

14 listed hospitals was 0.008. In contrast, the statewide average operating cost-to-charge ratio for the 43 hospitals was 0.3425 and the statewide average capital cost-to-charge ratio for the 14 hospitals was 0.035.

Because of hospitals' ability to increase their charges to lower their cost-to-charge ratios in order to be assigned the statewide average, in the March 5, 2003 proposed rule, we proposed to remove the requirement in our existing regulations that specified that a fiscal intermediary will assign a hospital the statewide average cost-to-charge ratio when the hospital has a cost-to-charge ratio that falls below the floor. We proposed that hospitals would receive their actual cost-to-charge ratios, no matter how low their ratios fall.

We proposed that statewide average cost-to-charge ratios would still apply in those instances in which a hospital's operating or capital cost-to-charge ratio exceeds the upper threshold. We indicated that cost-to-charge ratios above this range are probably due to faulty data reporting or entry and should not be used to identify and pay for outliers. In addition, we proposed that hospitals that have not yet filed their first Medicare cost reports with their fiscal intermediaries would still receive the statewide average cost-to-charge ratios.

B. Summary of Public Comments and Departmental Responses

Comment: Many commenters supported the proposal to remove the existing requirement that specified that a fiscal intermediary will assign a hospital the statewide average cost-to-charge ratio when the hospital has a cost-to-charge ratio that falls below the floor. However, they argued that the requirement to use the statewide average ratio for those hospitals that are above 3 standard deviations from the geometric mean should also be removed. The commenters reasoned that the policy should be consistent for the floor and the ceiling. As an alternative to using the statewide average (instead of ratios above the ceiling), some commenters suggested that we reduce the parameter of 3 standard deviations above the mean to a lower standard. Another commenter stated that CMS was acting in bad faith by eliminating the statewide average for the floor but not the ceiling.

Response: The changes we are making in this final rule are in response to a specific problem associated with hospitals intentionally taking advantage of our policy to assign the statewide cost-to-charge ratios when a hospital's own ratio fell below the floor. There is

no similar incentive for hospitals to increase their ratios to the ceiling. Also, we believe it is unlikely a hospital would maintain a cost-to-charge ratio as high as 3 standard deviations of the geometric mean over a period of years. Therefore, we continue to believe the statewide average should be assigned for those hospitals with ratios above the ceiling.

Comment: One commenter argued that a transition period would be necessary because this change would have an immediate impact on affected hospitals' credit stability and patient service levels in certain regions. Another commenter suggested a transition period for those hospitals that did not engage in aggressive pricesetting. The commenter suggested a gradual phaseout of the statewide average. On the other hand, many commenters also supported the immediate elimination of the statewide average from the floor.

Response: We believe that, for hospitals receiving the statewide average cost-to-charge ratio because their actual ratio fell below 3 standard deviations below the geometric mean, their actual ratio is a more accurate reflection of the relationship between their costs and charges. Although it may not have been a specific objective of each hospital currently in this situation to increase charges until its ratio fell below the floor, we are not persuaded there is any justification to continue making outlier payments to these hospitals on the basis of a cost-to-charge ratio that clearly results in excessive outlier payments. Therefore, we are adopting as final the proposed change that eliminates the use of the statewide average for hospitals below 3 standard deviations from the geometric mean effective for discharges occurring on or after 60 calendar days after the date of publication of this final rule.

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

We are implementing new regulations at §§ 412.84(h) and (i)(1) that are effective 60 calendar days after the date of publication of this final rule, that remove the existing requirement that a fiscal intermediary will assign a hospital the statewide average cost-to-charge ratio when the hospital has a cost-to-charge ratio that falls below the floor. Hospitals will receive their actual cost-to-charge ratios, no matter how low their ratios fall.

The statewide average cost-to-charge ratios will still apply in those instances in which a hospital's operating or capital cost-to-charge ratios fall outside

of reasonable parameters (that is, exceed the upper threshold). In addition, hospitals that have not yet filed their first Medicare cost reports with their fiscal intermediaries would still receive the statewide average cost-to-charge ratios. CMS will continue to set forth the reasonable parameters and the statewide cost-to-charge ratios in each year's annual notice of prospective payment rates published in the **Federal Register** in accordance with § 412.8(b).

V. Reconciling Outlier Payments Through Settled Cost Reports

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

Under the IPPS, hospitals submit a bill for each Medicare patient stay for which they expect a payment from Medicare. The bill includes information needed to: (1) Classify the case to a DRG; (2) determine whether the case was a transfer; (3) identify whether a new technology eligible for add-on payments was involved; and (4) calculate the costs of a case to determine whether it is eligible for an outlier payment or a new technology add-on payment. This latter calculation is based on the covered charges reported on the bill, which, as discussed above, are also used to estimate the covered costs of the case by applying the cost-to-charge ratio.

The information from the bill is processed through the fiscal intermediary's claims processing system to determine the payment amount for each case. Unless a hospital qualifies for periodic interim payments under § 412.116(b), or other interim payments, payment is made on the basis of the actual amount determined for each bill processed. For hospitals that qualify for periodic interim payments, the fiscal intermediary estimates a hospital's IPPS payments and makes biweekly payments equal to $\frac{1}{26}$ of the total estimated amount of payment for the year. However, outlier payments are not made on an interim basis, but are made on a claim-by-claim basis (even for hospitals that qualify for interim payments under § 412.116(b)), and generally represent final payment (§ 412.116(e)). This policy is in contrast to payments under the IME adjustment and the DSH adjustment, both of which are routinely adjusted when hospitals' cost reports are settled to reflect updated data such as the number of residents or patient days during the actual cost reporting period.

However, as stated earlier in this preamble, we are increasingly aware that some hospitals have taken advantage of the existing outlier policy