

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