

hospital were treating new or different types of cases.

Because we use settled cost reports to compute hospitals' cost-to-charge ratios, the recent dramatic increases in charges for these hospitals are not reflected in their cost-to-charge ratios. For example, among these 123 hospitals, the mean rate of increase in charges was 70 percent. Meanwhile, cost-to-charge ratios for these hospitals, which were based upon cost reports from prior periods, declined by only 2 percent.

Because a hospital has the ability to increase its outlier payments during this time lag through dramatic charge increases, in this proposed rule we are proposing 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 are proposing to revise our regulations to specify that fiscal intermediaries will use either the most recent settled 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 are proposing in this proposed rule, would reduce 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 are proposing to reduce the lag in time by proposing to revise the regulations to use the latest tentative settled cost report, rather than the latest settled cost report, if it 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 are

proposing to add a new provision to the regulations at § 412.84(i). Under this proposed provision, 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 are proposing to allow a hospital to contact its fiscal intermediary to request that its cost-to-charge ratios, otherwise applicable under § 412.84(i), 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. Statewide Averages

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, per 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 urban California hospital the statewide average cost-to-charge ratio of 0.328 (from Table 8A of the August 1, 2002 final rule, 67 FR 50263). In this case, receiving the statewide average cost-to-charge ratio 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 requesting that fiscal intermediaries 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, we are proposing to remove the current requirement in our regulations specifying 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 are proposing that hospitals would receive their actual cost-to-charge ratios, no matter how low their ratios fall.

We are proposing 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. 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, 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.

C. Reconciling Outlier Payments Through Settled Cost Reports

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