

determined that it would 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 proposing would better target outlier payments to the most costly cases. First, by proposing to use the cost-to-charge ratios from the latest tentative settled cost reports at the time the claim is processed, instead of the latest settled cost reports, the lag time between the cost-to-charge ratio used to adjust charges to costs and the charges on the claim will be reduced by a year or more. Second, we are proposing that fiscal intermediaries would 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. Finally, we are proposing that 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 proposed changes will redistribute outlier payments away from hospitals that have been aggressively gaming the existing outlier payment methodology by manipulating their charges toward those hospitals with truly high-cost cases. For some hospitals, the effects of this redistribution may be quite dramatic. For example, as noted previously, we have identified 123 hospitals that appear to have been most aggressively gaming the current policy. On average, current outlier payments for these hospitals comprise 24 percent of their total DRG payments. The changes we are proposing would be likely to greatly reduce the level of outlier payments for these hospitals.

However, as we also noted above, it is not currently possible to assess the extent to which other hospitals may have begun to engage in similar practices, particularly given the public attention that has focused on this problem. Therefore, hospitals that may not previously have been aggressively gaming the policy, and that would otherwise appear to benefit from the redistribution of outlier payments, may in fact also be negatively impacted by these proposed changes. At this time, however, data are not available to assess fully the degree to which other hospitals

began this practice during FY 2002, and no data are yet available for FY 2003.

Therefore, we are unable to quantify the likely impacts of these proposed changes. We anticipate that by the time we prepare the final rule, more data will be available to better assess the winners and losers of these proposed changes. If so, we will include a quantitative impact analysis at that time.

H. Alternatives Considered

For purposes of analysis, we considered several alternatives to the proposed changes 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 to ensure these payments go to truly expensive cases. Therefore, we do not believe that retaining our 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 proposed rule was reviewed by the Office of Management and Budget.

V. Response to Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the "DATES" section of this preamble, and, when we proceed with a subsequent document, we will

respond to the comments in the preamble to that document.

VI. Change of the Required 60-Day Comment Period to a 30-Day Comment Period

Section 1871 of the Social Security Act provides that the Secretary shall provide for notice of any proposed regulation in the **Federal Register** and a period of not less than 60 days for public comment before issuing a regulation in final form. However, this notice-and-comment procedure may be waived if the agency, for good cause, finds that the notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and the reasons for it into the notice issued.

We believe there is good cause to waive the 60-day comment period. In light of the importance of the outlier issue and the extensive changes being proposed, however, we believe it is also important to provide a public comment period on the proposed policies, not because it is required, but as a matter of good public policy. Accordingly, in order to balance these competing interests, we are voluntarily providing a 30-day period for the submission of public comments.

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. In addition, if these proposed changes are not implemented expeditiously, additional hospitals will likely begin to increase their charges to take advantage of the vulnerabilities of the current system, and those hospitals that already have engaged in this activity will continue to do so. This has the undesirable impact not only of further distorting the distribution of outlier payments, but it also has negative impacts on other insurers and the public. In the case of other insurers, Medicare's payments often serve as a benchmark for establishing their payments to individual hospitals. To the extent Medicare continues to pay excessive outlier payments to some hospitals, this may have spillover effects to private insurance companies. In the case of the public, particularly those without health insurance, they face the prospect of being expected to pay these exorbitant hospital charges when they