

Area (MSA) or New England County Metropolitan Area (NECMA). Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98-21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the IPPS, we classify these hospitals as urban hospitals.

It is clear that the changes we are making in this final rule will affect both a substantial number of small rural hospitals as well as other classes of hospitals, and that the effects on some hospitals might be significant. Therefore, the discussion of the quantitative analysis under section IX.G. of this preamble, in combination with the rest of this final rule, constitutes a combined regulatory impact analysis and regulatory flexibility analysis.

#### *E. Unfunded Mandates*

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4) also requires that agencies assess anticipated costs and benefits before issuing any proposed rule or a final rule, which has been preceded by a proposed rule, that may result in an expenditure in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of \$110 million. This final rule does not result in any unfunded mandates for State, local, or tribal governments or the private sector, as defined by section 202.

#### *F. Federalism*

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule and a subsequent final rule that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. We have reviewed this final rule in light of Executive Order 13132 and have determined that it does not have any negative impact on the rights, roles, and responsibilities of State, local, or tribal governments.

#### *G. Quantitative Analysis*

As described above, the changes we are making in this final rule will better target outlier payments to the most costly cases. First, we are providing that fiscal intermediaries will no longer assign the statewide average cost-to-charge ratio in place of the actual cost-to-charge ratio when the hospital's actual ratio is more than 3 standard deviations below the geometric mean cost-to-charge ratio. Second, we are implementing the use of the most recent tentatively settled Medicare cost report to determine a hospital's cost-to-charge

ratio. Third, outlier payments may be subject to reconciliation when the cost report corresponding with the outlier cases is settled, using the actual cost-to-charge ratio calculated from the final settled cost report rather than the cost-to-charge ratio from the latest tentative settled cost report at the time the claim is processed.

We anticipate these changes will lower payments to hospitals that have been aggressively gaming the existing outlier payment methodology by manipulating their charges toward those hospitals with truly high-cost cases (by lowering the thresholds). For some hospitals, the effects of the reduced payments may be quite dramatic. For those hospitals, the impact of this final rule will be to significantly decrease their outlier payments. It is difficult to quantify precisely the impact on these hospitals of this change because we will not know the final applicable cost-to-charge ratios until the cost reports are settled. However, assuming that once concurrent cost-to-charge ratios are used for these hospitals, their outlier payments as a percent of their total DRG payments are similar to past levels, we estimate a reduction of \$50 million in outlier payments to these hospitals for the 2 months remaining in FY 2003.

For the 43 hospitals currently receiving outlier payments on the basis of a statewide average cost-to-charge ratio because their actual ratios are below the lower threshold, their outlier payments will begin to decline effective for discharges occurring on or after 60 days following the date of publication of this final rule. However, it is difficult to quantify the impacts upon these hospitals because we do not have data available to assess whether they have increased their charges in order to offset any anticipated reduction in their outlier payments. However, assuming no behavioral responses on the part of hospitals, we estimate that, for the approximately 2 months remaining in FY 2003 after this change goes into effect, payments to these hospitals will decline by \$95 million.

For most hospitals, this final rule will not have an impact on their FY 2003 outlier payments. This is because the fixed-loss threshold is remaining at \$33,560, and for the changes effective during FY 2003, we will instruct the fiscal intermediaries to focus their limited resources only on those hospitals that appear to have disproportionately benefited from the time lag in updating their cost-to-charge ratios. Also, we will not require the use of more recent cost-to-charge ratios until FY 2004.

We have examined the potential impact of the changes in the methodology for determining cost-to-charge ratios for purposes of payment of high-cost outliers and short-stay outliers under the LTCH PPS. Because the LTCH PPS is a new system that has only been in effect since October 1, 2002, and the vulnerabilities that have surfaced under the IPPS do not yet necessarily apply to LTCHs, we do not believe these policies will have a significant financial impact on LTCHs in FY 2003.

#### *H. Alternatives Considered*

For purposes of this analysis, we considered several alternatives to the changes we are finalizing in this rule as discussed above. One alternative would be to not make any changes to the current outlier policy. However, we believe that in light of the evidence that hospitals have been manipulating our current outlier policy, it is important to change the current policy as it existed prior to this final rule, to ensure these payments go to truly expensive cases. Therefore, we do not believe retaining that current policy is a viable option.

We also considered establishing a policy that hospitals' cost-to-charge ratios would be based on their rates-of-increase in charges as an alternative to reconciling outlier payments on the cost reports. However, we believe this approach would be extremely complex. In addition, this approach would require us to make assumptions about the relationship between costs and charges that may not apply in particular circumstances. Therefore, this alternative would be likely to lead to inequitable treatment of some hospitals.

We considered eliminating the application of statewide average cost-to-charge ratios altogether. However, it is necessary to have some ratio to assign to new hospitals that have not yet filed their first cost report. Also, we believe it remains appropriate to assign the statewide average cost-to-charge ratio in cases where a hospital's cost-to-charge ratio exceeds 3 standard deviations from the geometric mean.

#### *I. Executive Order 12866*

In accordance with the provisions of Executive Order 12866, this final rule was reviewed by the Office of Management and Budget.

#### **List of Subjects in 42 CFR Part 412**

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

■ For the reasons stated in the preamble of this final rule, the Centers for