

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