTCH PPS proposed rule (68 FR 11250), and will explain that we have responded to comments submitted on behalf of LTCHs and finalized the LTCH PPS outlier policy in this final outlier rule. We believe it is appropriate to finalize the changes to the IPPS outlier policies and the LTCH PPS outlier policy at the same time because the LTCH PPS outlier policy is modeled after the IPPS outlier policy. Accordingly, following is a summary of the LTCH PPS outlier policy as proposed in the March 7, 2003, proposed rule and our responses to the public comments we received on that proposed rule.

Under the regulations at § 412.525(a), we make an adjustment for additional payments for outlier cases that have extraordinarily high costs relative to the costs of most discharges. Providing additional payments for outliers strongly improves the accuracy of the LTCH PPS in determining resource costs at the patient and hospital level. These additional payments reduce the financial losses that would otherwise be caused by treating patients who require more costly care and, therefore, reduce the incentives to underserve these patients. We include a provision for outlier payments under the LTCH PPS and set the outlier threshold before the beginning of the applicable rate update year so that total outlier payments are projected to equal 8 percent of total payments under the LTCH PPS.

Under § 412.525(a), we make outlier payments for any discharges if the estimated cost of a case exceeds the adjusted LTCH PPS payment for the LTC–DRG plus a fixed-loss amount. The fixed-loss amount is the amount used to limit the loss that a hospital will incur under an outlier policy. This results in Medicare and the LTCH sharing financial risk in the treatment of extraordinarily costly cases. The LTCH's loss is limited to the fixed-loss amount and the percentage of costs above the marginal cost factor. We calculate the estimated cost of a case by multiplying the overall hospital cost-to-charge ratio by the Medicare allowable covered charge. In accordance with § 412.525(a), we pay outlier cases 80 percent of the difference between the estimated cost of the patient case and the outlier threshold (the sum of the adjusted Federal prospective payment for the LTC–DRG and the fixed-loss amount).

We determine a fixed-loss amount, that is, the maximum loss that a LTCH can incur under the LTCH PPS for a case with unusually high costs before the hospital will receive any additional payments. We calculate the fixed-loss amount by simulating aggregate payments with and without an outlier policy. The fixed-loss amount results in estimated total outlier payments projected to be equal to 8 percent of projected total LTCH PPS payments.

Outlier payments under the LTCH PPS are determined consistent with the IPPS outlier policy. Currently, under the IPPS, a floor and a ceiling are applied to an acute care hospital's cost-to-charge ratio and if the acute care hospital's cost-to-charge ratio is either below the floor or above the ceiling, the applicable statewide average cost-to-charge ratio is assigned to the acute care hospital. Similarly, if a LTCH's cost-to-charge ratio is below the floor or above the ceiling, currently the applicable statewide average cost-to-charge ratio is assigned to the hospital. In addition, for LTCHs for which we are unable to compute a cost-to-charge ratio, we also assign the applicable statewide average. Currently, MedPAR claims data and cost-to-charge ratios based on the latest available cost report data from the Hospital Cost Report Information System (HCRIS) and corresponding MedPAR claims data are used to establish a fixed-loss threshold amount under the LTCH PPS.

B. Establishment of the Fixed-Loss Amount for Outlier Payments Under the LTCH PPS

For FY 2003, based on FY 2001 MedPAR claims data and cost-to-charge ratios based on the latest available data from HCRIS and corresponding MedPAR claims data from FYs 1998 and 1999, we established a fixed-loss amount of $24,450. In the March 7, 2003, proposed rule, for the 2004 LTCH PPS rate year, we proposed to continue to use the March 2002 update of the FY 2001 MedPAR claims data to determine a fixed-loss threshold that would result in outlier payments projected to be equal to 8 percent of total payments, based on the policies described in that proposed rule, because these data were the best data available. We calculated cost-to-charge ratios for determining the March 7, 2003, proposed fixed-loss amount based on the latest available cost report data in HCRIS and corresponding MedPAR claims data from FYs 1998, 1999, and 2000.

Consistent with the proposed outlier policy changes for acute care hospitals under the IPPS discussed in the March 5, 2003, proposed rule (68 FR 10420), in the March 7, 2003, LTCH PPS proposed rule, we proposed to no longer assign the applicable statewide average cost-to-charge ratio when a LTCH's cost-to-charge ratio falls below the floor. We proposed this policy change because, as is the case for acute care hospitals, we believe LTCHs 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), currently when a LTCH's actual cost-to-charge ratio falls below the floor, the LTCH's cost-to-charge ratio would be raised to the applicable statewide average. This application of the statewide average would result in inappropriately higher outlier payments. Accordingly, we proposed to apply the LTCH's actual cost-to-charge ratio to determine the cost of the case, even where the LTCH's actual cost-to-charge ratio falls below the floor. No longer applying the applicable statewide average cost-to-charge ratio when a LTCH's actual cost-to-charge ratio falls below the floor would result in a lower future cost-to-charge ratio. Applying this lower cost-to-charge ratio to charges in the future to determine the cost of the case would result in more appropriate outlier payments. Therefore, consistent with the proposed policy change for acute care hospitals under the IPPS, we proposed that LTCHs would receive their actual cost-to-charge ratios no matter how low their ratios fall. Also, consistent with the proposed policy change for acute care hospitals under the IPPS, we proposed under § 412.525(a)(4), by cross-referencing proposed § 412.84(i), to continue to apply the applicable statewide average cost-to-charge ratio when a LTCH's cost-to-charge ratio exceeds the ceiling by proposing to adopt the proposed policy at proposed § 412.84(i)(1)(ii). Cost-to-charge ratios above this range are probably due to faulty data reporting or entry, and, therefore, should not be used to identify and make payments for outlier cases because such data are clearly errors and should not be relied upon.

In addition, we proposed to make a similar change to § 412.529(c), by cross-referencing proposed § 412.84(i), for determining short-stay outlier payments to indicate that the applicable statewide average cost-to-charge ratio would be applied when a LTCH's cost-to-charge ratio exceeds the ceiling, but not when a LTCH's cost-to-charge ratio falls below the floor. Since cost-to-charge ratios are also used in determining short-stay outlier payments, the rationale for the proposed change mirrored that for high-cost outliers.

Therefore, consistent with IPPS outlier policy, in determining the proposed fixed-loss amount for the 2004 LTCH PPS rate year in the March 7, 2003, LTCH PPS proposed rule, we proposed to use only the current combined operating and capital cost-to-charge ratio ceiling under the IPPS of 1.421 (as explained in the IPPS final rule (67 FR 50125, August 1, 2002)). We believe that using the current combined IPPS operating and capital cost-to-charge ratio ceiling for LTCHs is appropriate since, as we explained in the August 30, 2002, LTCH PPS final rule (67 FR 55960), LTCHs are certified as acute care hospitals that meet the criteria set forth in section 1861(e) of the Act in order to participate in the Medicare program. As we also discussed in the August 30, 2002, LTCH PPS final rule (67 FR 55956), in general, hospitals are paid as a LTCH only because their average length of stay is greater than 25 days in accordance with § 412.23(e). Furthermore, prior to qualifying as a LTCH under § 412.23(e)(2)(i), the hospitals generally are paid as acute care hospitals under the IPPS during the period in which they demonstrate that they have an average length of stay of greater than 25 days. Accordingly, if a LTCH's cost-to-charge ratio is above this ceiling, we proposed to assign the applicable IPPS statewide average cost-to-charge ratio. (Currently, the applicable IPPS statewide averages can be found in Tables 8A and 8B of the August 1, 2002, IPPS final rule (67 FR 50263).) We also would assign the applicable statewide average for LTCHs for which we are unable to compute a cost-to-charge ratio. Accordingly, in the March 7, 2003, LTCH PPS proposed rule, for the proposed 2004 LTCH PPS rate year, we proposed a fixed-loss amount of $19,978. Thus, we proposed to pay an outlier case 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted Federal LTCH payment for the LTC–DRG and the proposed fixed-loss amount of $19,978).

C. Reconciliation of Outlier Payments Upon Cost Report Settlement

Under existing regulations at § 412.525(a), we specify that no retroactive adjustment will be made to the outlier payments upon cost report settlement to account for differences between the estimated cost-to-charge ratios and the actual cost-to-charge ratios for outlier cases. This policy is consistent with the existing outlier payment policy for short-term acute care hospitals under the IPPS. However, as discussed earlier, in the March 5, 2003 IPPS proposed rule (68 FR 10420), we proposed to revise the methodology for determining cost-to-charge ratios for acute care hospitals under the IPPS because we became aware that payment vulnerabilities exist in the current IPPS outlier policy. Because the LTCH PPS high-cost outlier and short-stay policies are modeled after the IPPS outlier policy, we believe they are susceptible to the same payment vulnerabilities and, therefore, merit revision.

As proposed for acute care hospitals under the IPPS at proposed § 412.84(m) in the March 5, 2003, proposed rule, we proposed in the March 7, 2003, LTCH PPS proposed rule under § 412.525(a)(4)(ii), by cross-referencing proposed § 412.84(m), that, for LTCHs, any reconciliation of outlier payments would be made upon cost report settlement to account for differences between the actual cost-to-charge ratio and the estimated cost-to-charge ratio for the period during which the discharge occurs. As was the case with the proposed changes to the outlier policy for acute care hospitals under the IPPS, we indicated that we were still assessing the procedural changes that would be necessary to implement this change for LTCHs under the LTCH PPS. In addition, we proposed to make a similar change in § 412.529(c)(4)(ii), by cross-referencing proposed § 412.84(m), to indicate that any reconciliation of payments for short-stay outliers would be made upon cost report settlement to account for differences between the estimated cost-to-charge ratio and the actual cost-to-charge ratio for the period during which the discharge occurs.

In addition, because we currently use cost-to-charge ratios based on the latest settled cost report, again consistent with the policy for acute care hospitals under the IPPS, any dramatic increases in charges by LTCHs during the payment year are not reflected in the cost-to-charge ratios when making outlier payments under the LTCH PPS. Consistent with the proposed policy change for acute care hospitals under the IPPS at proposed § 412.84(i) discussed in the March 5, 2003 IPPS proposed rule, because a LTCH has the ability to increase its outlier payments through a dramatic increase in charges and because of the lag time in the data used to calculate cost-to-charge ratios, in the March 7, 2003 LTCH PPS proposed rule, we proposed that fiscal intermediaries would use more recent data when determining a LTCH's cost-to-charge ratio. Therefore, under § 412.525(a)(4)(ii), by cross-referencing proposed § 412.84(i), we proposed that fiscal intermediaries would use either the most recent settled cost report or the most recent tentative settled cost report, whichever is later. In addition, we proposed to make a similar change to the short-stay outlier policy at § 412.529(c)(4)(ii), by cross-referencing proposed § 412.84(i), to indicate that subject to the proposed provisions in the regulations at § 412.84(i), fiscal

intermediaries would use either the most recent settled cost report or the most recent tentative settled cost report, whichever is later.

In the March 7, 2003, LTCH PPS proposed rule, when we calculated the proposed fixed-loss amount of $19,978 for the proposed 2004 LTCH PPS rate year, we did not assign the applicable statewide average cost-to-charge ratio when a LTCH's actual cost-to-charge ratio fell below the floor, consistent with the proposed IPPS outlier policy. However, because many features of the LTCH PPS are dependent upon IPPS outlier policies, we did not believe it was appropriate to finalize the proposed changes to the LTCH PPS outlier policy in the LTCH PPS final rule. Therefore, in calculating the final fixed-loss amount, we intend to apply the existing outlier policy (that is, not the policies proposed in the March 7, 2003, LTCH PPS proposed rule), using the statewide average for LTCHs whose cost-to-charge ratios fall below the floor. In addition, after analyzing the data that we would use to calculate the fixed-loss amount, we would only apply the statewide average to one LTCH that would have a cost-to-charge ratio that falls below the floor. Based on this analysis, we have concluded that it will not be necessary to recalculate a new fixed-loss amount once this outlier rule becomes effective because the difference between a fixed-loss amount based on the elimination of the floor and a fixed-loss amount based on the statewide average would be negligible. Thus, the fixed-loss amount published in the LTCH PPS final rule will not be affected by changes in the outlier policy.

D. Application of Outlier Policy to Short-Stay Outlier Cases

Under some rare circumstances, a LTCH discharge could qualify as a short-stay outlier case (as defined under § 412.529) and also as a high-cost outlier case. In such a scenario, a patient could be hospitalized for less than five-sixths of the geometric average length of stay for the specific LTC–DRG, and yet incur extraordinarily high treatment costs. If the costs exceeded the LTCH PPS outlier threshold (that is, the short-stay outlier payment plus the fixed-loss amount), the discharge would be eligible for payment as a high-cost outlier. Thus, for a short-stay outlier case, the high-cost outlier payment is based on 80 percent of the difference between the estimated cost of the case plus the outlier threshold (the sum of the fixed-loss amount and the amount paid under the short-stay outlier policy).

E. Summary of Public Comments on the LTCH PPS Outlier Policy in the March 7, 2003, Proposed Rule and Departmental Responses

Of the approximately 30 pieces of correspondence we received on the March 7, 2003, LTCH PPS proposed rule, 22 pieces contained public comments on the proposed LTCH PPS high-cost and short-stay outlier policies that were included in the proposed rule. A summary of those comments and our departmental responses follow.

Comment: Many commenters supported our proposal to use the most recent tentatively settled Medicare cost report to determine the cost-to-charge ratios to be used for outlier payments under the LTCH PPS, since this policy would provide the most current data reviewed by the fiscal intermediaries for purposes of the outlier payment. A number of commenters also agreed with the proposal to eliminate the use of statewide averages for hospitals with cost-to-charge ratios below the minimum floor cost-to-charge ratio, stating that this proposal would remove incentives to rapidly increase charges relative to costs.

Response: We agree with the commenters and we are adopting the proposal to use the most recent tentatively settled Medicare cost report to determine the cost-to-charge ratios and the proposal to eliminate the use of statewide averages for hospitals with cost-to-charge ratios below the minimum floor cost-to-charge ratio. However, we want to take the opportunity in this final rule to clarify some points about the application of these policies.

The IPPS outlier policy in this final rule, which requires applying a hospital's actual cost-to-charge ratio to determine the cost of a case, even where the hospital's actual cost-to-charge ratio falls below the floor, will become effective 60 calendar days after the date of publication of this final rule. This policy will similarly become effective for LTCHs 60 calendar days after the date of publication of this final rule. For purposes of making actual outlier payments for discharges between July 1, 2003, and the effective date of this outlier rule (60 calendar days after the date of publication), LTCHs' cost-to-charge ratios that are below the floor will be replaced by the statewide average as under existing policy, while any outlier payments made on or after the effective date of this outlier rule will be determined under the new policy using the LTCHs' actual cost-to-charge ratio, even if that cost-to-charge ratio is below the floor.

Following is an example of how the policy eliminating the floor cost-to-charge ratio will apply beginning July 1, 2003:

As of July 1, 2003, Hospital A has a cost-to-charge ratio of 0.250, which is above the current cost-to-charge ratio floor of 0.206. Therefore, for purposes of determining outlier payment in the 2004 LTCH PPS rate year (July 1, 2003, to June 30, 2004), Hospital A would continue to use its cost-to-charge ratio of 0.250 (unless the fiscal intermediary changes Hospital A's cost-to-charge ratio due to tentative settlement of a cost report) and use the fixed-loss amount to be published in the LTCH PPS final rule for the 2004 LTCH PPS rate year.

Hospital B has a cost-to-charge ratio of 0.200, which is below the cost-to-charge ratio floor of 0.206. For purposes of determining outlier payments from July 1, 2003, until the effective date of this final rule (60 calendar days after the date of publication), Hospital B continues to use the statewide average cost-to-charge ratio. However, beginning with the effective date of the final rule, Hospital B uses its actual cost-to-charge ratio of 0.200 (unless the fiscal intermediary changes Hospital B's cost-to-charge ratio due to tentative settlement of a cost report), and continues to use the fixed-loss amount to be published in the LTCH PPS final rule.

Comment: Numerous other commenters representing LTCHs disagreed with our proposed policy that, for LTCHs, any reconciliation of outlier payments would be made upon cost report settlement to account for differences between the actual cost-to-charge ratio and the estimated cost-to-charge ratio for the period during which the discharge occurs. One commenter stated that the proposal would create accounting difficulties for hospitals and fiscal intermediaries, and suggested that if CMS is concerned about ''gaming'' related to outlier payments, then, as an alternative, the fiscal intermediaries could monitor charges per diem using PS&R data, or a quarterly reporting mechanism can be established similar to the HCFA–91. Other commenters wrote that constant updates to the cost-to-charge ratios for outlier payments would be a costly and burdensome process for LTCHs and fiscal intermediaries to administer. The commenters recommended that CMS maintain its current policy of using the most recent final cost report for cost-to-charge ratios with no changes until the following fiscal year.

Another commenter stated that requiring the fiscal intermediary to notify providers every time a change is

made to the cost-to-charge ratio in the fiscal intermediary's system will cause the provider to make multiple unnecessary adjustments to properly account for the difference in payment for high-cost outliers and short-stay outlier cases. The commenter proposed that the fiscal intermediary should be required to send the provider notification each time the cost-to-charge ratio will be changed in its system.

Response: As explained in response to comments on the IPPS outlier proposed rule, although the provision concerning reconciliation is effective 60 days after the date of publication of this final rule, we understand that, given the large workload and limited resources of our fiscal intermediaries, attempting to implement this provision for all hospitals receiving outlier payments at the same time would create an administrative burden. Accordingly, we intend to issue a program instruction in the near future to assist fiscal intermediaries in implementing this provision during the remainder of the LTCH rate year.

Notably, however, for LTCHs, particularly because the universe of LTCHs is relatively small, we do not believe it will be overly burdensome for the fiscal intermediaries to rerun a LTCH's claims to determine the accurate outlier payment amount. We also do not believe that the reconciliation of outlier payments for LTCHs will be overly burdensome because LTCHs are on notice of the revised methodology.

We also are not adopting the commenter's recommendation to establish a system for monitoring PS&R data or for quarterly reporting. While those procedures might aid in detecting aberrant charge increases, we believe that the reconciliation process is preferable because it allows for outlier payments to be ultimately determined based on actual cost-to-charge ratios, rather than on estimates. Finally, we agree with the commenter that the fiscal intermediaries should notify the hospitals whenever a change is made to the cost-to-charge ratio. We plan to provide more details on this procedure in program instructions to be issued after the publication of this final rule.

Comment: Several commenters questioned whether CMS has the authority to retroactively adjust outlier payments, stating that it is ''completely contrary to the entire concept of a prospective payment system,'' and would generate budgeting uncertainty and administrative burden for hospitals and CMS.

One commenter claimed that the Secretary of the Department of Health and Human Services has argued in court that the Medicare statute does not allow retroactive adjustments to outlier payments. (See *County of Los Angeles* v. *Shalala*, 192 F.3d 1005 (D.C. Cir. 1999).)

Another commenter argued that since the LTCH PPS is uniquely different from the IPPS in that a much greater percentage of overall payment under the LTCH PPS is dependent upon cost-to-charge ratios (high-cost outliers and short-stay outliers combined), subjecting such a large portion of payments to a cost-based settlement approach defeats the purpose and benefits of a PPS. Specifically, the commenter noted that since the cost-to-charge ratio is used to determine payment for both high-cost outliers and for short-stay outliers, which combined, can represent a significant percentage of all discharges from a LTCH, both the classification of a case as a short-stay or high-cost outlier and the resulting payment amount would have to be reassessed and possible retroactive adjustments would have to be made following an audit of more recent cost report data. Therefore, the commenter believed that a policy that allows for retroactive adjustments to prior payment amounts introduces a large amount of uncertainty and complexity that the PPS was intended to eliminate.

Response: As an initial matter, our position in the court cases is more accurately presented as stating that the language of the statute does not clearly mandate that the actual amount of outlier payments must be between 5 and 6 percent of total outlier payments under the IPPS, and that our policy of not making retroactive adjustments to ensure that actual payments fall between that range is consistent with the intent of Congress. However, the commenters are correct in pointing out that a basic premise of a PPS is predictability of payment, the prospectivity of the system is undermined when it is manipulated and abused in order to maximize reimbursement. Under the IPPS, in light of the gross abuses of the current methodology by some hospitals, and the negative impact such overpayments ultimately have on other hospitals due to their impact on the fixed-loss amount, we believe the option of reconciling outlier payments based on the settled cost report for hospitals that have been initially paid using a significantly inaccurate cost-to-charge ratio compared to the actual ratio from the cost reporting period is now appropriate. We believe that at this time it is appropriate to adopt this policy for the LTCH PPS because it will contribute to the overall accuracy and fairness of the fixed-loss amount under the prospective payment system.

As we stated above, in our view, reconciling outlier payments because they were originally paid on the basis of a significantly inaccurate cost-to-charge ratio is similar to recovering outlier payments when adjustments are made to covered charges for any services that are not found to be medically necessary or appropriate under Medicare upon medical or other review. This review is explicitly provided for under the IPPS policy at § 412.84(d). This provision was established when the IPPS was first implemented for FY 1984 (48 FR 39785).

The court cases referenced by the commenters all addressed the issue of whether outlier payments must be retroactively adjusted when the level of the fixed-loss amount under the IPPS determined in advance of the fiscal year to which it applies ultimately results in actual IPPS outlier payments that are a smaller percentage of total IPPS DRG payments than was originally projected. We believe that an important goal of a PPS is predictability. Therefore, we believe that the fixed-loss outlier threshold, whether under the IPPS or the LTCH PPS, should be projected based on the best available historical data and should not be adjusted retroactively. We believe that a retroactive change to the fixed-loss outlier threshold would affect all hospitals subject to a PPS, thereby undercutting the predictability of the system as a whole. However, if we deem it necessary as a result of a hospital-specific data variance to reconcile outlier payments of an individual hospital, such action on our part would not affect predictability of the entire system. Rather, because each hospital is on notice as to our revised methodology for determining cost-to-charge ratios and that outlier payments are subject to possible reconciliation, we are able to maintain the predictability of the system as a whole. Further, because reconciliation of outlier payments will affect only certain hospitals, the administrative burden of implementing such a policy is minimized. Accordingly, we continue to believe that the fixed-loss amount should be based on projected payments using the latest available historical data without retroactive adjustments. This was our position in the court cases cited by the commenter, and it has been our consistent and often stated position, including earlier in this final rule and in the March 5, 2003, IPPS outlier proposed rule.

Comment: One commenter recommended that subregulatory

guidelines for the review of outlier payments be established, specifying what changes to the cost-to-charge ratios would trigger a review and what entity is responsible for determining whether a review is necessary. The commenter added that CMS should ensure that outlier thresholds are estimated to reflect 8 percent of total payments. Another commenter stated that the proposed reconciliation to cost-to-charge ratios should be limited only to those hospitals that meet certain criteria, such as hospitals that cross a defined threshold of charge increases combined with a high level of outlier payments compared to the norm. The commenter requested that the final rule include specific criteria to be used for the determination of hospitals that will be subject to such an adjustment.

Response: As we stated earlier in this final rule, we intend to issue a program instruction to the fiscal intermediaries in the near future that will provide specific criteria to be used in the reconciliation of outlier payments for the remainder of the LTCH PPS rate year.

For cost reporting periods beginning on or after October 1, 2003, we are considering instructing fiscal intermediaries to conduct reconciliation for those LTCHs whose actual cost-to-charge ratios are found to be plus or minus 10 percentage points from the cost-to-charge ratio used during that time period to make outlier payments, and that have total FY 2004 outlier payments (high-cost and short stay outlier payments combined) that exceed $500,000. We believe these thresholds would appropriately capture those LTCHs whose outlier payments will be substantially inaccurate when using the ratio from the contemporaneous cost reporting period compared to the ratio from the latest cost reporting period. LTCHs exceeding these thresholds during their applicable cost reporting periods would become subject to reconciliation of their outlier payments. These thresholds would be reevaluated annually and, if necessary, modified each year. However, fiscal intermediaries would also have the administrative discretion to reconcile additional LTCHs' cost reports based on analysis that indicates the outlier payments made to those hospitals are significantly inaccurate.

In addition, we will continue to ensure that outlier payments are projected to be equal to 8 percent of total LTCH PPS payments by using the best and most recent available data in computing the fixed-loss amount.

Comment: One commenter strongly supported and recommended approval of the proposals to use the most recent settled or tentatively settled cost report or other latest available data from the provider or the fiscal intermediary, and the reconciliation for outlier payments upon cost report settlement. The commenter was in favor of these proposals because the commenter believed that they correct the ''inappropriately harmful impact'' that the current rules have on those hospitals that hold charge increases to a level lower than their cost increases. The commenter recommended that these proposed policies should be applied retroactively to the beginning of the LTCH PPS. However, the commenter did not agree that an adjustment for the time value of overpayments or underpayments should be applied to outlier payments received in a cost reporting period, since the issue has already been addressed in the regulations at 42 CFR 405.378, and no other aspect of a final settlement reflects payment of interest.

Another commenter asserted that interest should not be assessed after the cost report is settled and before the provider has a chance to review and appeal potentially erroneous claims. Instead, the commenter recommended that CMS should allow a 180-day appeal period to give providers an opportunity to review the settlement and file appeals without interest.

Response: As we stated earlier, we are adopting as final the proposals to eliminate the use of statewide averages for hospitals with cost-to-charge ratios below the minimum floor cost-to-charge ratio, the use of the cost-to-charge ratio from a tentatively settled cost report or alternative best available data, and finalizing the reconciliation policy for outlier payments upon cost report settlement. We understand the commenters' concerns and acknowledge that a change in policy is needed, but under our rulemaking authority, there is a serious question as to whether we could apply these policies retroactively. Therefore, consistent with the rationale explained under the IPPS section of this final rule, the effective date of the policies concerning elimination of the floor, and using alternative data from the fiscal intermediary or the provider, is for discharges occurring on or after August 8, 2003. The use of the later of either the most recent tentatively settled cost report or the most recent settled cost report is effective for discharges occurring on or after October 1, 2003. The effective date of reconciliation of outlier payments is for discharges occurring on or after August 8, 2003.

As noted previously, although the provision concerning reconciliation is effective 60 days after the date of publication of this final rule, we understand that, given the large workload and limited resources of our fiscal intermediaries, attempting to implement this provision for all hospitals receiving outlier payments at the same time would create an administrative burden. We intend to issue a program instruction in the near future to assist fiscal intermediaries in implementing this provision during the remainder of the LTCH rate year.

We are implementing these effective dates under §§ 412.84(i) and (m), as referenced under the LTCH PPS outlier regulations at §§ 412.525(a)(4) and 412.529(c)(5).

In regard to the commenter's objection to the policy concerning the time value of money, outlier payments are uniquely susceptible to manipulation because hospitals set their own level of charges without review by the fiscal intermediary. Therefore, despite the recovery of the overpayment by CMS, a hospital would essentially benefit from an interest-free loan simply by increasing its charges in the interim. In order to ensure that hospitals are reimbursed fairly for extremely costly cases, it is necessary to establish a mechanism whereby an adjustment can be made to help guarantee that payments appropriately reflect the marginal costs of care for outlier cases. Under the LTCH PPS, it is also important to ensure that hospitals are paid correctly for short-stay outlier cases. We believe an adjustment for the time value of money is the appropriate mechanism to use to ensure equity and accuracy of payments.

Comment: Several commenters noted the potential implications a retroactive adjustment to high-cost outlier payments may have on a beneficiary's use of lifetime reserve days. Medicare beneficiaries in a LTCH are much more likely to exceed their 90 days of available inpatient care during a LTCH stay than during a short-term acute hospital stay. A Medicare beneficiary's lifetime reserve days (days 91 through 150) are not used as long as coinsurance days are available or as long as a stay is covered under the LTC–DRG. However, as soon as a day of care moves the beneficiary into the high-cost outlier category, this day and subsequent days are counted against the beneficiary's lifetime reserve days, and the stay is paid by Medicare as a high-cost outlier, with beneficiary coinsurance equal to half of the inpatient deductible amount. The commenters stated that the proposed policy would result in retroactive adjustments to the day on which a patient's stay moves into the

high cost category, thereby retroactively adjusting the lifetime reserve days available to a beneficiary.

One commenter stated that coverage based on a changing cost-to-charge ratio would not be a sound policy, and CMS should consider changing the high-cost outlier threshold determination to a per diem methodology to ensure that all beneficiaries receive the same number of benefit days and coverage.

The commenters also pointed out that, for similar reasons, a policy that would retroactively reconcile outlier payments will create an unworkable system for the administration of Medicare supplemental (Medigap and Medicaid) payments, since such a policy anticipates that the Medigap and Medicaid programs will make retroactive adjustments to beneficiary benefits and payments. The commenters recommended that CMS consider severing the link between the count of Part A benefit days and cost outlier status and, instead, count beneficiary Part A days on a per diem basis so that the Part A benefit is not dependent upon changes to the cost-to-charge ratio and high-cost outlier status.

Response: We have reviewed all the comments concerning the effect of the policy for reconciling outlier payments on a beneficiary's lifetime reserve days and eligibility for coverage under the Medigap and Medicaid programs. We believe that the commenters have raised a number of valid concerns. While we are adopting as final the policy to reconcile outlier payments upon cost report settlement to account for differences between the estimated cost-to-charge ratio and the actual cost-to-charge ratio for the period during which the discharge occurs, we believe that, because the outlier policy changes are intended to address accuracy of outlier payments rather than coverage or eligibility, any changes to a LTCH's outlier payments made as a result of reconciliation should not retroactively affect a beneficiary's lifetime reserve days or coverage status under Medigap or Medicaid. Specifically, no retroactive adjustments will be made to determine the day on which a beneficiary's stay moves to high-cost outlier status, and, therefore, no retroactive adjustments will be made to lifetime reserve days used or available. The reconciliation of outlier payments to the LTCH by the fiscal intermediary will simply be a redetermination of outlier payment upon cost report settlement. Similarly, no retroactive adjustments are required to be made to beneficiary benefits and payments under Medigap and Medicaid.

Accordingly, we do not believe it is necessary to adopt the policy suggested by the commenters under which beneficiary Part A days would be counted on a per diem basis, since the receipt of Part A benefits will not be dependent upon changes to the cost-to-charge ratio and outlier status.

Comment: Commenters wrote that since the LTCH PPS is new and CMS and the LTCH industry have almost no experience with the LTCH PPS and outlier payments, CMS has no policy reason for changing the LTCH PPS outlier policy at this time. The commenters stated that additional time and experience under the new system are needed before CMS has the information necessary to appropriately address potential problems.

Response: We disagree with the commenters' assertion that because the LTCH PPS is still in its nascent stages, the challenges that have surfaced under the IPPS may not yet necessarily apply to the LTCH PPS. However, we believe those same challenges may arise in the LTCH PPS context because many of this system's features are modeled after the IPPS. We believe that being proactive in ensuring the accuracy of outlier payments by making additional payments only for truly high-cost cases is a matter of sound public policy. It is also our responsibility to ensure the integrity of the Medicare Trust Fund, which we believe this policy accomplishes. We note that we will continue to monitor all aspects of the LTCH PPS, and may propose to make other adjustments in the future if warranted.

Comment: One commenter asked that CMS clarify the effective date of the proposed cost-to-charge ratio policies. The commenter stated that if the effective date is for discharges occurring on or after July 1, 2003, then, for LTCHs with a fiscal year end date of June 30, the implementation process would be eased for the fiscal intermediaries and LTCHs. However, for those LTCHs that do not have a fiscal year end date of June 30, the commenter asserted that the task of accounting for the proposed cost-to-charge ratio regulations would be administratively burdensome for the fiscal intermediaries and LTCHs. Therefore, the commenter requested that the effective date for the proposed outlier regulations should be for cost reporting periods beginning on or after July 1, 2003.

Response: We do not believe that the implementation of the outlier policies will be overly burdensome to LTCHs. As we noted previously, although this provision is effective 60 days after the date of publication of this final rule, we understand that, given the large workload and limited resources of our fiscal intermediaries, attempting to implement this provision for all hospitals receiving outlier payments at the same time would create an administrative burden. We intend to issue a program instruction in the near future to assist fiscal intermediaries in implementing this provision during the remainder of the LTCH rate year.

Also, as we stated in responses to comments above, the outlier policy on applying a LTCH's actual cost-to-charge ratio to determine the cost of a case, even where the LTCH's actual cost-to-charge ratio falls below the floor, will become effective for discharges occurring on or after August 8, 2003. For purposes of making outlier payments between July 1, 2003, and August 8, 2003, cost-to-charge ratios that fall below the floor will be replaced by the statewide average, while any outlier payments made on or after August 8, 2003, will be determined using the actual cost-to-charge ratio, even if that cost-to-charge ratio falls below the floor.

The policies at § 412.84(i)(1), (3), and (4) and § 412.84(m), as referenced under the LTCH PPS outlier regulations at § 412.525(a)(4) and § 412.529(c)(5) concerning use of alternative ratios and the elimination of the floor on cost-to-charge ratios are effective for discharges occurring on or after August 8, 2003. The effective date of the policy concerning use of the most recent tentatively settled cost report or the most recent settled cost report at § 412.84(i)(2) is for discharges occurring on or after October 1, 2003. The effective date of the policy regarding reconciliation of outlier payments is for discharges occurring on or after August 8, 2003.

For example, regardless of the fiscal year begin date, between July 1, 2003, and August 8, 2003, if a hospital's cost-to-charge ratio is below the floor, the hospital would continue to use the statewide average cost-to-charge ratio as under existing policy. However, beginning with discharges occurring on or after August 8, 2003, the hospital would use its actual cost-to-charge ratio, even if it were below the floor, and not the statewide average cost-to-charge ratio. Similarly, effective August 8, 2003, under § 412.84(i)(1), CMS may use an alternative cost-to-charge ratio, or a hospital may request that the fiscal intermediary use a different cost-to-charge ratio based on substantial evidence presented by the hospital. Then, regardless of a hospital's fiscal year begin date, effective for discharges occurring on or after October 1, 2003, a hospital's cost-to-charge ratio will be based on the data available from the most recently tentatively settled or final

settled cost report, whichever is later. Finally, once a hospital submits to the fiscal intermediary its cost report for the period ending on or after August 8, 2003, the fiscal intermediary would use the program instructions we intend to issue in the near future that will provide specific criteria for implementing this provision on reconciliation.

Comment: A commenter who wrote on behalf of LTCHs that have a fiscal year end date of December 31, asked the following questions related to the proposed cost-to-charge ratio policy: (1) Will the cost-to-charge ratio for outlier payments be derived from the prior year's (December 31, 2002) cost report or from the fiscal year ending December 31, 2001, cost report, since the fiscal year ending December 31, 2002, cost report is not due to the Medicare fiscal intermediary until May 31, 2003? (2) Will the cost-to-charge ratio change when the fiscal year ending December 31, 2003, cost report is filed on May 31, 2004? (3) Will the cost-to-charge ratio for fiscal year ending December 31, 2003, outlier payments change when the cost report is tentatively settled and finalized in 2004 or 2005? (4) Will the cost-to-charge ratios for fiscal year ending December 31, 2003, change when appeals are settled in 2006 or 2007? (5) Will each Medicare claim applicable to outlier payments be reprocessed when the cost-to-charge ratio changes?

Response: It appears that the commenter is essentially asking how cost report settlement will affect changes to a hospital's cost-to-charge ratio. As explained above, each hospital's cost-to-charge ratio may change effective for discharges occurring on or after August 8, 2003, in instances where the cost-to-charge ratio is below the floor, or CMS believes an alternative cost-to-charge ratio should be used. A hospital's cost-to-charge ratio also may change effective for discharges occurring on or after October 1, 2003, based on the most recent tentatively settled cost report, or the final settled cost report, whichever is later.

In response to the commenter's third question, the reconciliation policy is effective for discharges occurring on or after 60 calendar days after the publication of this final rule. As we stated above, we intend to issue a program instruction to fiscal intermediaries in the near future that will provide specific criteria for determining how the reconciliation of outlier payments will be implemented. However, we note, as with other cost report settlement issues, the hospital may appeal the Notice of Program Reimbursement for the December 31, 2004, cost report and the cost-to-charge ratio, and, therefore, outlier payments may change depending on the outcome of the appeal.

Finally, in response to the commenter's fifth question, not all claims may be reprocessed when the cost-to-charge ratio changes upon reconciliation. Again, as explained previously, we intend to issue a program instruction to fiscal intermediaries that will provide specific criteria for determining how the reconciliation of outlier payments will be implemented.

Comment: One commenter supported the proposal to use more recent cost-to-charge ratios to calculate outlier payments and eliminate the use of the statewide average cost-to-charge ratio floor, but expressed concern that an abrupt change to cost-to-charge ratios would create significant and unanticipated reductions in outlier payments and urged CMS to implement a transition period for all hospitals that would be adversely affected by the proposed policy changes.

Response: We have received many comments stating that a transition period is necessary, mostly in relation to the proposed policy for IPPS outlier payments. In the context of LTCHs, we do not believe that this policy will result in significant reductions in historic outlier payments, because the LTCH PPS is a new system, there were no outlier payments under the previous reasonable cost-based payment methodology, and LTCHs only recently had the opportunity to choose whether they wish to be reimbursed on a blend of LTCH PPS and reasonable cost-based payments over a 5-year period, or on 100 percent of the Federal rate. Therefore, we do not believe that the proposed changes to the outlier policy will place any LTCHs at risk for a substantial loss of reimbursement. In addition, as stated above, we believe that the proposed policy changes will ensure that the fixed-loss amount is established at a reasonable level and that each hospital will be reimbursed for high-cost and short-stay outlier cases in an accurate and equitable manner. Thus, we believe that it is in the best interest of CMS and the hospital community as a whole to forego a transition period and implement the proposed changes to the outlier policy as soon as possible.

E. Provisions of the Final Rule

Consistent with the final IPPS outlier policy in this final rule, we are revising §§ 412.525(a)(4) and 412.529(c)(5) to specify that, for discharges from LTCHs under the LTCH PPS occurring on or after October 1, 2002, and before August 8, 2003, no reconciliations will be made to high-cost outlier payments or to short-stay outlier payments, respectively, upon cost report settlement to account for differences between the estimated cost-to-charge ratio and the actual cost-to-charge ratio of the case. We are specifying in §§ 412.525(a)(4)(iii) and 412.529(c)(5)(iii) that for discharges from LTCHs under the LTCH PPS occurring on or after October 1, 2003, high-cost outlier payments and short-stay outlier payments, respectively, are subject to the provisions of § 412.84(i)(2) (which are applicable to IPPS hospitals).

G. Short-Stay Outlier Cases

A short-stay outlier case may occur when a beneficiary receives less than the full course of treatment at the LTCH before being discharged. These patients may be discharged to another site of care or they may be discharged and not readmitted because they no longer require treatment. Furthermore, patients may expire early in their LTCH stay.

As we discussed in the August 30, 2002, LTCH PPS final rule (67 FR 55970), generally LTCHs are defined by statute as having an average length of stay of greater than 25 days. We believe that a payment adjustment for short-stay outlier cases results in more appropriate payments, because these cases most likely would not receive a full course of treatment in such a short period of time and a full LTC–DRG payment may not always be appropriate. Payment-to-cost ratios simulated for LTCHs, for the cases described above, show that if LTCHs receive a full LTC–DRG payment for those cases, they would be significantly ''overpaid'' for the resources they have actually expended.

Under § 412.529, we adjust the per discharge payment for a short-stay outlier patient to the least of 120 percent of the cost of the case, 120 percent of the LTC–DRG specific per diem amount multiplied by the length of stay of that discharge, or the full LTC–DRG payment, for all cases with a length of stay up to and including five-sixths of the geometric average length of stay of the LTC–DRG.

As we discussed in section VI.C.3. of the March 7, 2003, proposed rule, in the March 5, 2003, proposed rule (68 FR 10420), we proposed to revise the methodology for determining cost-to-charge ratios for acute care hospitals under the IPPS because we became aware that payment vulnerabilities exist in the current IPPS outlier policy. Because the LTCH PPS high-cost outlier and short-stay outlier payments are also based on cost-to-charge ratios as under the IPPS, we believe they are

susceptible to the same payment vulnerabilities as the IPPS and, therefore, merit revision. As proposed for acute care hospitals under the IPPS at proposed § 412.84(i) and (m) in the March 5, 2003, proposed rule (68 FR 10429) and as we proposed for LTCHs above for high-cost outlier payments at § 412.525(a)(4)(ii), we proposed under § 412.529 that short-stay outlier payments would be subject to the proposed provisions in the regulations at § 412.84(i) and (m). Therefore, consistent with the proposed changes to the high-cost outlier policy discussed in section VI.C.3. of the March 7, 2003, proposed rule, we proposed, by cross-referencing § 412.84(i), that fiscal intermediaries would use either the most recent settled cost report or the most recent tentatively settled cost report, whichever is later, in estimating a LTCH's cost-to-charge ratio. We also proposed, by cross-referencing § 412.84(i), that the applicable statewide average cost-to-charge ratio would only be applied when a LTCH's cost-to-charge ratio exceeds the ceiling. Finally, we proposed, by cross-referencing § 412.84(m), that any reconciliation of payments for short-stay outliers would be made upon cost report settlement to account for differences between the estimated cost-to-charge ratio and the actual cost-to-charge ratio for the period during which the discharge occurs. We further noted that as was the case with the proposed changes to the outlier policy for acute care hospitals under the IPPS, we were still assessing the procedural changes that would be necessary to implement this change.

We received numerous comments on the proposed changes to the outlier policy as it relates to short-stay outliers. We have summarized and responded to these comments in the previous section related to outlier payments under the LTCH PPS. Therefore, as discussed above, under § 412.529, short-stay outlier payments are subject to the provisions of §§ 412.84(i)(1), (3), and (4) and § 412.84(m) for discharges occurring on or after August 8, 2003, and subject to the provisions of § 412.84(i)(2) for discharges occurring on or after October 1, 2003.

VIII. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), we are required to provide 30-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 (PRA) requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

In the March 5, 2003, proposed rule, we solicited comment on the recordkeeping requirements referenced in the proposed amendments to § 412.84. Under the proposed amendments to § 412.84(h), a hospital may request that its fiscal intermediary use a different (higher or lower) cost-to-charge ratio based on substantial evidence presented by the hospital. The burden imposed by this section is the time it takes to write the request. We estimated that 120 hospitals would make this request per year and that it would take each one 8 hours for a total annual burden of 960 hours.

We did not receive any comments on this information collection requirement and are making no revisions to it. We will submit this information collection requirement to the Office of Management and Budget for review and approval in accordance with the Paperwork Reduction Act. The requirement will not go into effect until we receive OMB approval.

If you comment on this information collection and recordkeeping requirement, please mail, e-mail or fax copies directly to the following:

Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Regulations Development and Issuances Group, Attn: Julie Brown, CMS–1243–F, Room C5–16–03, 7500 Security Boulevard, Baltimore, MD 21244–1850;

and

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503. Attn.: Brenda Aguilar, CMS Desk Officer, *baguilar@omb.eop.gov*. Fax: (202) 395–6974.

IX. Impact Analysis

A. Introduction

We have examined the impacts of this final rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review) and the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 Pub. L. 104–4), and Executive Order 13132.

B. Executive Order 12866

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year).

We have determined that this final rule is a major rule as defined in 5 U.S.C. 804(2). We estimate the total impact of the policies implemented in this final rule will be to reduce outlier payments for the remainder of FY 2003 by $150 million. Therefore, we have prepared the quantitative analysis under this impact analysis section at IX.G. of this preamble.

C. Regulatory Flexibility Analysis

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either based on their nonprofit status or by having revenues of $6 million to $29 million in any 1 year. For purposes of the RFA, all hospitals and other providers and suppliers are considered to be small entities. Individuals and States are not included in the definition of a small entity. As stated above, we have prepared the quantitative analysis under this impact analysis section at IX.G. of this preamble.

D. Effects on Rural Hospitals

Section 1102(b) of the Social Security Act requires us to prepare a regulatory impact analysis for any final rule that may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical

Area (MSA) or New England County Metropolitan Area (NECMA). Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the IPPS, we classify these hospitals as urban hospitals.

It is clear that the changes we are making in this final rule will affect both a substantial number of small rural hospitals as well as other classes of hospitals, and that the effects on some hospitals might be significant. Therefore, the discussion of the quantitative analysis under section IX.G. of this preamble, in combination with the rest of this final rule, constitutes a combined regulatory impact analysis and regulatory flexibility analysis.

E. Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) also requires that agencies assess anticipated costs and benefits before issuing any proposed rule or a final rule, which has been preceded by a proposed rule, that may result in an expenditure in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This final rule does not result in any unfunded mandates for State, local, or tribal governments or the private sector, as defined by section 202.

F. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule and a subsequent final rule that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. We have reviewed this final rule in light of Executive Order 13132 and have determined that it does not have any negative impact on the rights, roles, and responsibilities of State, local, or tribal governments.

G. Quantitative Analysis

As described above, the changes we are making in this final rule will better target outlier payments to the most costly cases. First, we are providing that fiscal intermediaries will no longer assign the statewide average cost-to-charge ratio in place of the actual cost-to-charge ratio when the hospital's actual ratio is more than 3 standard deviations below the geometric mean cost-to-charge ratio. Second, we are implementing the use of the most recent tentatively settled Medicare cost report to determine a hospital's cost-to-charge ratio. Third, outlier payments may be subject to reconciliation when the cost report corresponding with the outlier cases is settled, using the actual cost-to-charge ratio calculated from the final settled cost report rather than the cost-to-charge ratio from the latest tentative settled cost report at the time the claim is processed.

We anticipate these changes will lower payments to hospitals that have been aggressively gaming the existing outlier payment methodology by manipulating their charges toward those hospitals with truly high-cost cases (by lowering the thresholds). For some hospitals, the effects of the reduced payments may be quite dramatic. For those hospitals, the impact of this final rule will be to significantly decrease their outlier payments. It is difficult to quantify precisely the impact on these hospitals of this change because we will not know the final applicable cost-to-charge ratios until the cost reports are settled. However, assuming that once concurrent cost-to-charge ratios are used for these hospitals, their outlier payments as a percent of their total DRG payments are similar to past levels, we estimate a reduction of $50 million in outlier payments to these hospitals for the 2 months remaining in FY 2003.

For the 43 hospitals currently receiving outlier payments on the basis of a statewide average cost-to-charge ratio because their actual ratios are below the lower threshold, their outlier payments will begin to decline effective for discharges occurring on or after 60 days following the date of publication of this final rule. However, it is difficult to quantify the impacts upon these hospitals because we do not have data available to assess whether they have increased their charges in order to offset any anticipated reduction in their outlier payments. However, assuming no behavioral responses on the part of hospitals, we estimate that, for the approximately 2 months remaining in FY 2003 after this change goes into effect, payments to these hospitals will decline by $95 million.

For most hospitals, this final rule will not have an impact on their FY 2003 outlier payments. This is because the fixed-loss threshold is remaining at $33,560, and for the changes effective during FY 2003, we will instruct the fiscal intermediaries to focus their limited resources only on those hospitals that appear to have disproportionately benefited from the time lag in updating their cost-to-charge ratios. Also, we will not require the use of more recent cost-to-charge ratios until FY 2004.

We have examined the potential impact of the changes in the methodology for determining cost-to-charge ratios for purposes of payment of high-cost outliers and short-stay outliers under the LTCH PPS. Because the LTCH PPS is a new system that has only been in effect since October 1, 2002, and the vulnerabilities that have surfaced under the IPPS do not yet necessarily apply to LTCHs, we do not believe these policies will have a significant financial impact on LTCHs in FY 2003.

H. Alternatives Considered

For purposes of this analysis, we considered several alternatives to the changes we are finalizing in this rule as discussed above. One alternative would be to not make any changes to the current outlier policy. However, we believe that in light of the evidence that hospitals have been manipulating our current outlier policy, it is important to change the current policy as it existed prior to this final rule, to ensure these payments go to truly expensive cases. Therefore, we do not believe retaining that current policy is a viable option.

We also considered establishing a policy that hospitals' cost-to-charge ratios would be based on their rates-of-increase in charges as an alternative to reconciling outlier payments on the cost reports. However, we believe this approach would be extremely complex. In addition, this approach would require us to make assumptions about the relationship between costs and charges that may not apply in particular circumstances. Therefore, this alternative would be likely to lead to inequitable treatment of some hospitals.

We considered eliminating the application of statewide average cost-to-charge ratios altogether. However, it is necessary to have some ratio to assign to new hospitals that have not yet filed their first cost report. Also, we believe it remains appropriate to assign the statewide average cost-to-charge ratio in cases where a hospital's cost-to-charge ratio exceeds 3 standard deviations from the geometric mean.

I. Executive Order 12866

In accordance with the provisions of Executive Order 12866, this final rule was reviewed by the Office of Management and Budget.

List of Subjects in 42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

■ For the reasons stated in the preamble of this final rule, the Centers for

Medicare & Medicaid Services amends 42 CFR part 412 as follows:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

■ 1. The authority citation for Part 412 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

■ 2. Section 412.84 is amended by—
■ A. Revising paragraph (h).
■ B. Redesignating paragraphs (i), (j), and (k) as paragraphs (j), (k), and (l), respectively.
■ C. Adding a new paragraph (i).
■ D. In redesignated paragraph (k), removing the phrase ''paragraph (k) of this section'' and adding in its place ''paragraph (l) of this section.''
■ E. In redesignated paragraph (l), removing the phrase ''paragraph (j) of this section'' and adding in its place ''paragraph (k) of this section.''
■ F. Adding a new paragraph (m).
■ The additions and revisions read as follows:

§ 412.84 Payment for extraordinarily high-cost cases (cost outliers).

* * * * *

(h) For discharges occurring before October 1, 2003, the operating and capital cost-to-charge ratios used to adjust covered charges are computed annually by the intermediary for each hospital based on the latest available settled cost report for that hospital and charge data for the same time period as that covered by the cost report. For discharges occurring before August 8, 2003, statewide cost-to-charge ratios are used in those instances in which a hospital's operating or capital cost-to-charge ratios fall outside reasonable parameters. CMS sets forth the reasonable parameters and the statewide cost-to-charge ratios in each year's annual notice of prospective payment rates published in the **Federal Register** in accordance with § 412.8(b).

(i)(1) For discharges occurring on or after August 8, 2003, CMS may specify an alternative to the ratios otherwise applicable under paragraphs (h) or (i)(2) of this section. A hospital may also request that its fiscal intermediary use a different (higher or lower) cost-to-charge ratio based on substantial evidence presented by the hospital. Such a request must be approved by the CMS Regional Office.

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

(3) 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:

(i) New hospitals that have not yet submitted their first Medicare cost report. (For this purpose, a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with § 489.18 of this chapter.)

(ii) Hospitals whose operating or capital cost-to-charge ratio is in excess of 3 standard deviations above the corresponding national geometric mean. This mean is recalculated annually by CMS and published in the annual notice of prospective payment rates issued in accordance with § 412.8(b).

(iii) Other hospitals for whom the fiscal intermediary obtains accurate data with which to calculate either an operating or capital cost-to-charge ratio (or both) are not available.

(4) 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 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.

* * * * *

(m) Effective for discharges occurring on or after August 8, 2003, at the time of any reconciliation under paragraph (h)(3) of this section, outlier payments may be adjusted to account for the time value of any underpayments or overpayments. 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.

§ 412.116 [Amended]

■ 3. In § 412.116(e), the second sentence is removed.

■ 4. Section 412.525 is amended by revising paragraph (a)(4) to read as follows:

§ 412.525 Adjustments to the Federal prospective payment.

(a) *Adjustments for high-cost outliers.* * * *

(4)(i) For discharges occurring on or after October 1, 2002 and before August 8, 2003, no reconciliations will be made to outlier payments upon cost report settlement to account for differences between the estimated cost-to-charge ratio and the actual cost-to-charge ratio of the case.

(ii) For discharges occurring on or after August 8, 2003, high-cost outlier payments are subject to the provisions of §§ 412.84(i)(1), (i)(3), and (i)(4) and (m) for adjustments of cost-to-charge ratios.

(iii) For discharges occurring on or after October 1, 2003, high-cost outlier payments are subject to the provisions of § 412.84(i)(2) for adjustments to cost-to-charge ratios.

* * * * *

■ 5. Section 412.529 is amended by revising paragraph (c)(5) to read as follows:

§ 412.529 Special payment provision for short-stay outliers.

* * * * *

(c) * * *

(5)(i) For discharges occurring on or after October 1, 2002 and before August 8, 2003, no reconciliations will be made to short-stay outlier payments upon cost report settlement to account for differences between cost-to-charge ratio and the actual cost-to-charge ratio of the case.

(ii) For discharges occurring on or after August 8, 2003, short-stay outlier payments are subject to the provisions of §§ 412.84(i)(1), (i)(3), and (i)(4) and (m) for adjustments of cost-to-charge ratios.

(iii) For discharges occurring on or after October 1, 2003, short-stay outlier payments are subject to the provisions of § 412.84(i)(2) for adjustments to cost-to-charge ratios.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance.)

Dated: May 30, 2003.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Approved: June 3, 2003.

Tommy G. Thompson,

Secretary.

[FR Doc. 03–14492 Filed 6–5–03; 3:27 pm]

BILLING CODE 4120–01–P