

Medicare & Medicaid Services amends 42 CFR part 412 as follows:

## **PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES**

■ 1. The authority citation for Part 412 continues to read as follows:

**Authority:** Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

■ 2. Section 412.84 is amended by—

■ A. Revising paragraph (h).

■ B. Redesignating paragraphs (i), (j), and (k) as paragraphs (j), (k), and (l), respectively.

■ C. Adding a new paragraph (i).

■ D. In redesignated paragraph (k), removing the phrase “paragraph (k) of this section” and adding in its place “paragraph (l) of this section.”

■ E. In redesignated paragraph (l), removing the phrase “paragraph (j) of this section” and adding in its place “paragraph (k) of this section.”

■ F. Adding a new paragraph (m).

■ The additions and revisions read as follows:

### **§ 412.84 Payment for extraordinarily high-cost cases (cost outliers).**

\* \* \* \* \*

(h) For discharges occurring before October 1, 2003, the operating and capital cost-to-charge ratios used to adjust covered charges are computed annually by the intermediary for each hospital based on the latest available settled cost report for that hospital and charge data for the same time period as that covered by the cost report. For discharges occurring before August 8, 2003, statewide cost-to-charge ratios are used in those instances in which a hospital's operating or capital cost-to-charge ratios fall outside reasonable parameters. CMS sets 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).

(i)(1) For discharges occurring on or after August 8, 2003, CMS may specify an alternative to the ratios otherwise applicable under paragraphs (h) or (i)(2) of this section. 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. Such a request must be approved by the CMS Regional Office.

(2) 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.

(3) For discharges occurring on or after August 8, 2003, the fiscal intermediary may use a statewide average cost-to-charge ratio if it is unable to determine an accurate operating or capital cost-to-charge ratio for a hospital in one of the following circumstances:

(i) New hospitals that have not yet submitted their first Medicare cost report. (For this purpose, a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with § 489.18 of this chapter.)

(ii) Hospitals whose operating or capital cost-to-charge ratio is in excess of 3 standard deviations above the corresponding national geometric mean. This mean is recalculated annually by CMS and published in the annual notice of prospective payment rates issued in accordance with § 412.8(b).

(iii) Other hospitals for whom the fiscal intermediary obtains accurate data with which to calculate either an operating or capital cost-to-charge ratio (or both) are not available.

(4) For discharges occurring on or after August 8, 2003, any reconciliation of outlier payments will be based on operating and capital cost-to-charge ratios calculated based on a ratio of costs to charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled.

\* \* \* \* \*

(m) Effective for discharges occurring on or after August 8, 2003, at the time of any reconciliation under paragraph (h)(3) of this section, outlier payments may be adjusted to account for the time value of any underpayments or overpayments. Any adjustment will be based upon a widely available index to be established in advance by the Secretary, and will be applied from the midpoint of the cost reporting period to the date of reconciliation.

### **§ 412.116 [Amended]**

■ 3. In § 412.116(e), the second sentence is removed.

■ 4. Section 412.525 is amended by revising paragraph (a)(4) to read as follows:

### **§ 412.525 Adjustments to the Federal prospective payment.**

(a) *Adjustments for high-cost outliers.*

\* \* \*

(4)(i) For discharges occurring on or after October 1, 2002 and before August 8, 2003, no reconciliations will be made to outlier payments 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.

(ii) For discharges occurring on or after August 8, 2003, high-cost outlier payments are subject to the provisions of §§ 412.84(i)(1), (i)(3), and (i)(4) and (m) for adjustments of cost-to-charge ratios.

(iii) For discharges occurring on or after October 1, 2003, high-cost outlier payments are subject to the provisions of § 412.84(i)(2) for adjustments to cost-to-charge ratios.

\* \* \* \* \*

■ 5. Section 412.529 is amended by revising paragraph (c)(5) to read as follows:

### **§ 412.529 Special payment provision for short-stay outliers.**

\* \* \* \* \*

(c) \* \* \*

(5)(i) For discharges occurring on or after October 1, 2002 and before August 8, 2003, no reconciliations will be made to short-stay outlier payments upon cost report settlement to account for differences between cost-to-charge ratio and the actual cost-to-charge ratio of the case.

(ii) For discharges occurring on or after August 8, 2003, short-stay outlier payments are subject to the provisions of §§ 412.84(i)(1), (i)(3), and (i)(4) and (m) for adjustments of cost-to-charge ratios.

(iii) For discharges occurring on or after October 1, 2003, short-stay outlier payments are subject to the provisions of § 412.84(i)(2) for adjustments to cost-to-charge ratios.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance.)

Dated: May 30, 2003.

**Thomas A. Scully,**  
Administrator, Centers for Medicare & Medicaid Services.

Approved: June 3, 2003.

**Tommy G. Thompson,**  
Secretary.

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