

become hospitalized at an institution that has engaged in these practices. Extending the duration of these payment inequities would be contrary to the public interest and could adversely affect the provision of services to Medicare beneficiaries.

We believe that providing a 30-day comment period for the proposed policies in this document allows hospitals and the general public sufficient opportunity to address any concerns or issues that they may have, and at the same time, allows CMS to address the issue of excessive outlier payments within the current fiscal year (FY 2003). Hospitals are already familiar with the existing outlier payment policies and should be able to readily assess the impact that the proposed changes may have on their programs and respond to the proposed changes in the outlier payment methodology.

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 proposed rule, the Centers for Medicare & Medicaid Services proposes to amend 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 revisions read as follows:

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

* * * * *

(h) For discharges occurring before the effective date of the final rule, 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. 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 under § 412.8(b).

(i)(1) For discharges occurring on or after the effective date of the final rule, the operating and capital cost-to-charge ratios applied at the time a claim is processed are based on either the most recent settled or the most recent tentative settled cost report, whichever is from the latest cost reporting period (unless otherwise specified by CMS based on later available 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. Such a request must be approved by the CMS Regional Office. If a fiscal intermediary is unable to determine an accurate operating or capital cost-to-charge ratio for a hospital in one of the following circumstances, it may use a statewide average cost-to-charge ratio:

(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 three 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 published under § 412.8(b).

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

(2) For discharges occurring on or after the effective date of the final rule, 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 the effective date of the final

rule, at the time the cost report is settled, 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.

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

Dated: January 24, 2003.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Approved: February 6, 2003.

Tommy G. Thompson,

Secretary.

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FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 54

[CC Docket No. 96–45; FCC 03J–1]

Federal-State Joint Board on Universal Service Seeks Comment on Certain of the Commission's Rules Relating to High-Cost Universal Service Support and the ETC Designation Process

AGENCY: Federal Communications Commission.

ACTION: Solicitation of comments.

SUMMARY: On November 8, 2002, the Federal Communications Commission requested that the Federal-State Joint Board on Universal Service “review certain of the Commission's rules relating to the high-cost universal service support mechanisms to ensure that the dual goals of preserving universal service and fostering competition continue to be fulfilled.” In particular, the Commission asked the Joint Board to review the Commission's rules relating to high-cost universal service support in study areas in which a competitive eligible telecommunications carrier is providing services, as well as the Commission's rules regarding support for second lines. The Commission also asked the Joint Board to examine the process for designating ETCs. In this document, the Joint Board invite public comment on whether these rules continue to fulfill their intended purposes, whether