

settled cost report, whichever is later. Finally, once a hospital submits to the fiscal intermediary its cost report for the period ending on or after August 8, 2003, the fiscal intermediary would use the program instructions we intend to issue in the near future that will provide specific criteria for implementing this provision on reconciliation.

Comment: A commenter who wrote on behalf of LTCHs that have a fiscal year end date of December 31, asked the following questions related to the proposed cost-to-charge ratio policy: (1) Will the cost-to-charge ratio for outlier payments be derived from the prior year's (December 31, 2002) cost report or from the fiscal year ending December 31, 2001, cost report, since the fiscal year ending December 31, 2002, cost report is not due to the Medicare fiscal intermediary until May 31, 2003? (2) Will the cost-to-charge ratio change when the fiscal year ending December 31, 2003, cost report is filed on May 31, 2004? (3) Will the cost-to-charge ratio for fiscal year ending December 31, 2003, outlier payments change when the cost report is tentatively settled and finalized in 2004 or 2005? (4) Will the cost-to-charge ratios for fiscal year ending December 31, 2003, change when appeals are settled in 2006 or 2007? (5) Will each Medicare claim applicable to outlier payments be reprocessed when the cost-to-charge ratio changes?

Response: It appears that the commenter is essentially asking how cost report settlement will affect changes to a hospital's cost-to-charge ratio. As explained above, each hospital's cost-to-charge ratio may change effective for discharges occurring on or after August 8, 2003, in instances where the cost-to-charge ratio is below the floor, or CMS believes an alternative cost-to-charge ratio should be used. A hospital's cost-to-charge ratio also may change effective for discharges occurring on or after October 1, 2003, based on the most recent tentatively settled cost report, or the final settled cost report, whichever is later.

In response to the commenter's third question, the reconciliation policy is effective for discharges occurring on or after 60 calendar days after the publication of this final rule. As we stated above, we intend to issue a program instruction to fiscal intermediaries in the near future that will provide specific criteria for determining how the reconciliation of outlier payments will be implemented. However, we note, as with other cost report settlement issues, the hospital may appeal the Notice of Program Reimbursement for the December 31,

2004, cost report and the cost-to-charge ratio, and, therefore, outlier payments may change depending on the outcome of the appeal.

Finally, in response to the commenter's fifth question, not all claims may be reprocessed when the cost-to-charge ratio changes upon reconciliation. Again, as explained previously, we intend to issue a program instruction to fiscal intermediaries that will provide specific criteria for determining how the reconciliation of outlier payments will be implemented.

Comment: One commenter supported the proposal to use more recent cost-to-charge ratios to calculate outlier payments and eliminate the use of the statewide average cost-to-charge ratio floor, but expressed concern that an abrupt change to cost-to-charge ratios would create significant and unanticipated reductions in outlier payments and urged CMS to implement a transition period for all hospitals that would be adversely affected by the proposed policy changes.

Response: We have received many comments stating that a transition period is necessary, mostly in relation to the proposed policy for IPPS outlier payments. In the context of LTCHs, we do not believe that this policy will result in significant reductions in historic outlier payments, because the LTCH PPS is a new system, there were no outlier payments under the previous reasonable cost-based payment methodology, and LTCHs only recently had the opportunity to choose whether they wish to be reimbursed on a blend of LTCH PPS and reasonable cost-based payments over a 5-year period, or on 100 percent of the Federal rate.

Therefore, we do not believe that the proposed changes to the outlier policy will place any LTCHs at risk for a substantial loss of reimbursement. In addition, as stated above, we believe that the proposed policy changes will ensure that the fixed-loss amount is established at a reasonable level and that each hospital will be reimbursed for high-cost and short-stay outlier cases in an accurate and equitable manner. Thus, we believe that it is in the best interest of CMS and the hospital community as a whole to forego a transition period and implement the proposed changes to the outlier policy as soon as possible.

E. Provisions of the Final Rule

Consistent with the final IPPS outlier policy in this final rule, we are revising §§ 412.525(a)(4) and 412.529(c)(5) to specify that, for discharges from LTCHs under the LTCH PPS occurring on or after October 1, 2002, and before August

8, 2003, no reconciliations will be made to high-cost outlier payments or to short-stay outlier payments, respectively, upon cost report settlement to account for differences between the estimated cost-to-charge ratio and the actual cost-to-charge ratio of the case. We are specifying in §§ 412.525(a)(4)(iii) and 412.529(c)(5)(iii) that for discharges from LTCHs under the LTCH PPS occurring on or after October 1, 2003, high-cost outlier payments and short-stay outlier payments, respectively, are subject to the provisions of § 412.84(i)(2) (which are applicable to IPPS hospitals).

G. Short-Stay Outlier Cases

A short-stay outlier case may occur when a beneficiary receives less than the full course of treatment at the LTCH before being discharged. These patients may be discharged to another site of care or they may be discharged and not readmitted because they no longer require treatment. Furthermore, patients may expire early in their LTCH stay.

As we discussed in the August 30, 2002, LTCH PPS final rule (67 FR 55970), generally LTCHs are defined by statute as having an average length of stay of greater than 25 days. We believe that a payment adjustment for short-stay outlier cases results in more appropriate payments, because these cases most likely would not receive a full course of treatment in such a short period of time and a full LTC-DRG payment may not always be appropriate. Payment-to-cost ratios simulated for LTCHs, for the cases described above, show that if LTCHs receive a full LTC-DRG payment for those cases, they would be significantly "overpaid" for the resources they have actually expended.

Under § 412.529, we adjust the per discharge payment for a short-stay outlier patient to the least of 120 percent of the cost of the case, 120 percent of the LTC-DRG specific per diem amount multiplied by the length of stay of that discharge, or the full LTC-DRG payment, for all cases with a length of stay up to and including five-sixths of the geometric average length of stay of the LTC-DRG.

As we discussed in section VI.C.3. of the March 7, 2003, proposed rule, in the March 5, 2003, proposed rule (68 FR 10420), we proposed to revise the methodology for determining cost-to-charge ratios for acute care hospitals under the IPPS because we became aware that payment vulnerabilities exist in the current IPPS outlier policy. Because the LTCH PPS high-cost outlier and short-stay outlier payments are also based on cost-to-charge ratios as under the IPPS, we believe they are