

percent from the most recent tentative settled cost report. In the third year, this gradual decrease from the base year could continue or CMS could cease from blending the cost-to-charge ratio.

The second recommendation was a 3-year transition period using blended cost-to-charge ratios as follows: The first year would be 75 percent of the old cost-to-charge ratio and 25 percent of the new. The second year would be 50 percent of the old cost-to-charge ratio and 50 percent of the new cost-to-charge ratio. The third year would be 25 percent of the old cost-to-charge ratio and 75 percent of the new cost-to-charge ratio. During the transition period, CMS would monitor outlier payments to ensure they remain in statutory limits. Only those hospitals that have not been identified by CMS as having excessive outlier payments would qualify for the transition period.

Response: As noted previously, we believe it is essential to eliminate the effects of the inappropriate redistribution of outlier payments as soon as possible; that is, by not allowing hospitals that have benefited from the time lag resulting from the use of the latest settled cost-to-charge ratios to continue to do so. We do not believe any transition period would be appropriate, as it would continue to lead to lower outlier payments to those hospitals that have already been harmed by the inappropriate redistribution of outliers described above. Therefore, although in this final rule we are delaying the effective date of this provision until discharges occurring on or after October 1, 2003, so that most hospitals that had relied on outlier payments based on existing policy may continue to do so for the remainder of the Federal fiscal year, we are not adopting the commenters' suggestions to further delay the effective date by allowing for a blended cost-to-charge ratio.

Comment: Several other commenters offered different recommendations on how CMS should administer updating of a hospital's cost-to-charge ratio. One commenter recommended that hospitals be notified in advance of any change to their cost-to-charge ratio and be given the opportunity to appeal the fiscal intermediary's decision of any change to their cost-to-charge ratio. Another commenter suggested that parameters be set, such as those in Program Memorandums A-02-122 (released December 3, 2002) and A-02-126 (released December 20, 2002), to determine when a cost-to-charge ratio should be updated. One commenter proposed that CMS use an expedited process when a hospital is requesting

that its cost-to-charge ratio be decreased and not require the use of "substantial evidence" for a reduction. For increases in cost-to-charge ratios, the commenter suggested that CMS might want to reserve final approval and substantial evidence standards. Other commenters suggested that hospitals be provided with an expedited appeals process to resolve quickly any disputes with the fiscal intermediaries over the accuracy of their cost-to-charge ratios. Some commenters supported using a hospital's tentative settled cost report to update cost-to-charge ratios but believed that fiscal intermediaries should have discretion to change a hospital's cost-to-charge ratio.

Response: As we proposed, in this final rule we are implementing a new regulation that specifies that CMS may direct the fiscal intermediary to change a hospital's operating and capital cost-to-charge ratios to reflect the high-charge increases evidenced by the later data. Fiscal intermediaries will not have their own discretion to update a hospital's cost-to-charge ratio. Only CMS will have the authority to direct the fiscal intermediary that an update is necessary in the event more recent charge data indicates that a hospital's charges have been increasing at an excessive rate (relative to the rate-of-increase among other hospitals).

C. Provisions of the Final Rule Relating to Updating Cost-to-Charge Ratios

We are establishing a new § 412.84(i)(1), which specifies that, for discharges occurring on or after 60 calendar days after the date of publication of this final rule, 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 may 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. 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. Before the change can go into effect, the CMS Regional Office must approve the request.

We also are establishing § 412.84(i)(2), which provides that, for discharges occurring on or after October 1, 2003, the operating and capital cost-to-charge ratios applied at the time a claim is processed are based on either the most recent settled cost report or the most recent tentative settled cost report, whichever is from the latest cost reporting period.

IV. Statewide Average Cost-to-Charge Ratios

A. Background and Provisions of the March 5, 2003 Proposed Rule

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, under 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 hospital the statewide average cost-to-charge ratio of 0.328 (from Table 8A of the August 1, 2002 IPPS final rule (67 FR 50263)). In this case, the assignment of the statewide average cost-to-charge ratio to this hospital 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, which requested fiscal intermediaries to 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