this language to mean that, if a hospital's cost report for the most recent cost reporting period ending on or before September 30, 2002, has been settled, then, unless the hospital submits a timely request to use the cost reporting period that includes July 1, 2003, we would use the hospital's settled cost report without further audit to determine possible reductions to the FTE resident caps. We also are proposing to interpret this language to mean that if a hospital's cost report for the most recent cost reporting period ending on or before September 30, 2002, has not been settled, the hospital's as-submitted cost report for the most recent cost reporting period ending on or before September 30, 2002, would be subject to audit by the fiscal intermediary. In addition, as stated under section 1886(h)(7)(A)(ii)(II) of the Act, use of a hospital's cost report that includes July 1, 2003 is made ''after audit and subject to the discretion of the Secretary.'' A hospital's cost report that includes July 1, 2003 may be at various stages of settlement, or may not even be submitted at the time this proposed rule is published. For example, if a hospital has a fiscal year end of June 30, its cost reporting period that includes July 1, 2003 would not end until June 30, 2004. This cost report is not required to be submitted until 5 months after the cost reporting period closes, which would be by December 1, 2004. In any case, the fiscal intermediary would need to make a determination as to whether a hospital has actually increased its resident level due to an expansion of an existing program that is not reflected on the most recent settled cost report. Further, the FTE resident counts that are included (or would be included) in the cost report that includes July 1, 2003, are subject to audit by the fiscal intermediary to ensure that an appropriate determination is made as to whether, and by how much, a hospital's FTE resident cap will be reduced. To facilitate these determinations, we are proposing that the fiscal intermediaries may audit the FTE resident counts as necessary in the most recently settled cost reports and in the cost reports up to and including the cost report for the cost reporting period that includes July 1, 2003.

Fiscal intermediaries will perform desk or onsite audits related to section 422, using instructions that will be issued in a separate document. As we explained in the OTN, Transmittal No. 77, CR 3247, in the interest of time and the most efficient use of audit resources, we have required that if a hospital would like CMS to use its cost report that includes July 1, 2003, as its reference period due to an expansion of an existing program, the hospital must notify the fiscal intermediary in accordance with the instructions provided in the OTN by June 4, 2004. If a hospital submits a timely request that its cost report that includes July 1, 2003, be used, the fiscal intermediary would audit that cost report and previous cost reports as necessary to determine if the hospital increased its resident level due to an expansion of an existing program that is not reflected on the most recent settled cost report. If a hospital does not submit a timely request to the fiscal intermediary that its cost report that includes July 1, 2003, be used, the fiscal intermediary would use the cost report for the most recent cost reporting period ending on or before September 30, 2002, to determine if, and by how much, a hospital's FTE resident cap should be reduced, as specified under section 1886(h)(7)(A)(ii)(I) of the Act. If the cost report that is used to determine the possible reduction to a hospital's FTE resident count is for a period of less than or more than 12 months, we are proposing that the fiscal intermediary would prorate the FTE resident caps and unweighted FTE residents to equal 12-month counts.

(4) Expansions Under Newly Approved Programs

Under section 1886(h)(7)(ii)(III) of the Act, as added by section 422(a)(3) of Public Law 108–173, a hospital may request that its reference resident level be adjusted to include residents in certain newly approved programs. Specifically, if a hospital's new program was accredited by the appropriate accrediting body (that is, the Accreditation Council on Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA)) before January 1, 2002, but was not in operation during the hospital's reference period, the hospital may submit a timely request that we adjust the reference resident level to include the number of residents for which a new program was accredited at a hospital(s). For a hospital that requests an adjustment due to a newly approved program, we are proposing to determine a hospital's reference period as we otherwise would. If a hospital received accreditation for a new medical residency training program before January 1, 2002, but the program was not in operation (that is, the hospital did not begin training residents in that program) during its reference period (which will be either the most recent cost reporting period ending on or before September 30, 2002, or the cost reporting period that includes July 1, 2003), the hospital may submit a timely request by June 4, 2004, as explained in the OTN, that its resident level for its reference period be adjusted to reflect the number of accredited slots for which that new medical residency training program was approved. We note that section 1886(h)(7)(A)(ii)(III) of the Act does not require that CMS include the number of residents for which the new program is accredited in the hospital's reference cost reporting period for purposes of determining direct GME and IME payment in that reference cost reporting period. Rather, CMS is only required to include the number of residents for which a new program was accredited in the resident level for purposes of determining if, and by how much, a hospital's FTE resident cap should be reduced.

For example, assume a hospital that has a fiscal year end of June 30 received accreditation in October 2001 to train 10 residents in a new surgery program. The hospital does not have an expansion of an existing program not reflected on its most recent settled cost report, so its reference period is the most recent cost reporting period ending on or before September 30, 2002. The hospital first begins to train residents in the new surgery program on July 1, 2002. The new surgery residents are not reflected on the hospital's June 30, 2002 cost report, which is the hospital's most recent cost reporting period ending on or before September 30, 2002. Thus, the hospital may submit a timely request that we increase its resident level for the cost report ending June 30, 2002, by 10 FTE residents to reflect the residents approved for the new surgery program for purposes of determining if the hospital's reference resident level is below its otherwise applicable resident cap. However, we note that if the hospital's fiscal year end in this example was September 30, a program accredited in October 2001 and begun on July 1, 2002, would be in operation during the hospital's cost reporting period ending on September 30, 2002, and the hospital could not receive an increase to its resident level for its cost reporting period ending September 30, 2002, to include the total number of accredited resident positions in the new surgery program. If the new program was accredited for a range of residents (for example, a hospital receives accreditation to train 6 to 8 residents in a new internal medicine program), we are proposing that the hospital may request that its resident level for its most recent cost reporting period ending on or before September 30, 2002 be

adjusted to reflect the maximum number of accredited positions (which, in this example, would be 8 internal medicine residents). We also are proposing that at the time the hospital makes the timely request to have its resident level adjusted to include the number of accredited resident positions, the new program need not be training the full complement of residents for which the program was accredited. (Proposed redesignated 413.79(c)(3)(A)(*3*)(*ii*)). In addition, if more than one hospital was approved as a training site for the residents in the newly accredited program (that is, more than one hospital sponsors the program or there are other participating institutions that serve as training sites for the residents in the program), we are proposing that the adjustment to a requesting hospital's reference resident level would reflect the appropriate portions of the FTE residents in the new program that would be training at that hospital.

Similarly, if, in addition to having accreditation for a new program, a hospital has an expansion of an existing program that is not reflected on the most recent settled cost report, that hospital may submit a timely request that its resident level for the cost reporting period that includes July 1, 2003, be adjusted to include the number of resident positions for which a new program was accredited. We are proposing that a hospital whose reference period is the one that includes July 1, 2003, may only request that its reference resident level be adjusted to include the accredited number of residents for a new program if, in accordance with section 1886(h)(7)(A)(ii)(III) of the Act, the new program was approved by the appropriate accrediting body before January 1, 2002, but was not in operation during the cost reporting period that includes July 1, 2003. This proposal is based on our interpretation of the statutory language, which states that ''the Secretary shall adjust the reference resident level *specified under subclause (I) or (II)* to include the number of residents that were approved * * * for a medical residency program * * * but which was not in operation *during the cost reporting period used under subclause (I) or (II)* * * *'' (emphasis added). Because the statute provides for an adjustment to the reference resident level ''specified under subclause I or II,'' as mentioned above, for hospitals that request an adjustment under section 1886(h)(7)(A)(ii)(III) of the Act, we are proposing to identify the applicable reference period as we otherwise would under section 1886(h)(7)(A)(ii)(I) and (II) of the Act. That is, we are proposing to use the hospital's most recent cost reporting period ending on or before September 30, 2002, as the reference cost reporting period, unless the hospital submits a timely request to use the cost reporting period that includes July 1, 2003, due to an expansion of an existing program that is not reflected on the most recent settled cost report. We also note that, as mentioned above, subclause (III) requires that the program be accredited before January 1, 2002, but not be in operation during the hospital's reference cost reporting period, or in this case, the period that includes July 1, 2003. This means that, in order for the hospital to receive an adjustment to its reference resident level under section 1886(h)(7)(A)(ii)(III) of the Act for the cost reporting period that includes July 1, 2003, the new program also cannot be in operation in the cost reporting period that includes July 1, 2003. Thus, while we believe it is possible for a hospital to qualify for this adjustment because the hospital started a new program that is not reflected on its most recent cost reporting period ending on or before September 30, 2002, we believe that few, if any, hospitals will qualify for this adjustment for a new program that was not in operation in the cost report that includes July 1, 2003, because it is unlikely that a program would receive its accreditation prior to January 1, 2002, and still not be in operation by July 1, 2003.

(5) Affiliations

Section 1886(h)(7)(A)(iii) of the Act, as added by section 422(a)(3) of Public Law 108–173, directs the Secretary to consider whether a hospital is a member of a Medicare GME affiliated group (as defined under § 413.86(b)) as of July 1, 2003, in determining whether a hospital's FTE resident cap should be reduced. As described above, some hospitals that have reduced their resident levels below their FTE resident caps may have affiliated with other hospitals that would otherwise exceed their FTE resident caps. Thus, while some hospitals were below their FTE resident caps prior to entering into a Medicare GME affiliation agreement, upon affiliating, their FTE resident caps were temporarily reduced because some or all of their excess FTE slots were temporarily added to the FTE caps of other hospitals as part of the affiliation agreement. Under the Medicare GME affiliation agreement, these otherwise ''excess'' FTE slots have been transferred for use by other hospitals, and, therefore, CMS would take into account the revised caps under the affiliation agreement for both the hospital that would otherwise be below its FTE resident cap and the revised caps of the other hospital(s) that are part of an affiliated group. In determining whether hospitals' FTE resident caps should be reduced under section 1886(h)(7)(A)(i) of the Act, section 1886(h)(7)(A)(iii) of the Act directs CMS to consider hospitals ''which are members of the same affiliated group * * * as of July 1, 2003.'' We are proposing that hospitals that are affiliated ''as of July 1, 2003'' means hospitals that have in effect a Medicare GME affiliation agreement, as defined in existing § 413.86(b), for the program year July 1, 2003 through June 30, 2004, and have submitted a Medicare GME affiliation agreement by July 1, 2003 to their fiscal intermediaries with a copy to CMS. These hospitals may have already been affiliated prior to July 1, 2003, or may have affiliated for the first time on July 1, 2003. In either case, in determining possible reductions to a hospital's FTE resident cap, we are proposing to use a hospital's cap as revised by the July 1, 2003 Medicare GME affiliation agreement. We believe this interpretation is consistent with the intent of section 1886(h)(7)(A)(iii) of the Act, as added by section 422(a)(3) of Public Law 108–173, in that a hospital's FTE resident cap should not be reduced if some or all of its excess resident slots have been transferred for use by hospitals with which it is affiliated (that is, the hospital is training at least as many FTE residents as are in its ''affiliated'' FTE resident cap).

Although hospitals in an affiliated group base the FTE cap adjustments on an aggregate FTE resident cap, we are proposing that we would determine whether a hospital's FTE resident cap should be reduced on a hospital-specific basis. Section 1886(h)(7)(A)(iii) of the Act states that ''the provisions of *clause (i)* shall be applied to hospitals which are members of the same affiliated group * * *'' (emphasis added). Clause (i) of section 1886(h)(7)(A), as described above, requires the reduction of hospitals' FTE resident caps under certain circumstances, based on the otherwise applicable FTE resident cap and the resident level in the applicable reference period, as described above (which would be either a hospital's most recent cost reporting period ending on or before September 30, 2002, or the cost reporting period that includes July 1, 2003). We are proposing to interpret this reference to clause (i) to mean that the Secretary is to use a hospital's July 1, 2003 ''affiliated'' FTE resident cap as

the otherwise applicable FTE resident cap when determining a possible reduction to the FTE resident cap. In other words, if a hospital is affiliated as of July 1, 2003, we are proposing to superimpose the ''affiliated'' FTE resident cap onto the hospital's reference cost reporting period.

Specifically, as we stated under section IV.O.2.f.(1) of this preamble, consistent with section 1886(h)(7)(A)(ii)(I) of the Act, to determine possible reductions to a hospital's FTE resident cap, we would use a hospital's most recent cost reporting period ending on or before September 30, 2002. If a hospital is part of a Medicare affiliated group for the program year beginning July 1, 2003, we are proposing to compare the hospital's July 1, 2003 ''affiliated'' FTE resident cap to its resident level on the most recent cost report ending on or before September 30, 2002. If the hospital's resident level from its most recent cost report ending on or before September 30, 2002, is below its July 1, 2003 ''affiliated'' FTE resident cap, we are proposing to permanently reduce the hospital's FTE resident cap, that is, the hospital's FTE resident cap without the temporary adjustment under the July 1, 2003 affiliation agreement, by 75 percent of the difference between the hospital's resident level and the July 1, 2003 ''affiliated'' FTE resident cap.

Alternatively, as stated above under section IV.O.2.f.(2) of this preamble, consistent with section 1886(h)(7)(A)(ii)(II) of the Act, a hospital may submit a timely request to CMS that its cost report that includes July 1, 2003, be used as the reference period to determine possible FTE resident cap reductions because of an expansion of an existing program that is not reflected on the hospital's most recent settled cost report. If a hospital is affiliated for the program year beginning July 1, 2003, and we grant the hospital's timely request to use the cost reporting period that includes July 1, 2003, because its expansion of an existing program(s) is not reflected on the most recent settled cost report, we are proposing to compare the hospital's July 1, 2003 ''affiliated'' FTE resident cap to its resident level on the cost report that includes July 1, 2003. If the hospital's resident level from its cost report that includes July 1, 2003 is below its July 1, 2003 ''affiliated'' FTE resident cap, we are proposing to permanently reduce the hospital's FTE resident cap, that is, the hospital's FTE resident cap without the temporary adjustment under the July 1, 2003 affiliation agreement, by 75 percent of the difference between the hospital's resident level and the July 1, 2003 ''affiliated'' FTE resident cap.

For example, Hospital A's most recent cost report ending on or before September 30, 2002 is FYE December 31, 2001. Hospital A has a direct GME FTE resident cap (unadjusted for an affiliation) of 100, and an IME FTE resident cap (unadjusted for an affiliation) of 90. Hospital A did not have an expansion of an existing program that was not reflected on its most recent settled cost report, and therefore, its FYE December 31, 2001 cost report is being used as the reference period for purposes of determining a possible reduction to its FTE resident caps. Hospital A's unweighted direct GME count of allopathic and osteopathic FTE residents on its December 31, 2001 cost report is 60. Hospital A's IME count of allopathic and osteopathic FTE residents on its December 31, 2001 cost report is 55.

Hospital B, with a FYE of September 30, expanded an existing program, and that expansion is not reflected on its most recent settled cost report. Hospital B has submitted, and we have granted, a timely request that its cost report that includes July 1, 2003 (that is, its FYE September 30, 2003 cost report) be used for purposes of determining a possible reduction to its FTE resident caps. Hospital B has a direct GME FTE resident cap (unadjusted for an affiliation) of 100, and an IME FTE resident cap (unadjusted for an affiliation) of 95. Hospital B's direct GME unweighted count of allopathic and osteopathic FTE residents on its September 30, 2003 cost report is 120, and its IME count of allopathic and osteopathic FTE residents for the same period is 110.

On July 1, 2003, Hospital A and Hospital B entered into a Medicare GME affiliation agreement. Under the affiliation agreement, the hospitals' FTE resident caps are revised as follows:

AFFILIATION YEAR JULY 1, 2003 THROUGH JUNE 30, 2004

	Direct GME FTE resident cap	Direct GME affiliated cap	IME FTE resident cap	IME affiliated cap.
Hospital A	100	60	90	55
Hospital B	100	140	95	130

To apply section 1886(h)(7)(A)(i) of the Act, Hospital A's affiliated FTE resident caps as of July 1, 2003, are compared to its direct GME and IME allopathic and osteopathic FTE resident counts from its FYE December 31, 2001 cost report, and Hospital B's affiliated FTE resident caps as of July 1, 2003, are compared to its direct GME and IME allopathic and osteopathic FTE resident counts from its FYE September 30, 2003 cost report, as follows:

	Affiliated direct GME cap	Unweighted allopathic and osteopathic FTE count	Unweighted count below affiliated cap?	If yes, reduce actual FTE resident cap by 75 percent of difference between affiliated cap and unweighted count.
Hospital A	60	[1] 60	No.	
Hospital B	140	[2] 120	Yes	100 − [.75(140 − 120)] = 85

[1] From FYE 12/31/01.
[2] From FYE 9/30/03.

	Affiliated IME cap	Allopathic and osteopathic FTE count	Count below affiliated cap?	If yes, reduce actual FTE resident cap by 75 percent of difference between affiliated cap and unweighted count.
Hospital A	55	[1] 55	No.	
Hospital B	130	[2] 110	Yes	95 − [.75(130 − 110)] = 80

[1] From FYE 12/31/01.
[2] From FYE 9/30/03.

Effective for portions of cost reporting periods beginning on or after July 1, 2005, Hospital A's FTE resident caps for direct GME and IME will remain at 100 and 90, respectively, while Hospital B's FTE resident caps for direct GME and IME will be reduced to 85 and 80, respectively.

We also note that there are hospitals that may have been members of a Medicare GME affiliated group in program years that coincide with or overlap the reference cost reporting periods, but these hospitals were not affiliated as of July 1, 2003. As such, they are not subject to the proposed policy described above applicable to section 1886(h)(7)(A)(iii) of the Act, as added by section 422(a)(3). For such hospitals, we are proposing to compare the resident level in the applicable reference period to the FTE resident cap as adjusted by the affiliation agreement applicable to that reference period. If a hospital's resident level is below its otherwise applicable FTE resident cap for that reference period cost report, we are proposing to permanently reduce the hospital's FTE resident cap, that is, the hospital's FTE resident cap without the temporary adjustment under the affiliation agreement for that period, by 75 percent of the difference between the hospital's resident level and the otherwise applicable FTE resident cap. (Proposed redesignated § 413.79(c)(3)(iv)(B)). For example, assume a hospital with a June 30 fiscal year end affiliated for one program year from July 1, 2001, through June 30, 2002. On its June 30, 2002 cost report (that is, its most recent cost report ending on or before September 30, 2002), its FTE resident cap is 20, its cap as revised by the affiliation agreement is 25, and its resident level is 21 FTEs. Because this hospital's resident level of 21 is below its otherwise applicable FTE resident cap of 25, the hospital's FTE resident cap of 20 will be reduced as follows: 20 − [(.75(25 − 21)] = 17. We are proposing to apply the same methodology described above in the event that the reference period is a hospital's cost report that includes July 1, 2003 (that is, for a hospital that had an expansion of a program that is not reflected on its most recent settled cost report and that made a timely request to use the period that includes July 1, 2003), if that hospital is not affiliated as of July 1, 2003, but its cost report that includes July 1, 2003 overlaps with a program year for which the hospital was affiliated. In other words, section 1886(h)(7)(A)(i) of the Act will be applied by comparing a hospital's reference resident level to the otherwise applicable FTE resident cap, as adjusted for any affiliation agreement for the reference period.

g. Criteria for Determining Hospitals That Will Receive Increases in Their FTE Resident Caps

Generally, under section 1886(h)(7) of the Act, as added by section 422(a)(3) of Public Law 108–173, CMS is to reduce by 75 percent the ''unused'' resident slots from hospitals that were below their FTE resident caps in a specific reference period, and ''redistribute'' the FTE slots for use by other hospitals. Under section 1886(h)(7)(B) of the Act, as added by section 422 of Public Law 108–173, the Secretary is authorized to increase the otherwise applicable FTE resident cap for each qualifying hospital that submits a timely application by a number that the Secretary may approve, for portions of cost reporting periods occurring on or after July 1, 2005. In implementing section 1886(h)(7)(B) of the Act, we note the difficulty in deciding which teaching hospitals are more ''deserving'' than others to receive the redistributed unused resident slots. Therefore, we are proposing a decision making process that is an objective process. In addition, we note that section 422 does not provide detailed guidance to the Secretary for deciding which hospitals should receive the unused resident slots, but rather gives the Secretary discretion in making the choice of which hospitals should qualify.

Section 1886(h)(7)(B) of the Act, as added by section 422, does establish certain parameters in the statutory language for hospitals to qualify to receive increases in their FTE resident caps. First, section 1886(h)(7)(B)(i) of the Act states that the aggregate number of increases in the otherwise applicable resident limits (caps) may not exceed the estimate of the aggregate reduction in the resident limits determined under section 1886(h)(7)(A) of the Act (as specified in section IV.O.2.e. of this preamble). Section 1886(h)(7)(B)(iv) of the Act states that in no case will any hospital receive an FTE cap increase of more than 25 FTE additional residency slots as a result of the redistribution. (Proposed redesignated 413.79(c)(4)). In addition, section 1886(h)(7)(B)(ii) of the Act specifies that in determining which hospitals will receive the increases in their FTE resident caps, the Secretary is required to take into account the demonstrated likelihood that the hospital would be able to fill the position(s) within the first three cost reporting periods beginning on or after July 1, 2005.

In setting up an application process for hospitals to apply for the unused resident slots discussed in section IV.O.2.h. of this preamble, we are proposing to implement this ''demonstrated likelihood'' requirement as an eligibility criterion that a hospital *must* meet in order for CMS to further consider the hospital's application for an increase in its FTE resident cap. Thus, we are proposing that, in order to be eligible for consideration for an increase under section 1886(h)(7)(B) of the Act, a hospital must first demonstrate the likelihood that it will able to fill the slots within the first three cost reporting periods beginning on or after July 1, 2005, by meeting at least one of the following four criteria and by providing documentation that it meets that criterion in its application for an increase in its FTE resident cap:

Demonstrated Likelihood Criterion 1. The applying hospital intends to use the additional FTEs to establish a new residency program(s) on or after July 1, 2005 (that is, a newly approved program that begins training residents on or after July 1, 2005).

The hospital must meet the requirements in provisions (1) and (2) below:

(1) In order to demonstrate that the hospital is, in fact, establishing a new residency program, the hospital must—

• Submit an application for approval of a new residency program to the ACGME or the AOA by December 1, 2004, and include a copy of that application with the application for an increase in its FTE resident cap; or

• Submit an application for approval of a new residency program to the ACGME or the AOA by December 1, 2004, and, if establishing an allopathic program, include a copy of the hospital's institutional review document or program information form concerning the new program with the application for the unused FTE resident slots; or

• Submit an application for approval of a new residency program to the ACGME or the AOA by December 1, 2004, and include written correspondence from the ACGME or AOA acknowledging receipt of the application for the new program, or other types of communication from the accrediting bodies concerning the new program approval process (such as notification of site visit).

(2) To demonstrate that the hospital will be likely to fill the slots requested, the hospital must comply with one of the following:

• If the hospital has other previously established programs, submit documentation that each of the hospital's existing residency programs had a resident fill rate of at least 95 percent in each of program years 2001 through 2003; or

• If the hospital has other previously established residency programs, submit copies of the cover page of the hospital's employment contracts with the residents who are or will be participating in the new residency program (resident specific information may be redacted); or

• If the hospital is establishing a new residency program in a particular specialty, submit documentation indicating that the specialty has a resident fill rate nationally, across all hospitals, of at least 95 percent.

Demonstrated Likelihood Criterion 2. The applying hospital intends to use the additional FTEs to expand an existing residency training program (that is, to increase the number of FTE resident slots in the program) on or after July 1, 2005, and before July 1, 2008.

The hospital must comply with the requirements in provisions (1) and (2) below:

(1) To demonstrate that the hospital intends to expand an existing program, the hospital must comply with one of the following:

• Document that the appropriate accrediting body (the ACGME or the AOA) has approved the hospital's expansion of the number of FTE residents in the program; or

• Document that the National Residency Match Program or the American Osteopathic Association Residency Match Program has accepted or will be accepting the hospital's participation in the match for the existing program that will include additional resident slots in that residency training program; or

• If expanding an allopathic program, submit a copy of the hospital's institutional review document or program information form for the expansion of the existing residency training program.

(2) To demonstrate that the hospital will be likely to fill the slots of the expanded residency program, the hospital must comply with one of the following:

• Submit copies of the cover page of the hospital's employment contracts with the residents who are or will be participating in the expanded program (resident specific information may be redacted) and copies of the cover page of the hospital's employment contracts with the residents participating in the program prior to the expansion of the program.

• If the hospital has other previously established residency programs, submit documentation that each of the residency programs had a resident fill rate of at least 95 percent in each of program years 2001 through 2003.

• If the hospital is expanding an existing program in a particular specialty, submit documentation that the specialty has a resident fill rate nationally, across all hospitals, of at least 95 percent.

• If the hospital is expanding a program in order to train residents that need a program because another hospital in the State has closed a similar program, and the applying hospital received a temporary adjustment to its FTE cap(s) (under the requirements of § 413.86(g)(9)), submit documentation of this action.

Demonstrated Likelihood Criterion 3. The hospital is applying for an increase in its FTE resident cap because the hospital is already training residents in an existing residency training program(s) in excess of its direct GME FTE cap or IME FTE cap, or both.

The hospital must submit, with its application, each of the following:

• Copies of the most recent as-submitted Medicare cost reports documenting on Worksheet E, Part A and Worksheet E3, Part IV the resident counts and FTE resident caps for both direct GME and IME for the relevant cost reporting periods.

• Copies of the 2004 residency match information concerning the number of residents the hospital intends to have in its existing programs.

• Copies of the most recent accreditation letters on all of the hospital's training programs in which the hospital trains and counts FTE residents for direct GME and IME.

Demonstrated Likelihood Criterion 4. The hospital is applying for the unused FTE resident slots because the hospital is at risk of losing accreditation of a residency training program if the hospital does not increase the number of FTE residents in the program on or after July 1, 2005.

The hospital must submit, with its application for an increase in its FTE resident cap, documentation from the appropriate accrediting body of the hospital's risk of lost accreditation as a result of an insufficient number of residents in the program.

We are proposing that *each* hospital must meet at least one of the above criteria in order to demonstrate the likelihood that it will be able to fill the additional slots associated with any increase in the hospital's FTE resident cap within the first three cost reporting periods beginning on or after July 1, 2005. In other words, each hospital that wishes to apply for an increase in its FTE resident cap must, as a preliminary matter, meet the eligibility requirement of demonstrating the likelihood that it will fill the additional positions, in order for CMS to further consider the hospital's application for an increase in its FTE resident cap.

h. Application Process for the Increases in Hospitals' FTE Resident Caps

As stated above, we are proposing an objective decision making process for determining how hospitals will be prioritized when identifying the hospitals that will receive increases in their FTE resident caps. In order for hospitals to be considered for increases in their FTE resident caps, section 1886(h)(7)(B)(i) of the Act, as added by section 422(a)(3) of Public Law 108–173, requires that each ''qualifying hospital'' submit a ''timely application.'' We are proposing that each hospital must submit the following information on its application for an increase in its FTE resident cap:

• The name and Medicare provider number of the hospital.

• The total number of requested FTE resident slots (for all residency programs at the hospital) for direct GME or IME, or both (up to 25 FTEs).

• A completed copy of the CMS Evaluation Form (as described below) for each residency program for which

the applicant hospital intends to use the requested increase in the number of FTE residents and source documentation to support the assertions made by the hospital on the Evaluation Form. (For example, if the hospital checks off on the Evaluation Form that the hospital is located in a geographic Health Professions Shortage Area (HPSA), the hospital would include documentation to support that assertion.) A copy of the blank proposed CMS Evaluation Form appears at the end of this section of the preamble.

- FTE resident counts for direct GME and IME and FTE resident caps for direct GME and IME reported by the hospital in the most recent as-filed cost report.
- An attestation, signed and dated by an officer or administrator of the hospital who signs the hospital's Medicare cost report, of the following information in the hospital's application for an increase in its FTE resident cap:

''I hereby certify that I understand that misrepresentation or falsification of any information contained in this application may be punishable by criminal, civil, and administrative action, fine and/or imprisonment under federal law. Furthermore, I understand that if services identified in this application were provided or procured through payment directly or indirectly of a kickback or where otherwise illegal, criminal, civil, and administrative action, fines and/or imprisonment may result. I also certify that, to the best of my knowledge and belief, it is a true, correct, and complete application prepared from the books and records of the hospital in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding Medicare payment to hospitals for the training of interns and residents.''

We are further proposing that any hospital that wishes to receive an increase in its FTE resident cap(s) must submit a copy of its completed application (as described above) to the CMS Central Office and to the CMS Regional Office for the region in which the applicant hospital is located, and that the application must be received on or before December 1, 2004. (The mailing addresses for the CMS offices are indicated at the end of this section of the preamble.) We note that some hospitals' FTE counts will be subject to audit for purposes of section 1886(h)(7)(B) of the Act, and those audits may not be completed by December 1, 2004. Because the results of such an audit may be a factor in a hospital's decision whether to request an increase in its FTE resident cap under section 1886(h)(7)(B) of the Act, we are proposing to allow a later date for those hospitals to apply for increases in their FTE resident caps. Therefore, if a hospital's resident level is audited for purposes of section 1886(h)(7)(A) of the Act, and that hospital also wishes to apply for an increase in its FTE resident cap(s) available through section 1886(h)(7)(B) of the Act, we are proposing that such a hospital must submit a completed application to CMS and that the application must be received on or before March 1, 2005. We are proposing that all completed applications that are timely received according to the above deadlines will be evaluated by CMS according to the criteria described under section IV.O.2.i. of this preamble for determining the priority distribution of FTE resident slots. Hospitals that satisfy at least one of the ''demonstrated likelihood'' criteria will be further evaluated by the evaluation criteria described below. Those hospitals that are chosen to receive an increase in their FTE resident caps would be notified by CMS by July 1, 2005.

i. CMS Evaluation of Applications for Increases in FTE Resident Caps

As noted in section IV.O.2.h. of this preamble, we are proposing to require hospitals to submit, with their applications for increases in their FTE resident caps, a completed copy of the CMS Evaluation Form. As we have stated, we are proposing to make the process of evaluating the applications as objective as possible. Therefore, we are proposing to use a CMS Evaluation Form that the hospital must complete and submit as part of its application. The CMS Evaluation Form will ask the hospital to check off which of the ''demonstrated likelihood'' criteria (described above in section IV.O.2.g. of this preamble) the hospital meets. We also are proposing to require the hospital to provide the documentation that supports the ''demonstrated likelihood'' criteria it has checked off on the Evaluation Form.

Assuming that hospitals interested in applying for the increase in their FTE caps meet the eligibility criterion of ''demonstrated likelihood,'' we are proposing that applicant hospitals indicate on the CMS Evaluation Form the category(ies) for which it believes it will qualify. CMS will use this indication to prioritize the applications. Such prioritization is derived from section 1886(h)(7)(B) of the Act, as added by section 422 of Public Law 108–173. That section established the following priority order to determine the hospitals that will receive increases in their FTE caps:

First, to hospitals that are ''located in rural areas, as defined in section 1886(d)(2)(D)(ii) of the Act'' (section 1886(h)(7)(B)(iii)(I) of the Act). Section 1886(d)(2)(D)(ii) of the Act defines a rural area as any area outside a Metropolitan Statistical Area (MSA). Under the existing implementing regulations at § 413.62(f)(ii), an ''urban area'' means (1) a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA); or (2) the following New England counties: Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island. Under existing § 413.62(f)(iii), a ''rural area'' means any area outside an urban area. However, we note that under section III. of this preamble, which discusses proposed changes in wage areas for FY 2005, we are proposing to no longer recognize NECMAs as a distinct category of wage areas. Thus, for purposes of the amendments made by section 422, we are proposing that any hospital located in an area that is not in a MSA is a rural hospital, regardless of any reclassification under § 412.102 or § 412.103. We note that this definition of ''rural'' is consistent with our proposal under section III. of this preamble concerning designation of wage index areas.

Second, to hospitals that are located in urban areas that are not large urban areas, as defined for purposes of section 1886(d) of the Act (section 1886(h)(7)(B)(iii)(II) of the Act). Section 1886(d)(2)(D) of the Act defines ''*large* urban area'' as an ''urban area which the Secretary determines * * * has a population of more than 1,000,000.'' Existing implementing regulations at § 412.63(c)(6) state generally that the term ''large urban area'' means an MSA with a population of more than 1,000,000. Again, we note that we are proposing changes to the definition of ''urban area'' to reflect the new geographic areas designated by the Office of Management and Budget under section III. of the preamble of this proposed rule. Therefore, if the eligible hospital applying for an increase in its FTE resident cap is an urban hospital that is located in the proposed redefined MSA area with a population of less than 1,000,000, CMS will give such a hospital second priority (after all rural hospitals in the first priority category under the statute) in deciding which hospitals should receive an increase in their FTE resident caps.

Third, hospitals that currently operate, or will operate, a residency training program in a specialty for which there are not other residency training programs in the State (section 1886(h)(7)(B)(iii)(III) of the Act). We are proposing to interpret ''a specialty for which there are not other residency training programs in the State'' to mean the only specialty in either allopathy or osteopathy in a particular State. For example, if in State X, Hospital A would like to use the additional FTE residents in order to establish a new osteopathic emergency medicine program (which would be the first osteopathic emergency medicine program in State X), and Hospital B has already established an allopathic emergency medicine program in State X, Hospital A's application for an increase in its FTE resident cap(s) would be put in the third priority category because Hospital A would be establishing a new osteopathic emergency medicine program, a specialty for which there are not other osteopathic emergency medicine programs in the State. We believe that a more ''expansive'' interpretation of ''a specialty for which there are not other residency programs'' allows more hospitals to fit into this third priority category. In addition, it is our understanding that allopathic and osteopathic programs are, at least, nominally different disciplines in medicine. As a result, we believe that this more ''expansive'' interpretation for ''a specialty for which there are not other residency programs'' is the more appropriate interpretation.

As we described above, we are proposing that applicant hospitals indicate on the CMS Evaluation Form the category(ies) for which it believes it will qualify; we will use this indication to prioritize the applications. Each of the categories (described below) is derived from the priorities established by section 1886(h)(7)(B) of the Act, as added by section 422 of Public Law 108–173. We would use the following categories to determine the order in which hospitals would be eligible to receive increases in their FTE resident caps:

First Level Priority Category: The hospital is a rural hospital and has the only specialty training program in the State.

Second Level Priority Category: The hospital is a rural hospital only.

Third Level Priority Category: The hospital is a ''small'' urban hospital (that is, an urban hospital that is located in a ''not large urban area'') and has the only specialty program in the State.

Fourth Level Priority Category: The hospital is a ''small'' urban hospital only.

Fifth Level Priority Category: The hospital has the only specialty training program in the State.

Sixth Level Priority Category: The hospital meets none of the statutory priority criteria.

We believe the proposed first and third level categories are appropriate for CMS evaluation purposes (which is explained further below) because some hospitals that apply for the additional resident slots may fit into more than one of the three statutory priority categories listed in section 1886(h)(7)(B) of the Act. In addition, we are proposing to give consideration first to those hospitals that meet more than one of the statutory priority categories over those hospitals that meet only one of the statutory priorities (see second, fourth, and fifth level priority categories.) We also are proposing a sixth level priority category to identify those section 1886(d) hospitals that apply for additional resident slots, but do not fit into any of the priority categories listed in section 1886(h)(7)(B) of the Act (for example, hospitals in large urban areas).

As specified by the statute, we are proposing to put each hospital's application for an increase in its FTE resident cap (based on how the hospital describes itself on the CMS Evaluation Form) into one of the ''level priority categories'' for evaluation purposes, giving first and second priority to the rural hospitals, as defined above. In addition, we note that we are proposing that hospital applicants provide residency specialty program information as part of the application for the increase to the cap(s), as well as a CMS Evaluation Form for each residency program for which the applicant hospital intends to use the increased FTE resident slots. Our intention in proposing these requirements is for CMS to be able to discern within which level priority category the applicant hospital's application should be placed based on the residency specialty program for which the FTE cap increase is being requested. In other words, it is possible that a hospital will apply for an increase in its FTE caps for more than one residency program at the hospital. It is possible that applications for the programs would fall within different level priority categories, for example, if a hospital is applying for an increase in its cap(s) for one program that is the ''only specialty training program in the State'' (which would place the hospital's application in the fifth level priority category on the CMS Evaluation Form) and for another program that is NOT the only program in the State (which, assuming the hospital is an urban hospital, would place the hospital on that Evaluation Form in the sixth level priority category). Therefore, we are proposing that hospitals complete an Evaluation Form for each residency program for which it is requesting an increase in its FTE resident cap.

We note that section 1886(h)(7)(B)(iii) of the Act states that ''increases of residency limits within the same priority category * * * shall be determined by the Secretary.'' Therefore, we are proposing to use the following criteria for evaluating the applications for increases in hospitals' FTE resident caps within each of the six level priority categories described above:

Evaluation Criterion One. The hospital that is requesting the increase in its FTE resident cap(s) has a Medicare inpatient utilization over 60 percent, as reflected in at least two of the hospital's last three most recent audited cost reporting periods for which there is a settled cost report. We have selected 60 percent utilization because it will identify hospitals where Medicare beneficiaries will benefit the most from the presence of a residency program, and it is consistent with the utilization percentage required for Medicare-dependent, small rural hospitals (MDHs) as specified in § 412.108. In addition, it identifies a type of hospital that warrants atypical treatment by the Medicare program because it is so reliant on Medicare funding.

Evaluation Criterion Two. The hospital will use the additional slots to establish a new geriatrics residency program, or to add residents to an existing geriatrics program. We believe that, of all the medical specialties, geriatrics is the one specialty that is devoted primarily to the care of Medicare beneficiaries. In addition, we note that encouraging residency training in geriatrics is consistent with Congressional intent as expressed, among other places, in section 712 of Public Law 108–173.

Evaluation Criterion Three. The hospital does not qualify for an adjustment to its FTE caps under existing § 413.86(g)(12) (proposed to be redesignated as § 413.79(k) in this proposed rule) for a rural track residency program, but is applying for an increase in its FTE resident cap(s) under section 1886(h)(7)(B) of the Act because it rotates (or in the case of a new program, will rotate) residents for at least 25 percent of the duration of the residency program to any combination of the following: A rural area, as defined in section 1886(d)(2)(D)(ii) of the Act

and § 412.62(f)(1)(iii) of the regulations; a rural health clinic (RHC), as defined in section 1861(aa)(1) of the Act and § 491.2 of the regulations; or a Federally Qualified Health Center (FQHC), as defined in section 1861(aa)(3) of the Act and § 405.2401(b) of the regulations. We believe that Congress intended that the Secretary use section 422 to encourage resident training in rural areas, and we believe this criterion furthers this intention. We are proposing to include residency training in FQHCs in this criterion because we understand that some FQHCs are located in rural areas. In addition, we would like to encourage residency training at FQHCs because we believe that, similar to rural providers and RHCs, FQHCs provide services for medically underserved areas or populations, or both.

Evaluation Criterion Four. In portions of cost reporting periods prior to July 1, 2005, the hospital qualified for a temporary adjustment to its FTE cap under existing § 413.86(g)(9) (proposed to be redesignated as § 413.79(h) in this proposed rule) because it was training displaced residents from either a closed program or a closed hospital, and, even after the temporary adjustment, the hospital continues to train residents in the specialty(ies) of the displaced residents and is training residents in excess of the hospital's direct GME FTE cap or IME FTE cap, or both, for that reason. We believe this criterion is appropriate because it will help to sustain the level of residency training in the community.

Evaluation Criterion Five. The hospital is above its FTE caps because it was awaiting accreditation of a new program from the ACGME or the AOA during the base period for its FTE cap(s), but was not eligible to receive a new program adjustment as stated under existing § 413.86(g)(6)(ii) (proposed to be redesignated as § 413.79(e)(2) in this proposed rule). Under existing § 413.86(g)(6)(ii) and § 413 .86(g)(13) (proposed to be redesignated as § 413.79(l) in this proposed rule), a hospital that had allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996 could receive an adjustment to its unweighted FTE cap for a new medical residency training program that either received its initial accreditation or began training residents on or after January 1, 1995 and on or before August 5, 1997. If a hospital failed to meet those deadlines, it was not eligible to have its cap(s) adjusted to include residents in a new program. Under this proposed criterion, a hospital would apply for additional FTE residents if the hospital had submitted its application for a new program to the accrediting body before August 5, 1997, and received its accreditation after August 5, 1997 but before August 5, 1998. This would allow some hospitals to receive increases in their FTE resident caps in cases in which, in good faith, the hospital had submitted an application for accreditation for a new program prior to the date of enactment of FTE resident caps under the BBA, but because of the timing of the implementation of the FTE resident cap(s), had not yet received direct GME and IME payment for residents in the newly accredited program during the base period for the hospital's FTE resident cap(s).

Evaluation Criterion Six. The hospital is training residents in excess of its FTE resident caps because, despite qualifying for an FTE cap adjustment for a new program under § 413.86(g)(6)(i) or (g)(6)(ii) (proposed to be redesignated as § 413.79(e)(1) and (e)(2) in this proposed rule), it was unable to ''grow'' its program to the full complement of residents for which the program was accredited before the hospital's FTE resident cap was permanently set beginning with the fourth program year of the new program. Similar to evaluation criterion five above, this criterion would allow some hospitals that had, in good faith, started up a new residency program as required in the regulations but could not completely fill the new program within the allowed regulatory period, to receive increases in their FTE resident caps. For instance, this could have occurred because the program was a program of long duration (such as a 5-year general surgery program), and the hospital did not have the opportunity to ''grow'' the program to its full complement of residents because the regulations at §§ 413.86(g)(6)(i) or (g)(6)(ii) allow a program to grow for only 3 years before the hospital's FTE resident cap is permanently adjusted for the new program.

Evaluation Criterion Seven. The hospital is located in any one (or a combination) of the following: a geographic HPSA, as defined in 42 CFR 5.2; a population HPSA, (also defined at 42 CFR 5.2); or a Medicare physician scarcity county, as defined under section 413 of Public Law 108–173. We are proposing to use this 3-part criterion in order to capture, as objectively as possible, medically underserved areas or patient populations (many of which are Medicare beneficiaries), or both. We understand that if a particular community has been designated a HPSA (either a geographic or population HPSA), the designation information is available to hospitals from the Health Resources and Services Administration (HRSA) HPSA database at the Web site: *http://belize.hrsa.gov/newhpsa/newhpsa.cfm.* In addition, hospitals will be able to determine whether they are located in a Medicare physician scarcity county (consistent with section 413 of Pub. L. 108–173) on the CMS Internet Web site at *www.cms.hhs.gov* or upon publication of the annual final rule setting forth the Medicare physician fee schedule (which is generally published by November 1 of each year). We note that if Medicare does not publish the final rule setting forth the Medicare physician fee schedule in time for the application deadline for increases in FTE resident caps (December 1, 2004, or March 1, 2005, depending on the hospital), we are proposing that we will not use the Medicare physician scarcity county designations (as defined under section 413 of Pub. L. 108–173) for purposes of this criterion.

Evaluation Criterion Eight. The hospital is in a rural area (as defined under section 1886(d)(2)(D)(ii) of the Act) and is a training site for a rural track residency program (as specified under § 413.86(g)(12) (proposed to be redesignated as § 413.79(k) in this proposed rule)), but is unable to count all of the FTE residents training at the rural hospital in the rural track because the rural hospital's FTE cap is lower than the hospital's unweighted count of allopathic or osteopathic FTE residents beginning with portions of cost reporting periods on or after July 1, 2005.

Evaluation Criterion Nine. The hospital is affiliated with a historically Black medical college. According to the language in the Conference Report for Public Law 108–173 (pages 204–205), the Conference agreement on section 422 generally restated the three statutory priority categories described above (rural, ''small'' urban, and only specialty program in the State) in terms of giving guidance to the Secretary for deciding which hospitals should receive the redistributed FTE resident slots. However, there was one additional cited criterion that the Conference indicated the Secretary should use in evaluating the hospital applications. Specifically, the Conference agreement states that the Secretary should consider whether the hospital is a ''historically *large* medical college'' (emphasis added). Upon consideration of this particular terminology, which, on its face, seems to contradict the three statutory priority categories (that is, rural, ''small'' urban, and only specialty program in the State), we are proposing to view the reference to ''historically *large* medical colleges''

as a scrivener's error, and to read this language to refer to ''historically *Black* medical colleges.'' This proposed interpretation accomplishes two goals: first, we believe this interpretation serves the greater policy goal of encouraging residency training for the benefit of medically underserved populations. Second, we believe that this interpretation reflects the Conferees' intent in the language in the Conference Report. In addition, we are proposing to identify ''historically Black medical colleges'' as Howard University College of Medicine, Morehouse School of Medicine, Meharry Medical College, and Charles R. Drew University of Medicine and Science. These four medical schools are identified as ''historically Black medical colleges'' by the American Medical Association (see *http://www.ama–assn.org/ama/pub/category/7952.html).* We are proposing that the hospital will meet this criterion if it intends to use an increase in its FTE resident cap(s) under section 1886(h)(7)(B) of the Act to count residents in residency programs sponsored by a historically Black medical college listed above.

Evaluation Criterion Ten. The hospital is training residents in residency program(s) sponsored by a medical school(s) that is designated as a Center of Excellence for Underserved Minorities (COE) under section 736 of the Public Health Service Act in FY 2003. We understand that the COE program was established to be a catalyst for institutionalizing a commitment to underserved students and faculty, and to serve as a national resource and educational center for diversity and minority health issues. Therefore, we believe that it is appropriate to encourage hospitals to train residents in residency programs sponsored by medical schools that are designated as COEs. A hospital can verify whether it is training residents in programs sponsored by a medical school that is a COE. Medical schools that are COEs in FY 2003 are listed at the following Web site: *http://bhpr.hrsa.gov/diversity/coe/grantees2003.htm.* We note that, in FY 2003, there were 28 medical schools that were designated to be COEs.

We are proposing to use the above set of criteria to evaluate the applications by hospitals for increases in their FTE resident caps that fall within each of the six level priority categories. We would place each application in the appropriate priority level category based on the information the hospitals check off on the proposed CMS Evaluation Form for each allopathic and osteopathic specialty program requested by the applicant hospital, and the corresponding requested FTE cap increase (see the proposed form below). We are proposing to place all of these evaluation criteria on the Evaluation Form and to ask the hospital to check off on the form which criteria apply for each specialty program for which an FTE cap increase is requested. Based on the assertions checked off on the form, CMS would score each CMS Evaluation Form (one point per criterion checked off). The higher scoring CMS Evaluation Form(s) for each applicant hospital within each level priority category would be awarded the FTE resident cap increases first. As we described above, we are proposing to award the cap increases in the order of the six specified level priority categories because, as a general rule, we believe hospitals that meet more than one of the statutory priorities should be awarded the increases in their FTE resident caps first before other hospitals. However, we also believe that hospitals that meet a higher statutory priority category should receive first consideration by CMS over hospitals that meet lower statutory priorities. That is the reason, for instance, we are proposing the first level (rural hospital + only specialty program in the State) and second level (rural only) priority categories to give all rural hospitals first consideration by CMS before any small urban hospital, as required by the statute.

Thus, first level priority category hospitals that score highest on the evaluation criteria on the CMS Evaluation Form for a particular specialty program would receive the increases in their FTE resident caps first. For example, if Hospital D is a rural hospital and is establishing the first osteopathic internal medicine residency program in State Y, thereby falling within the first level priority category, and Hospital D checks off on the CMS Evaluation Form that it has a Medicare utilization of 60 percent, is located in a geographic HPSA, and is affiliated with a historically Black medical college, Hospital D would receive a score of 3 points on the completed CMS Evaluation Form for the osteopathic internal medicine residency program and accompanying application. We are proposing that we would first award FTE cap increases to hospitals whose CMS Evaluation Forms for a particular program receive 10 points based on the number of evaluation criteria checked off by the hospital for the program (if there are any) and then to those with successively fewer points within the level priority category. Hospital D would receive the increase in its FTE resident cap(s) requested on its application after all the hospitals in the first level priority category whose applications receive 10 through 4 points are awarded their requests first.

We are proposing that we would award the increases in FTE resident caps to all those hospitals that are in the first level priority category (rural hospitals + only specialty program in the State) before evaluating those hospitals in the second level priority category (rural hospital), and would award the FTE resident slots to all those hospitals in the second level priority category before evaluating those hospitals in the third level priority category (''small'' urban hospital + only specialty in the State), and so on. Once we reach an aggregate number of FTE resident cap increases from the aggregate estimated pool of FTE resident positions under section 1886(h)(7)(A) of the Act, but are unable, based on the number of remaining slots, to meet all of the requests at the next level priority category at the next score level, we are proposing to prorate any remaining estimated FTE resident slots among all the applicant hospitals within that level priority category and with the same score on the hospital's application.

For example, assume all applicant hospitals in the first through fourth level priority categories receive the requested increases in their FTE resident caps by CMS, and CMS next evaluates hospital applications and accompanying CMS Evaluation Forms in the fifth level priority category (only specialty program in the State). At the point that CMS has awarded cap increases for all the fourth level priority category hospitals that scored 5 or above on their CMS Evaluation Forms for each residency program, CMS finds that there is only a sufficient number of resident slots remaining in the estimated pool to grant half of the requests for slots from hospitals that scored 4 points. We are proposing that we would prorate all of the remaining FTEs among the 4-point CMS Evaluation Forms and accompanying applications in the fourth level priority category. Thus, if CMS could have awarded a total of 200 FTE slots for direct GME and 185 FTE slots for IME to only the first 50 percent of the 4-point CMS Evaluation Forms in the fourth level priority category at the point that the estimated pool of FTE slots is spent, we are proposing to prorate all of the 200 FTE slots for direct GME and 185 FTE slots for IME among all of the 4-point CMS Evaluation Forms and accompanying applications in that fourth priority category, no matter what level of FTE resident cap increase was requested on the individual hospital's application.

We recognize the complexity of this proposed evaluation process for the award of increases in hospital's FTE resident caps under section 1886(h)(7)(B) of the Act. Therefore, we are including some further examples depicting the proposed procedures:

Example 1: Hospital M in State Z is an urban hospital located in an MSA that has a population of less than 1 million. Hospital M can demonstrate the likelihood that it will fill the requested five FTEs resident slots for direct GME and IME because it is currently training a number of FTE residents in geriatrics that exceeds both of its FTE caps, and has attached to its application for an increase in its FTE resident caps a copy of Hospital M's past three Medicare cost reports (as filed or audited, whichever is most recent and available), which documents on Worksheet E, Part A and Worksheet E3, Part IV that, according to the resident counts and the FTE resident caps, Hospital M is training residents in excess of its caps. Hospital M has taken on residents from a teaching hospital in the community that closed, and is also located in a Medicare physician scarcity county.

Hospital M's application would be evaluated by CMS accordingly: Fourth level priority category (''small'' urban hospital); score of 3 (expanding geriatrics program, Medicare physician scarcity area, residents from a closed hospital).

Example 2: Hospital K is a large academic medical center located in an MSA with a population of greater than 1,000,000 and is in a population HPSA. Hospital K regularly trains residents in programs sponsored by Meharry Medical College, and wishes to add more residents from Meharry, and therefore, has requested accreditation from the ACGME to expand the number of Meharry residents training in both allopathic surgery and osteopathic pediatrics programs. Hospital K is above both its direct GME and IME FTE caps.

Hospital K's CMS Evaluation Forms for allopathic surgery and osteopathic pediatrics would be evaluated (separately) by CMS accordingly: Sixth level priority category (large urban hospital); can demonstrate likelihood of filling the slots (because Hospital K can document both that the hospital is above its caps and that it has requested ACGME accreditation to expand the programs); and a score of 2 (population HPSA, historically Black medical college).

Example 3: Hospital E is a rural hospital located in a Medicare physician scarcity area and a geographic HPSA. It is a rural training site for a rural track residency program that has only been a training site since 2002. Therefore, Hospital E has an FTE resident cap of zero FTEs for direct GME and IME.

Hospital E's CMS Evaluation Form for the rural track family practice program and accompanying application would be evaluated CMS accordingly: Second level priority category (rural hospital); can demonstrate the likelihood of filling slots (because Hospital E can document that it is both over its cap of zero FTEs, and that it is a training site for an accredited rural track residency program; and a score of 2 (a training site for a rural track, and a Medicare physician scarcity area, and a geographic HPSA).

Example 4: Hospital W is a rural hospital that has FTE caps of 15 FTEs for both direct GME and IME. Hospital W requests an FTE cap adjustment of 25 FTEs for both direct GME and IME; 5 FTEs to expand an existing geriatric fellowship; 20 FTEs to establish the first osteopathic emergency medicine program in State K, in which Hospital W is located. Hospital W can document that it is at its FTE caps with existing residency programs. CMS would make the following assessment for Hospital W's Evaluation Form for the geriatric fellowship: Hospital W falls into the second level priority category for being a rural hospital; can demonstrate the likelihood that it will fill the 5 FTE slots of the geriatric program by documenting that it has requested additional slots in the accreditation of the geriatrics program and that Hospital W is above its caps. Hospital W would receive a score of 1 on its CMS Evaluation Form for the geriatrics program. CMS would make the following assessment for Hospital W's CMS Evaluation Form for the new osteopathic emergency medicine program: Hospital W would meet the first level priority category for this Evaluation Form because, not only is it a rural hospital, but it is also requesting 20 FTEs for the only osteopathic emergency medicine program in the State; can demonstrate the likelihood that it will fill the 20 osteopathic emergency medicine FTEs by documenting the accreditation request and that it is over its FTE caps. Hospital W would receive a score of zero, because it did not meet any of the 10 evaluation criteria on the CMS Evaluation Form.

j. Application of Locality-Adjusted National Average Per Resident Amount (PRA)

Section 1886(h)(7)(B)(v) of the Act, as added by section 422 of Public Law 108–173, provides that, with respect to additional residency slots attributable to the increase in the hospital's FTE resident cap as a result of redistribution of resident positions, the approved FTE resident amount, or PRA, is deemed to be equal to the locality-adjusted national average per resident amount computed for that hospital. In other words, section 1886(h)(7)(B)(v) of the Act requires that, for purposes of determining direct GME payments for portions of cost reporting periods occurring on or after July 1, 2005, a hospital that receives an increase in its direct GME FTE resident cap under section 1886(h)(7)(B) of the Act will receive direct GME payments with respect to those additional FTE residents using the locality-adjusted national average PRA. Thus, we are proposing that a hospital that receives an increase in its FTE resident cap under section 1886(h)(7)(B) of the Act would receive direct GME payments based on the sum of two different direct GME calculations: one that is calculated using the hospital's actual PRAs (primary care PRA or nonprimary care PRA) applicable under existing § 413.86(e)(4) (proposed to be redesignated as § 413.77(d) in this proposed rule) and the hospital's number of FTE residents not attributable to an FTE cap increase under section 1886(h)(7)(B) of the Act; and another that is calculated using the locality-adjusted national average PRA under existing § 413.86(e)(4)(ii)(B) (proposed to be redesignated as § 413.77(d)(2)(ii) in this proposed rule) inflated to a hospital's current cost reporting period, and the hospital's number of FTE residents that is attributable to the increase in the hospital's FTE resident cap under section 1886(h)(7)(B).

Section 422(a) of Public Law 108–173 contains a cross-reference in the new section 1886(h)(7)(B)(v) of the Act to the locality adjusted national average PRA ''computed under paragraph (4)(E).'' However, section 1886(h)(4)(E) of the Act does not relate to the locality-adjusted national average PRA. Rather, it relates to the circumstances under which a hospital may count FTE resident time spent training in nonhospital sites.

We have concluded that the cross-reference to section 1886(h)(4)(E) of the Act is a legislative drafting error, or scrivener's error. Instead, we believe Congress intended to refer to section 1886(h)(2)(E), which explicitly provides for the determination of locality-adjusted national average PRAs. Because the drafting error is apparent, and a literal reading of the cross-reference as specified in the statute would produce absurd results, we are proposing to interpret the cross-reference to section 1886(h)(4)(E) of the Act in the new section 1886(h)(7)(B)(v) of the Act as if the reference were to section 1886(h)(2)(E) of the Act.

We note that section 1886(h)(7)(B)(v) of the Act, which addresses the applicability of the locality-adjusted national average PRAs with respect to redistributed slots for the direct GME payment, makes no reference to section 1886(h)(4)(G) of the Act, which is the provision concerning the rolling average count of FTE residents. That is, the statute does not provide for an exclusion from application of the rolling average for residents counted as a result of FTE cap increases under section 1886(h)(7)(B) of the Act. In light of the absence of a specific pronouncement in section 1886(h)(7)(B) of the Act exempting those residents from application of the rolling average, and with no apparent reason to treat residents counted as a result of the FTE

cap increases under section 1886(h)(7)(B) of the Act differently for purposes of the rolling average, we are proposing to require that if a hospital increases its direct GME FTE count of residents as a result of an FTE resident cap increase under section 1886(h)(7)(B) of the Act, those FTE residents are immediately subject to the rolling average calculation. Furthermore, we believe that, given potentially significant shifts of FTE slots among hospitals as a result of section 1886(h)(7) of the Act, the inclusion of FTE residents counted as a result of section 1886(h)(7)(B) of the Act in the rolling average introduces a measure of stability and predictability, and mitigates radical shifts in direct GME payments from period to period. Thus, any increase in a hospital's direct GME payment relating to an FTE cap increase under section 1886(h)(7)(B) of the Act will be phased-in over a 3-year period because the additional FTE residents are immediately included in the rolling average calculation and would only gradually be included in the hospital's FTE count.

Following is an example of how direct GME payment would be determined for a hospital that received an increase in its direct GME FTE cap under section 1886(h)(7)(B) of the Act. Hospital A has a fiscal year end (FYE) of June 30, and a direct GME FTE resident cap of 20 FTEs. During its FYEs June 30, 2004 and June 30, 2005, Hospital A trained 20 nonprimary care residents. During FYE June 30, 2006, Hospital A trains 25 nonprimary care FTE residents. Hospital A's FYE June 30, 2006 nonprimary care PRA is $100,000. The FYE June 30, 2006 locality-adjusted national average PRA for Hospital A is $84,000. Hospital A's Medicare utilization is 35 percent. Effective July 1, 2005, under section 1886(h)(7)(B) of the Act, Hospital A receives an increase to its direct GME FTE resident cap of 5 FTEs, for a total adjusted direct GME FTE resident cap of 25 FTEs. For the FYE June 30, 2006 cost report, the direct GME payment is calculated as follows:

Step 1. For residents NOT counted pursuant to section 1886(h)(7)(B) of the Act—

For July 1, 2005 through June 30 2006:

- Rolling average count: 20 + 20 + 20/3 = 20.
- Direct GME computation: $100,000 × 20 × .35 = $700,000.

Step 2. For residents counted pursuant to section 1886(h)(7)(B) of the Act—

For July 1, 2005 through June 30, 2006:

- Rolling average count: 25 + 20 + 20/3 = 21.7
- Difference between rolling average count for residents counted pursuant to section 1886(h)(7)(B) of the Act and rolling average count for residents counted not pursuant to section 1886(h)(7)(B) of the Act (rolling average count under step 2 minus rolling average count under step 1): 21.7 − 20 = 1.7.
- Direct GME computation: $84,000 × 1.7 × .35 = $49,980.

Step 3. Direct GME payment for FYE June 30, 2006: $700,000 + $49,980 = $749,980.

k. Application of Section 422 to Hospitals That Participate in Demonstration Projects or Voluntary Reduction Programs

Section 1886(h)(7)(B)(vi) of the Act, as amended by section 422(a)(3) of Public Law 108–173, states that ''Nothing in this subparagraph shall be construed as permitting the redistribution of reductions in residency positions attributable to voluntary reduction programs * * * under a demonstration project approved as of October 31, 2003.'' This language is referring to the New York Medicare GME Demonstration Project and the Voluntary Resident Reduction Project (VRRP) under section 402 of Public Law 90–248. In July 1997, 42 New York teaching hospitals participated in the demonstration project. As there were two entry points for this demonstration, an additional seven hospitals joined the program in July 1998. The purpose of the demonstration project was to test reimbursement changes associated with residency training to determine whether hospitals could use time-limited transition funding to replace and reengineer the services provided by a portion of their residency trainees. In exchange for reducing its count of residents by 20 to 25 percent over a 5-year period, while maintaining or increasing its primary care-to-specialty ratio of residents, a participating hospital (or consortium of hospitals) would receive ''hold harmless payments'' for 6 years. These payments represented a declining percentage of the Medicare GME reimbursement the participating hospitals would have received had their number of residents not been reduced.

For hospitals that successfully completed the demonstration project, the Balanced Budget Act of 1997 states that if a hospital increases the number of full-time equivalent residents permitted under its reduction plan as of the completion of the plan, it is liable for repayment of the total amounts paid under the demonstration. Following the demonstration's period of performance, which ended June 30, 2003, if a hospital exceeds its post-demonstration cap and trains residents in excess of the FTE levels achieved under the demonstration, the hospital is not permitted to count those excess residents for purposes of Medicare GME payments until such time as the hold harmless funds paid under the demonstration project have been repaid in full.

Similarly, with the VRPP, hospitals could use time-limited transition funding to replace the services provided by a portion of their residents. In exchange for reducing its count of residents by 20 to 25 percent over a 5-year period, while maintaining or increasing its primary care-to-specialty ratio of residents, a VRRP participating hospital would receive ''hold harmless payments'' for 5 years. These payments represented a declining percentage of the Medicare GME reimbursement the VRRP participating hospital would have received had its number of residents not been reduced.

We believe that the language of section 1886(h)(7)(B)(vi) of the Act precludes the Secretary from redistributing residency positions that are unused due to a hospital's participation in a demonstration project or the VRRP to other hospitals that seek to increase their FTE resident caps under section 1886(h)(7)(B)(i) of the Act. That is, if we were to propose that hospitals that participated in a demonstration project or the VRRP are subject to possible reductions to their FTE resident caps under section 1886(h)(7)(A)(i) of the Act, any excess slots resulting from reductions made under section 1886(h)(7)(A)(i) of the Act attributable to the demonstration or the voluntary reduction program at these hospitals would not be allocated to the resident pool and redistributed to other hospitals. We also believe that section 1886(h)(7)(B)(vi) of the Act is silent as to whether the Secretary should apply the possible reductions under section 1886(h)(7)(A)(i) of the Act to the FTE resident caps of these hospitals. Congress recognized the unique status of reductions in FTE resident counts made by these hospitals that participated in a demonstration project under the authority of section 402 of Public Law 90–248, or a VRRP under section 1886(h)(6) of the Act, in which these hospitals received hold-harmless payments from Medicare for reducing the number of residents that they were training. Accordingly, we are proposing to recognize the unique status of FTE reductions made by these hospitals, and

are applying the discretion that Congress has granted the Secretary under section 1886(h)(7)(A)(ii) of the Act in determining the reference resident level applicable to these hospitals, to determine the extent to which section 1886(h)(7)(A)(i) of the Act applies to these hospitals.

We note that section 1886(h)(7)(B)(vi) of the Act only applies to these hospitals to the extent that a hospital's ''reductions in residency positions'' were ''*attributable*'' to its participation in the demonstration project or the VRRP. In determining the reference resident level for these hospitals, we are proposing to adjust the reference resident level for ''reductions in residency positions attributable'' to participation in the demonstration project or the VRRP. We are proposing to define ''reductions in residency positions attributable'' to participation in the demonstration project or the VRRP as the difference between the number of unweighted allopathic and osteopathic residents training at the hospital at the start of a hospital's participation in the demonstration project or the VRRP, (that is, the base number of residents as defined by the terms of the demonstration project and the VRRP,) and the number of such residents training at the hospital in the hospital's most recent cost reporting period ending on or before September 30, 2002. We are proposing that, in determining any possible adjustments to the reference resident level for hospitals that participated in the demonstration project or the VRRP, we would differentiate between hospitals that withdrew from participation *prior* to the beginning of the most recent cost reporting period ending on or before September 30, 2002, and hospitals that either have not withdrawn from participation, or withdrew sometime during or after the most recent cost reporting period ending on or before September 30, 2002.

Specifically, we are proposing that, if a hospital was participating in the demonstration project or the VRRP at any time during the hospital's most recent cost reporting period ending on or before September 30, 2002, for purposes of determining possible reductions to the FTE resident caps, we would compare the higher of the hospital's base number of residents, and the resident level in the hospital's most recent cost reporting period ending on or before September 30, 2002, to the hospital's otherwise applicable FTE resident cap. If the higher of the base number of residents or the resident level in the hospital's most recent cost reporting period ending on or before September 30, 2002, is still less than the otherwise applicable FTE resident cap, we are proposing to reduce the hospital's FTE resident cap amount by 75 percent of the difference, effective July 1, 2005. We would also use those slots in the redistribution process under section 1886(h)(7)(B) of the Act since those slots are not ''attributable'' to participation in the demonstration project or the VRRP.

Under section 1886(h)(7)(A)(ii)(II) of the Act, a hospital may submit a timely request to use its cost report that includes July 1, 2003, for purposes of determining the reference resident level if the hospital has an expansion of an existing program that is not reflected on the hospital's most recent settled cost report. If a hospital that was still participating in the demonstration project or the VRRP at some time during its most recent cost reporting period ending on or before September 30, 2002, had an expansion of an existing program that is not reflected on its most recent settled cost report, and the resident level for its cost reporting period that includes July 1, 2003, is higher than the resident level for the most recent cost reporting period ending on or before September 30, 2002, and is higher than the base number of residents, we anticipate that the hospital would submit a timely request that its resident level from its cost reporting period that includes July 1, 2003, be compared to its otherwise applicable FTE resident cap, for purposes of determining a possible reduction to the hospital's FTE resident cap. We believe that under the proposed policy discussed above, a hospital would only request that we utilize its cost reporting period that includes July 1, 2003, if the number of allopathic and osteopathic residents it trained in that cost reporting period is higher than its base number of residents and its base number of residents is less than its FTE resident cap. If we grant the hospital's request that we utilize its cost reporting period that includes July 1, 2003, and the resident level for that period is less than the FTE resident cap, we would reduce the FTE resident cap by 75 percent of the difference between the two numbers. We would also use those slots in the redistribution process under section 1886(h)(7)(B) of the Act, since those slots are not ''attributable'' to participation in the demonstration project or the VRRP.

If a hospital withdrew from participation in the demonstration project or the VRRP prior to its most recent cost reporting period ending on or before September 30, 2002, we are proposing that such a hospital would be subject to the procedures applicable to all other hospitals for determining possible reductions to the FTE resident caps. However, we note that such a hospital may still apply for an increase to its FTE caps as specified under section 1886(h)(7)(B) of the Act (the proposals for applying for the increase are described above).

l. Application of Section 422 to Hospitals That File Low Utilization Medicare Cost Reports

In general, section 422 of Public Law 108–173 applies to hospitals that are Medicare-participating providers and that train residents in approved residency programs. However, because Medicare-participating children's hospitals primarily serve a non-Medicare population and, therefore, receive minimal Medicare payments relative to other Medicare-participating hospitals, some children's hospitals choose (with approval from their fiscal intermediaries) to submit low utilization (abbreviated) Medicare cost reports. Typically, such low utilization cost reports do not include the information that would be necessary for us to calculate Medicare GME payments, such as FTE resident counts and caps. Thus, children's hospitals that submit these low utilization cost reports do not receive Medicare GME payments.

Under section 1886(h)(7)(A) of the Act, as added by section 422(a) of Public Law 108–173, we are proposing that determinations as to whether, and by how much, a children's hospital's FTE resident cap will be reduced will be made using the same methodology (that is, utilizing the same reference cost reporting periods and the same reference resident levels) that we are proposing for other Medicare-participating teaching hospitals. We note that the low utilization cost reports may be filed with or without Worksheet E–3, Part IV (the worksheet on which the Medicare direct GME payment is calculated). If a children's hospital files a low utilization cost report in a given cost reporting period, and does not file the Worksheet E–3, Part IV, for Medicare purposes, that hospital is not considered by Medicare to be a teaching hospital in that cost reporting period. (We realize that a children's hospital that files a low utilization cost report may have a ''resident cap'' that is applicable for payment purposes under the Children's Hospital Graduate Medical Education (CHGME) Payment Program, administered by the Health Resources and Services Administration (HRSA), but this resident cap is not the Medicare FTE resident cap.) As stated in the One-Time Notification published on April 30, 2004 (Transmittal 77, CR

3247), if a children's hospital filed a low utilization cost report in its most recent cost reporting period ending on or before September 30, 2002, and did not file the Worksheet E–3, Part IV, there could be no reduction under section 1886(h)(7)(A) of the Act because there is no reference resident level for such a hospital. This would be the case even in instances where such a children's hospital has a FTE resident cap (for example, from 1996) that is recognized for Medicare purposes, because there would still be no reference resident level for its most recent cost reporting period ending on or before September 30, 2002, on which to determine a possible reduction to the children's hospital FTE resident cap.

Although section 1886(h)(7)(A) of the Act does not apply to children's hospitals that filed a low utilization cost report (and no Worksheet E–3, Part IV) for the most recent cost reporting period ending on or before September 30, 2002, we are proposing that, regardless of how a children's hospital has previously filed its Medicare cost report (that is, a full cost report or an abbreviated one), or how it is treated for CHGME payment purposes, a children's hospital would be eligible to apply for an increase in its FTE resident cap under section 1886(h)(7)(B) of the Act, subject to the same demonstrated likelihood and evaluation criteria proposed above for all hospitals. However, we are proposing that, in order to receive an increase in its FTE resident cap under section 1886(h)(7)(B) of the Act, effective July 1, 2005, in addition to complying with the proposed application requirements described above, the hospital must file Worksheet E–3, Part IV, with its Medicare cost report for its cost reporting period that includes July 1, 2005. We are proposing that the children's hospital comply with this requirement because section 422 is intended to allow a hospital to increase its FTE counts for purposes of Medicare GME payments. We do not believe it would be appropriate to grant an increase in a hospital's FTE resident cap under section 1886(h)(7)(B) of the Act if the hospital does not use the slots for Medicare purposes (but only for purposes of the CHGME Payment Program) as would be evidenced by not filing a Worksheet E–3, Part IV.

m. Specific Solicitation for Public Comment on the Proposals

We specifically solicit public comment on the proposals in this section IV.O.2. In particular, in section IV.O.2.g. of this preamble on the determination of the hospitals that will receive increases in their FTE resident caps, we have considered many possible alternatives to evaluate hospital applications. We specifically solicit public comments on how hospitals should ''demonstrate the likelihood'' of filling the additional residency slots, and in a way that is documentable for all hospitals and verifiable by CMS. We also specifically solicit public comments on the criteria we have proposed for evaluating the hospital applications and are open to suggestions from the public on what other criteria we should use to determine which hospitals should receive the increases in their FTE resident caps. We ask the public to keep in mind that criteria should be documentable for all hospitals and verifiable by CMS.

n. CMS Evaluation Form

CMS Evaluation Form as Part of the Application for the Increase in a Hospital's FTE Cap(s) Under Section 422 of the Medicare Modernization Act of 2003

Directions: Please fill out the information below for each residency program for which the applicant hospital intends to use the increase in its FTE cap(s). CMS notes that the applicant hospital is responsible for complying with the other requirements listed in the FY 2005 hospital inpatient prospective payment system proposed rule in order to complete its application for the increase in its FTE cap(s) under section 422 of Public Law 108–173.

NAME OF HOSPITAL: _____

MEDICARE PROVIDER NUMBER: _____

NAME OF SPECIALTY TRAINING PROGRAM: _____

(Check one): ☐ Allopathic Program ☐ Osteopathic Program

NUMBER OF FTE SLOTS REQUESTED FOR PROGRAM:

Direct GME:_____ IME:_____

Section A: Demonstrated Likelihood of Filling the FTE Slots

(Place an ''X'' in the box for the applicable criterion and subcriteria.)

☐ A1: *Demonstrated Likelihood Criterion 1.* The hospital intends to use the additional FTEs to establish a new residency program (listed above) on or after July 1, 2005 (that is, a newly approved program that begins training residents on or after July 1, 2005).

☐ (1) Hospital is establishing this newly approved residency program. (Check one of the following.)

☐ Application for approval of the new residency program has been submitted to the ACGME or the AOA by December 1, 2004. (Copy attached.)

☐ The hospital has submitted an institutional review document or program information form concerning the new program in an application for approval of the new program by December 1, 2004. (Copy attached.)

☐ The hospital has received written correspondence from the ACGME or AOA acknowledging receipt of the application for the new program, or other types of communication from the accrediting bodies concerning the new program approval process (such as notification of site visit). (Copy attached.)

☐ (2) Hospital will likely fill the slots requested. (Check one of the following.)

☐ The hospital s existing residency programs had a resident fill rate of at least 95 percent in each of program years 2001 through 2003. (Documentation attached.)

☐ The hospital has the cover page of its employment contracts with the residents who are or will be participating in the new residency program (resident specific information may be redacted). (Copies attached.)

☐ The specialty program (listed above) has a resident fill rate nationally, across all hospitals, of at least 95 percent. (Documentation attached.)

☐ A2: *Demonstrated Likelihood Criterion 2.* The applying hospital intends to use the additional FTEs to expand an existing residency training program that is listed above (that is, to increase the number of FTE resident slots in the program) on or after July 1, 2005, and before July 1, 2008.

☐ (1) Hospital intends to expand an existing program. (Check one of the following.)

☐ The appropriate accrediting body (the ACGME or the AOA) has approved the hospital s expansion of the number of FTE residents in the program. (Documentation attached.)

☐ The National Residency Match Program or the American Osteopathic Association Residency Match Program has accepted or will be accepting the hospital s participation in the match for the existing program that will include additional resident slots in that residency training program. (Documentation attached.)

☐ The hospital has institutional review document or program information form for the expansion of the existing residency training program. (Copy attached.)

☐ (2) Hospital will likely fill the slots of the expanded residency program. (Check one of the following.)

☐ Hospital has employment contracts with the residents who are or will be participating in the expanded program (resident specific information may be redacted) and employment contracts with the residents participating in the program prior to the expansion of the program. (Copy of the cover page of both documents attached.)

☐ Hospital has other previously established residency programs. (Documentation attached evidencing that each of the residency programs had a resident fill rate of at least 95 percent in each of program years 2001 through 2003.)

☐ Hospital is expanding an existing program in a particular specialty. (Documentation attached evidencing that the specialty has a resident fill rate nationally, across all hospitals, of at least 95 percent.)

☐ Hospital is expanding a program in order to train residents that need a program because another hospital in the State has closed a similar program, and the applying hospital received a temporary adjustment to its FTE cap(s) (under the requirements of § 413.86(g)(9)). (Documentation attached.)

☐ A3: *Demonstrated Likelihood Criterion 3.* Hospital is applying for an increase in its FTE resident cap because the hospital is already training residents in an existing residency training program(s) in excess of its direct GME FTE cap or IME FTE cap, or both. (Copies of *EACH* of the following attached.)

- Copies of the most recent as-submitted Medicare cost reports documenting on Worksheet E, Part A and Worksheet E3, Part IV the resident counts and FTE resident caps for both direct GME and IME for the relevant cost reporting periods.
- Copies of the 2004 residency match information concerning the number of residents the hospital intends to have in its existing programs.
- Copies of the most recent accreditation letters on all of the hospital s training programs in which the hospital trains and counts FTE residents for direct GME and IME.

☐ A4: *Demonstrated Likelihood Criterion 4.* The hospital is applying for the unused FTE resident slots because the hospital is at risk of losing accreditation of a residency training program if the hospital does not increase the number of FTE residents in the program on or after July 1, 2005. (Documentation attached from the appropriate accrediting body of the hospital's risk of lost accreditation as a result of an insufficient number of residents in the program.)

Section B. Level Priority Category

☐ (Place an ''X'' in the appropriate box that is applicable to the level priority category that describes the applicant hospital.)

☐ B1: *First Level Priority Category:* The hospital is a rural hospital and has the only specialty training program in the State (for the program requested on page 1 of this CMS Evaluation Form).

☐ B2: *Second Level Priority Category:* The hospital is a rural hospital only.

☐ B3: *Third Level Priority Category:* The hospital is a small urban hospital (that is, an urban hospital that is located in a ''not large urban area'') and has the only specialty program in the State (for the program requested on this CMS Evaluation Form).

☐ B4: *Fourth Level Priority Category:* The hospital is a ''small'' urban hospital only.

☐ B5: *Fifth Level Priority Category:* The hospital has the only specialty training program in the State (for the program requested on page 1 of this CMS Evaluation Form).

☐ B6: *Sixth Level Priority Category:* The hospital meets none of the statutory priority criteria.

Section C. Evaluation Criteria

(Place an X in the box for each criterion that is appropriate for the applicant hospital and for the program for which the increase in the FTE cap is requested.)

☐ C1: *Evaluation Criterion One.* The hospital that is requesting the increase in its FTE resident cap(s) has a Medicare inpatient utilization over 60 percent, as reflected in at least two of the hospital s last three most recent audited cost reporting periods for which there is a settled cost report.

☐ C2: *Evaluation Criterion Two.* The hospital needs the additional slots to establish a new geriatrics residency program, or adding residents to an existing geriatrics program.

☐ C3: *Evaluation Criterion Three.* The hospital does not qualify for an adjustment to its FTE caps under existing § 413.86(g)(12) for a rural track residency program, but is applying for an increase in its FTE resident cap(s) under section 1886(h)(7)(B) of the Act because it rotates (or in the case of a new program, will rotate) residents for at least 25 percent of the duration of the residency program to any one (or in combination thereof) of the following: a rural area, as defined in section 1886(d)(2)(D)(ii) of the Act and § 412.62(f)(1)(iii) of the regulations; a rural health clinic (RHC), as defined in section 1861(aa)(1) of the Act and § 491.2 of the regulations; or a Federally Qualified Health Center (FQHC), as defined in section 1861(a)(3) of the Act and § 405.2401(b) of the regulations.

☐ C4: *Evaluation Criterion Four.* In portions of cost reporting periods prior to July 1, 2005, the hospital qualified for a temporary adjustment to its FTE cap under existing § 413.86(g)(9) because it was training displaced residents from either a closed program or a closed hospital, and, even after the temporary adjustment, the hospital continues to train residents in the specialty(ies) of the displaced residents and is above the hospital's direct GME FTE cap or IME FTE cap, or both, for that reason.

☐ C5: *Evaluation Criterion Five.* The hospital is above its FTE caps because it was awaiting accreditation of a new program from the ACGME or the AOA during the base period for its FTE cap(s) but was not eligible to receive a new program adjustment as stated under existing § 413.86(g)(6)(ii).

☐ C6: *Evaluation Criterion Six.* The hospital is above its FTE resident caps because, despite qualifying for an FTE cap adjustment for a new program under § 413.86(g)(6)(i) or (g)(6)(ii), it was unable to ''grow'' its program to the full complement of residents for which the program was accredited before the hospital's FTE resident cap was permanently set beginning with the fourth program year of the new program.

☐ C7: *Evaluation Criterion Seven.* The hospital is located in any one (or in combination thereof) of the following: a geographic HPSA, as defined in 42 CFR 5.2; a population HPSA (also defined at 42 CFR 5.2); or a Medicare physician scarcity county, as defined under section 413 of Public Law 108–173.

☐ C8: *Evaluation Criterion Eight.* The hospital is in a rural area (as defined under section 1886(d)(2)(D)(ii) of the Act) and is a training site for a rural track residency program (as specified under § 413.86(g)(12), but is unable to count all of the FTE residents training at the rural hospital in the rural track because the rural hospital's FTE cap is lower than the hospital's unweighted count of allopathic or osteopathic FTE residents beginning with portions of cost reporting periods on or after July 1, 2005.

☐ C9: *Evaluation Criterion Nine.* The hospital is affiliated with a historically Black medical college.

☐ C10: *Evaluation Criterion Ten:* The hospital is training residents in residency program(s) sponsored by a medical school(s) that is designated as a Center of Excellence for Underserved Minorities (COE) under section 736 of the Public Health Service Act in FY 2003.

o. CMS Central and CMS Regional Office Mailing Addresses for Applications for Increases in FTE Resident Caps

Central Office

Centers for Medicare and Medicaid Services (CMS), Director, Division of Acute Care, 7500 Security Boulevard, Mail Stop C4–08–06, Baltimore, Maryland 21244.

Region I (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont)

Centers for Medicare and Medicaid Services (CMS), Associate Regional Administrator, Division of Medicare Financial Management, Region I, JFK Federal Building, Room 2325, Boston, MA 02203, Phone: (617) 565–1185.

Region II (New York, New Jersey, U.S. Virgin Islands, and Puerto Rico)

Centers for Medicare and Medicaid Services (CMS), Associate Regional Administrator, Division of Medicare Financial Management, Region II, 26 Federal Plaza, 38th Floor, New York, NY 10278, Phone: (212) 264–3657.

Region III (Delaware, Maryland, Pennsylvania, Virginia and West Virginia, and the District of Columbia)

Centers for Medicare and Medicaid Services (CMS), Associate Regional Administrator, Division of Medicare Financial Management, Region III, Public Ledger Building, Suite 216, 150 South Independence Mall West, Philadelphia, PA 19106, Phone: (215) 861–4140.

Region IV (Alabama, North Carolina, South Carolina, Florida, Georgia, Kentucky, Mississippi, and Tennessee)

Centers for Medicare and Medicaid Services (CMS), Associate Regional Administrator, Division of Medicare Financial Management, Region IV, Atlanta Federal Center, 61 Forsyth Street, SW., Suite 4T20, Atlanta, GA 30303–8909, Phone: (404) 562–7500.

Region V (Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin)

Centers for Medicare and Medicaid Services (CMS), Associate Regional Administrator, Division of Medicare Financial Management, Region V, 233 North Michigan Avenue, Suite 600, Chicago, IL 60601, Phone: (312) 886–6432.

Region VI (Arkansas, Louisiana, New Mexico, Oklahoma, and Texas)

Centers for Medicare and Medicaid Services (CMS), Associate Regional Administrator, Division of Medicare Financial Management, Region VI, 1301 Young Street, Suite 714, Dallas, TX 75202, Phone: (214) 767–6423.

Region VII (Iowa, Kansas, Missouri, and Nebraska)

Centers for Medicare and Medicaid Services (CMS), Associate Regional Administrator, Division of Medicare Financial Management, Region VII, Richard Bolling Federal Building, Room 235, 601 East 12th Street, Kansas City, MO 64106.

Region VIII (Colorado, Montana, North Dakota, South Dakota, Utah and Wyoming)

Centers for Medicare and Medicaid Services (CMS), Associate Regional Administrator, Division of Medicare Financial Managment, Region VIII, Colorado State Bank Building, 1600 Broadway, Suite 700, Denver, CO 80202, Phone: (303) 844–2111.

Region IX (Arizona, California, Hawaii, and Nevada and Territories of American Samoa, Guam and the Commonwealth of the Northern Mariana Islands)

Centers for Medicare and Medicaid Services (CMS), Associate Regional Administrator, Division of Medicare Financial Management, Region IX, 75 Hawthorne St., Suite 408, San Francisco, CA 94105, Phone: (415) 744–3501.

Region X (Alaska, Idaho, Oregon, and Washington)

Centers for Medicare and Medicaid Services (CMS), Associate Regional Administrator, Division of Medicare Financial Management, Region X, 2201 Sixth Avenue, MS–40, Seattle, WA 98121, Phone: (206) 615–2306.

3. Direct GME Initial Residency Period (Proposed New § 413.79, a Proposed Redesignation of Existing § 413.86(g))

a. Background

As we have generally described above, the amount of direct GME payment to a hospital is based in part on the number of FTE residents who are training at the hospital during a year. The number of FTE residents training at a hospital, and thus the amount of direct GME payment to a hospital, is directly affected by CMS policy on how ''initial residency periods'' are determined for residents.

Section 1886(h)(5)(A) of the Act defines ''approved medical residency training program'' as ''a residency or other postgraduate medical training program, participation in which may be counted toward certification in a specialty or subspecialty.'' This provision is implemented in regulations at existing § 413.86(b). In accordance with section 1886(h)(5)(I) of the Act, the term ''resident'' is defined to include ''an intern or other participant in an approved medical residency training program.'' Existing § 413.86(b) defines ''resident'' as an ''intern, resident, or fellow who participates in an approved medical residency training program * * * as required in order to become certified by the appropriate specialty board.''

Section 1886(h)(4)(C)(ii) of the Act provides that while a resident is in the ''initial residency period,'' the resident is weighted at 1.00 (existing § 413.86(g)(2) of the regulations). Section 1886(h)(4)(C)(iii) of the Act requires that if a resident is ''not in the resident's initial residency period,'' the resident is weighted as .50 FTE resident (existing § 413.86(g)(3) of the regulations).

Section 1886(h)(5)(F) of the Act defines ''initial residency period'' as the ''period of board eligibility,'' and, subject to specific exceptions, limits the initial residency period to an ''aggregate period of formal training'' of no more than 5 years for any individual. Section 1886(h)(5)(G) of the Act generally defines ''period of board eligibility'' for a resident as ''the minimum number of years of formal training necessary to satisfy the requirements for initial board eligibility in the particular specialty for which the resident is training.'' Existing § 413.86(g)(1) of the regulations generally defines ''initial residency period'' as the ''minimum number of years required for board eligibility.''Existing § 413.86(g)(1)(iv) provides that ''time spent in residency programs that do not lead to certification in a specialty or subspecialty, but that otherwise meet the definition of approved programs . . . is counted toward the initial residency period limitation.'' Section 1886(h)(5)(F) of the Act further provides that ''the initial residency period shall be determined, with respect to a resident, as of the time the resident enters the residency training program.''

The initial residency period is determined as of the time the resident enters the ''initial'' or first residency training program and is based on the period of board eligibility associated with that medical specialty. Thus, this

provision limits the amount of direct GME that Medicare pays a hospital for a resident who switches specialties to a program with a longer period of board eligibility or completes training in a specialty and then continues training in a subspecialty (for example, cardiology and gastroenterology are subspecialties of internal medicine).

b. Direct GME Initial Residency Period Limitation: Simultaneous Match Issue

CMS understands there are numerous programs, including anesthesiology, dermatology, psychiatry, and radiology, that require a year of generalized clinical training to be used as a prerequisite for the subsequent training in the particular specialty. For example, in order to become board eligible in anesthesiology, a resident must first complete a generalized training year and then complete 3 years of training in anesthesiology. This first year of generalized residency training is commonly known as the ''clinical base year.'' Commonly, the clinical base year requirement is fulfilled by completing either a preliminary year in internal medicine (although the preliminary year can also be in other specialties such as general surgery or family practice), or a transitional year program (which is not associated with any particular medical specialty).

In many cases, during the final year of medical school, medical students apply for training in specialty programs. Typically, a medical student who wants to train to become a specialist is ''matched'' to both the clinical base year program and the residency training specialty program at the same time. For example, the medical student who wants to become an anesthesiologist will apply and ''match'' simultaneously for a clinical base year in an internal medicine program for year 1 and for an anesthesiology training program in years 2, 3, and 4.

Based on our interpretation of the statute, CMS' policy is that the initial residency period is determined for a resident based on the program in which he or she participates in the resident's first year of training, without regard to the specialty in which the resident ultimately seeks board certification. Therefore, for example, a resident that chooses to fulfill the clinical base year requirement for an anesthesiology program with a preliminary year in an internal medicine program will be ''labeled'' with the initial residency period associated with internal medicine, or 3 years (3 years of training are required to become board eligible in internal medicine), even though the resident may seek board certification in anesthesiology, which requires a minimum of 4 years of training to become board eligible. As a result, this resident would be weighted at 0.5 FTE in his or her fourth year of training for purposes of direct GME payment.

We understand that some hospitals have been assigning residents that complete a clinical base year in a different specialty from the one in which they ultimately train an initial residency period and a weighting factor based on the specialty associated with second program year in which the residents train. As a result, some residents have been assigned a weighting factor of 1.0 FTE for years beyond their initial residency periods, rather than the applicable 0.5 FTE weighting factor. This error results in Medicare overpayments, the size of which is dependent upon the hospital's direct GME PRA and its Medicare utilization. In addition, we have received numerous requests from the health care industry to revise our policy concerning the initial residency period for residency programs that require a clinical base year because some entities in the industry believe that our current policy is unfair to those individuals who ''match'' simultaneously for both a preliminary year (for example, the clinical base year in internal medicine) and the longer specialty residency program (for example, anesthesiology, dermatology, or radiology).

To address these concerns, we are considering making a change in policy that addresses these ''simultaneous match'' residents. Specifically, we are considering a policy that, if a hospital can document that a particular resident matches simultaneously for a first year of training in a clinical base year in one medical specialty, and for additional year(s) of training in a different specialty program, the resident's initial residency period would be based on the period of board eligibility associated with the specialty program in which the resident matches for the subsequent year(s) of training and not on the period of board eligibility associated with the clinical base year program, for purposes of direct GME payment. In addition, we are considering a new definition of ''residency match'' to mean, for purposes of direct GME, a national process by which applicants to approved medical residency programs are paired with programs on the basis of preferences expressed by both the applicants and the program directors.

This policy could apply regardless of whether the resident completes the first year of training in a separately accredited transitional year program or in a preliminary (or first) year in another residency training program such as internal medicine.

Under such a policy, hospitals would apply a weight of 1.0 FTE (instead of 0.5) for an additional year or two to some residents who, as a prerequisite for training in a specialty program, complete a first year of training in a different specialty program. This would probably cause an increase in direct GME payments. This provision would apply to such programs as anesthesiology, dermatology, radiology, and physical medicine and rehabilitation. In 2004, there were approximately 1,840 residents in these specialties that would be affected by this proposal, as compared to the approximately 83,000 residents in total for whom Medicare makes direct GME payments. Under current policy, these 1,840 residents would be weighted at 0.5 FTE in their 4th year (and 5th year, if applicable) of training. Therefore, direct GME spending for these 1,840 residents should currently be $26.5 million ($1,840 \times 0.5 \times 82,249$[5] $\times .35$[6]). Under the policy CMS is considering, direct GME spending would be twice that amount at $53 million ($1,840 \times \$82,249 \times .35$). However, because we believe a number of fiscal intermediaries may have been applying current policy incorrectly and instead have been weighting approximately 920 residents at 1.0 in their 4th year (and 5th year, if applicable) of training, the cost of this change would be expected to be closer to $13.25 million ($920 \times 0.5 \times \$82,249 \times .35$). We are providing this cost impact analysis to the public for its information in consideration of any such proposed change.

We note that in the Conference Committee report that accompanied Public Law 108–173, the Committee stated: ''The conferees also clarify that under section 1886 (h)(5)(F), the initial residency period for any residency for which the ACGME requires a preliminary or general clinical year of training is to be determined in the resident's second year of training.'' (Conference Committee Agreement Accompanying Public Law 108–173, 108 Cong., 2d Sess., 276 (2003)) The Conference Committee included this language as part of its explanation of section 712 of Public Law 108–173, which clarifies an exception to the initial residency period for geriatric fellowship programs (see section IV.O.3.c. of this preamble). We are

[5] $82,249 is the estimated national average per resident amount for FY 2005.

[6] .35 is the estimated average Medicare utilization.

considering making a policy change for determining the initial residency period for a resident who participates in a clinical base year program based on the resident's second year of training, as the Conference Committee suggests. However, we understand that not all residents who participate in the clinical base year programs simultaneously match in specialty training programs before the residents' first year of training. Thus, if we were to propose a ''second year'' policy, there would be no way to distinguish in the second year of training among those residents who simultaneously matched in a specialty program prior to their first year of training; those residents who did not match simultaneously, but participated in a clinical base year and then continued on to train in a different specialty; and those residents who simply switched specialties in their second year. As we have stated earlier, the initial residency period is to be determined based on the ''initial'' or first program in which a resident trains. Section 1886(h)(5)(F) of the Act provides that ''the initial residency period shall be determined, with respect to a resident, as of the time the resident *enters* the residency training program.'' (Emphasis added.)

Therefore, we believe it is appropriate for us to consider changes to the ''simultaneous match'' policy that would allow for documentation that the residents' training program is arranged to continue in another medical specialty after the resident completes the clinical base year. However, we also specifically solicit comments concerning the issue of how to establish the initial residency period for a resident who does not match simultaneously for the first and second year, completes the first year in a preliminary program in one specialty, and then continues his or her training in a different specialty program that requires completion of a clinical base year.

We note that if we were to propose such a change in the initial residency period policy, the change, if finalized, could result in an adjustment to the PRA applicable for the direct GME payments made to the hospital for a resident in a clinical base year. By treating the first year as part of a nonprimary care specialty program (for example, anesthesiology), the hospital would be paid at the lower nonprimary care PRA rather than the higher primary care PRA, which would be used for residents training in a clinical base year in a primary care program (for example, internal medicine). We note in conjunction with our proposal that the initial residency period would be established based upon the period of board eligibility for the specialty program for residents who simultaneously match with a clinical base year and a specialty program that we believe all of the programs that require a clinical base year are nonprimary care specialties. Because we are considering a policy change that the initial residency period would be based upon the period of board eligibility for the specialty program rather than the clinical base year, we would also consider a policy change that the nonprimary care PRA would apply for the duration of their initial residency period.

Thus, we are considering making the above policy changes to address the clinical base year initial residency period issue. We specifically solicit comments on the changes we are considering to the existing initial residency period policy and other approaches to address this issue, particularly those that do not increase Medicare expenditures.

c. Exception to Initial Residency Period for Geriatric Residency or Fellowship Programs (Section 712 of Public Law 108–173 and Proposed Redesignated § 413.79(a) (a proposed redesignation of existing § 413.86(g)(1))

As explained further below, under Medicare direct GME payment rules, the initial residency period is generally defined as the minimum number of years of training required for a resident to become board eligible in a specialty (not to exceed 5 years) and is established at the time the resident enters his or her first training program. For purposes of direct GME payments, a resident's full-time equivalent (FTE) training time is weighted at 1.0 during the initial residency period and 0.5 for training that continues beyond the initial residency period. Section 1886(h)(5)(F) of the Act generally limits a resident's initial residency period to no longer than 5 years. That section also provides an exception that allows FTE training time spent by residents in an approved geriatric residency program to be treated as part of the resident's initial residency period, that is, weighted at 1.0 FTE for up to an additional 2 years after conclusion of the otherwise applicable initial residency period.

We understand, based on information provided by the American Geriatric Society (AGS), that in 1998, the American Board of Internal Medicine and the American Board of Family Physicians (hereinafter ''the Boards'') reduced the minimum number of years of formal training required for residents to become board eligible in geriatrics from 2 years to 1 year. As a result, the initial residency period, and full direct GME funding for residents in geriatric training programs, would be limited to 1 year.

However, we understand that many teaching hospitals continue to run geriatric residency or fellowship programs of at least 2 years in length (some are even 3 years). We also understand that, despite the decrease in the minimum requirements for board eligibility, the Accreditation Council for Graduate Medicare Education (ACGME) continues to accredit some geriatric training programs for the full duration of the fellowships. For example, if a hospital's geriatric fellowship is 3 years in length, the program may continue to be accredited by the ACGME for the full 3 years, but the FTE time spent by a resident training in the geriatric program would be weighted at 1.0 for the first year of the resident's training and at 0.50 for the second and third year of the fellowship. (However, we note that FTE residents' time is not weighted for purposes of IME payments.)

Effective October 1, 2003, section 712 (a) of Public Law 108–173 clarified that Congress intended to provide an exception to the initial residency period for purposes of direct GME payments for geriatric residency or fellowship programs such that ''where a particular approved geriatric training program requires a resident to complete 2 years of training to initially become board eligible in the geriatric specialty, the 2 years spent in the geriatric training program are treated as part of the resident's initial residency period, but are not counted against any limitation on the initial residency period.'' Therefore, we are proposing that, effective for cost reporting periods beginning on or after October 1, 2003, if a resident is training in an accredited geriatric residency or fellowship program of 2 (or more) years in duration, hospitals may treat training time spent during the first 2 years of the program as part of the resident's initial residency period and weight the resident's FTE time at 1.0 during that period, regardless of the fact that the minimum number of years of training required for board eligibility in geriatrics is only 1 year. We note that the statutory language quoted above does not allow a hospital to treat time spent by a resident in the second year of geriatric training as part of the resident's initial residency period in the case where the resident trained in a geriatric residency or fellowship program that is accredited as a 1-year program because, in that case, the

resident could be board eligible after only 1 year of training.

Even though Congress gave the Secretary authority to implement section 712 of Public Law 108–173 through an interim final rule with comment period, we chose to provide instructions in a One-Time Notification (OTN) to fiscal intermediaries and providers (Transmittal 61, CR 3071), ''Changes to the FY 2004 Graduate Medical Education (GME) Payments as Required by the Medicare Modernization Act of 2003 (MMA), P.L. 108–173,'' issued on March 12, 2004, and are implementing the statutory provision in our regulations through this notice and comment rulemaking process. We are proposing to revise proposed redesignated § 413.79(a) (a proposed redesignation of § 413.86(g)(1)) to incorporate the provision of section 712(a) of Public Law 108–173.

4. Per Resident Amount: Extension of Update Limitation on High-Cost Programs

(Section 711 of Public Law 108–173 and § 413.77(d)(*2*)(iii)(B)(*3*) (a proposed redesignation of existing § 413.86(e)(4)(ii)(C)(*2*)(*iii*)))

Section 1886(h)(2) of the Act, as amended by section 311 of the Balanced Budget Refinement Act (BBRA) of 1999 (Pub. L. 106–113), establishes a methodology for the use of a national average per resident amount (PRA) in computing direct GME payments for cost reporting periods beginning on or after October 1, 2000, and on or before September 30, 2005. Generally, section 1886(h)(2)(D)(ii) of the Act establishes a ''floor'' for hospital-specific PRAs at 70 percent of the locality-adjusted national average PRA. In addition, section 1886(h)(2)(D)(iv) of the Act establishes a ''ceiling'' that limits the annual adjustment of a hospital-specific PRA if the PRA exceeded 140 percent of the locality-adjusted national average PRA. Section 511 of the Benefits Improvement and Protection Act (BIPA) of 2000 (Pub. L. 106–554) further amended section 1886 (h)(2) of the Act to increase the floor that was established by the BBRA to 85 percent of the locality-adjusted national average PRA. For purposes of calculating direct GME payments, each hospital-specific PRA is compared to the floor and ceiling to determine whether the hospital-specific PRA should be revised. (We direct readers to Program Memorandum A–01–38, March 21, 2001 for historical reference on calculating the floor and ceiling.)

Section 711 of Public Law 108–173 amended section 1886 (h)(2)(D)(iv) of the Act to freeze the annual CPI-U updates to hospital-specific PRAs for those PRAs that exceed the ceiling for FYs 2004 through 2013. Therefore, we are proposing that, for cost reporting periods beginning during FY 2004 through FY 2013, we would calculate a ceiling that is equal to 140 percent of the locality-adjusted national average PRA for each hospital and compare it to each hospital-specific PRA. If the hospital-specific PRA for the preceding year is greater than 140 percent of the locality-adjusted national average PRA ''ceiling'' in the current fiscal year, the hospital-specific PRA for the current year is frozen at the preceding fiscal year's hospital-specific PRA and is not updated by the CPI-U factor. We note that a hospital may have more than one PRA. Each of a hospital's PRAs must be separately compared to the ''ceiling'' PRA to determine whether that PRA should be frozen at the level for the previous year or updated by the CPI-U factor.

For example, to determine the applicable PRA for a cost reporting period beginning during FY 2004, we would compare the hospital-specific PRA from the cost reporting period that began during FY 2003 to the FY 2004 locality-adjusted national average PRA for that hospital. If the FY 2003 hospital-specific PRA exceeds 140 percent of the FY 2004 locality-adjusted national average PRA, the FY 2004 hospital-specific PRA is frozen at the level of the FY 2003 hospital-specific PRA and is not updated by the CPI–U factor for FY 2004.

Due to the effective date of the statutory provision of section 711 of Public Law 108–173, we issued a notification to fiscal intermediaries and providers regarding the provision in the OTN issued on March 12, 2004 (Transmittal 61, CR 3071). In this proposed rule, to incorporate the changes made by section 711 of Public Law 108–173 in our regulations regarding the determination of PRAs, we are proposing to: (1) revise proposed redesignated § 413.77(d)(2)(iii)(B)(*3*) (a proposed redesignation of existing § 413.86(e)(4)(ii)(C)(*2*)(*iii*)) to make it applicable only to FY 2003; (2) further redesignate proposed newly redesignated § 413.77(d)(2)(iii)(B)(*4*) (the proposed redesignation of existing § 413.86(e)(4)(ii)(C)(*2*)(*iv*)) as § 413.77(d)(2)(iii)(B)(*4*); and (3) add a proposed new § 413.77(d)(2)(iii)(B)(*4*).

5. Residents Training in Nonhospital Settings

a. Background

With respect to reimbursement of direct GME costs, since July 1, 1987, hospitals have been allowed to count the time residents spend training in sites that are not part of the hospital (referred to as ''nonprovider'' or ''nonhospital sites'') under certain conditions. Section 1886(h)(4)(E) of the Act requires that the Secretary's rules concerning computation of FTE residents for purposes of direct GME payments ''provide that only time spent in activities relating to patient care shall be counted and that all the time so spent by a resident under an approved medical residency training program shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs all, or substantially all, of the costs for the training program in that setting.'' (Section 1886(h)(4)(E) of the Act, as added by section of 9314 of the Omnibus Budget Reconciliation Act of 1986, Pub. L. 99–509.)

Regulations regarding time spent by residents training in nonhospital sites for purposes of direct GME payment were first implemented in the September 29, 1989 final rule (54 FR 40286). We stated in that rule (under § 413.86(f)(3)) that a hospital may count the time residents spend in nonprovider settings for purposes of direct GME payment if the residents spend their time in patient care activities and there is a written agreement between the hospital and the nonprovider entity stating that the hospital will incur all or substantially all of the costs of the program. The regulations at that time defined ''all or substantially all'' of the costs to include the residents' compensation for the time spent at the nonprovider setting.

Prior to October 1, 1997, for IME payment purposes, hospitals could only count the time residents spend training in areas subject to the IPPS and outpatient areas of the hospital. Section 4621(b)(2) of the Balanced Budget Act of 1997 (Pub. L. 105–33) revised section 1886(d)(5)(B) of the Act to allow providers to count time residents spend training in nonprovider sites for IME purposes, effective for discharges occurring on or after October 1, 1997. Specifically, section 1886(d)(5)(B)(iv) of the Act was amended to provide that ''all the time spent by an intern or resident in patient care activities under an approved medical residency program at an entity in a nonhospital setting shall be counted towards the determination of full-time equivalency if the hospital incurs all, or substantially all, of the costs for the training program in that setting.''

In the regulations at §§ 412.105(f)(1)(ii)(c) and 413.86(f)(4)

(as issued in the July 31, 1998 **Federal Register**), we specify the requirements a hospital must meet in order to include the time spent by a resident training in a nonhospital site in its FTE count for Medicare reimbursement for portions of cost reporting periods occurring on or after January 1, 1999 for both direct GME and for IME payments. The regulations at § 413.86(b) redefine ''all or substantially all of the costs for the training program in the nonhospital setting'' as the residents' salaries and fringe benefits (including travel and lodging where applicable), and the portion of the cost of teaching physicians' salaries and fringe benefits attributable to direct GME. A written agreement between the hospital and the nonhospital site is required before the hospital may begin to count residents training at the nonhospital site; the agreement must provide that the hospital will incur the costs of the resident's salary and fringe benefits while the resident is training in the nonhospital site. The hospital must also provide reasonable compensation to the nonhospital site for supervisory teaching activities, and the written agreement must specify that compensation amount.

b. Moratorium on Disallowances of Allopathic or Osteopathic Family Practice Residents Training Time in Nonhospital Settings (Section 713 of Pub. L. 108–173 and Proposed Redesignated § 413.78 (a proposed redesignation of existing § 413.86(f))

As we mentioned above, under existing § 413.86(f)(4), for portions of cost reporting periods occurring on or after January 1, 1999, the time residents spend in nonhospital settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs may be included in determining the hospital's number of FTE residents for purposes of calculating both direct GME and IME payments, if the following conditions are met:

(1) The resident spends his or her time in patient care activities.

(2) There is a written agreement between the hospital and the nonhospital site that indicates that the hospital will incur the costs of the resident's salary and fringe benefits while the resident is training in the nonhospital site, and the hospital is providing reasonable compensation to the nonhospital site for supervisory teaching activities. The agreement must indicate the compensation the hospital is providing to the nonhospital site for supervisory teaching activities.

(3) The hospital incurs ''all or substantially all'' of the costs for the training program in the nonhospital setting. ''All or substantially all'' means the residents'' salaries and fringe benefits (including travel and lodging where applicable) and the portion of teaching physicians' salaries and fringe benefits attributable to direct graduate medical education.

In order for the hospital to incur ''all or substantially all'' of the costs in accordance with the regulations, the actual cost of the time spent by teaching physicians in supervising residents in the nonhospital setting must be compensated by the hospital. The amount of supervisory GME costs is dependent upon the teaching physician's salary and the percentage of time that he or she devotes to activities related to the residency program at the nonhospital site. As long as there are supervisory costs associated with the nonhospital training, the hospital must reimburse the nonhospital setting for those costs in order to count FTE resident time spent in the nonhospital site for purposes of IME and direct GME payments.

Many hospitals have entered into written agreements with teaching physicians that state that the teaching physician is ''volunteering'' his or her time in the nonhospital site, and, therefore, the hospital is not providing any compensation to the teaching physician. Other hospitals have paid only a nominal amount of compensation for the supervisory teaching physicians' time in the nonhospital setting. Because the existing regulations at § 413.86(f)(4) state that the hospital must incur all or substantially all of the direct GME costs, including those costs associated with the teaching physician, regardless of whether the written agreement states that the teaching physician is ''volunteering,'' we have required that the hospital must pay these costs in order to count FTE residents training in the nonhospital site, as long as these teaching physician costs exist.

However, during the 1-year period from January 1, 2004 through December 31, 2004, section 713 of Public Law 108–173, through a moratorium, allows hospitals to count allopathic or osteopathic family practice residents training in nonhospital settings for IME and direct GME purposes, without regard to the financial arrangement between the hospital and the teaching physician practicing in the nonhospital setting to which the resident is assigned. We implemented section 713 in the One-Time Notification (OTN), ''Changes to the FY 2004 Graduate Medical Education (GME) Payments as Required by the Medicare Modernization Act of 2003 (MMA)'' (CR 3071, Transmittal 61, issued on March 12, 2004). Generally, to implement the provisions of section 713, we stated in the OTN that, when settling prior year cost reports during this 1-year period, or for family practice residents actually training in nonhospital settings during this 1-year period, the fiscal intermediaries should allow the hospitals to count allopathic and osteopathic family practice residents training in the nonhospital setting for direct GME and IME payment purposes without regard to the financial arrangement between the hospital and the nonhospital site pertaining to the teaching physicians' costs associated with the residency program.

(1) Cost Reports That Are Settled Between January 1, 2004 and December 31, 2004.

When fiscal intermediaries settle cost reports during January 1, 2004 through December 31, 2004 (Calendar Year (CY) 2004), a hospital that seeks to count allopathic or osteopathic family practice FTE residents training in a nonhospital setting(s) is allowed to count those FTEs for IME and direct GME purposes, even in instances where the written agreement between the hospital and a teaching physician or a nonhospital site does not mention teaching physician compensation, specifies only a nominal amount of compensation, or states that the teaching physician is ''volunteering'' his or her time training the residents. For example, when a fiscal intermediary is settling a cost report during CY 2004 that has a fiscal year end of June 30, 2001, the fiscal intermediary will allow the hospital to count family practice FTE residents that trained in a nonhospital setting during the period covered by the June 30, 2001 cost report, regardless of the financial arrangement in place between the hospital and the teaching physician at the nonhospital site during the period covered by the June 30, 2001 cost report.

We note that this moratorium does not apply to cost reports that are *not* settled during January 1 through December 31, 2004, that do not coincide with, or overlap, the January 1 through December 31, 2004 period. For example, if a cost report for fiscal year ended December 31, 2003 (or June 30, 2003, or others) is not settled during the January 1 through December 31, 2004 period, the moratorium would not apply.

(2) Family Practice Residents That Are Training in Nonhospital Settings Between January 1, 2004 and December 31, 2004.

In addition to allowing family practice residents that trained in nonhospital settings to be counted in

cost reports that the fiscal intermediaries settle during the period of January 1, 2004 through December 31, 2004, without regard to the financial arrangements between the hospital and the teaching physician at the nonhospital site, the fiscal intermediaries are to allow family practice residents that actually are or will be training in nonhospital settings during January 1, 2004 through December 31, 2004, without regard to the financial arrangements between the hospital and the teaching physician at the nonhospital site. That is, when fiscal intermediaries settle cost reports that cover service periods of January 1, 2004 through December 31, 2004, a hospital that seeks to count allopathic or osteopathic family practice FTE residents training in a nonhospital setting(s) would be allowed to count those FTEs, even in instances where the written agreement between the hospital and a teaching physician or a nonhospital site does not mention teaching physician compensation, specifies only a nominal amount of compensation, or states that the teaching physician is ''volunteering'' his or her time training the residents. If a hospital has a fiscal year that is other than a calendar year, the hospital may count the family practice residents training in the nonhospital setting during those portions of its fiscal years that fall within the January 1, 2004 and December 31, 2004 period. For example, when a fiscal intermediary is settling a hospital's June 30, 2004 cost report, the hospital would be allowed to count family practice FTE residents that trained in a nonhospital setting during the period of January 1, 2004 through June 30, 2004, regardless of the financial arrangement between the hospital and the teaching physician at the nonhospital site from January 1 through June 30, 2004. Similarly, when a fiscal intermediary settles the hospital's June 30, 2005 cost report, the hospital would be allowed to count family practice FTE residents that trained in a nonhospital setting during the period of July 1, 2004 through December 31, 2004, regardless of the financial arrangement between the hospital and the teaching physician at the nonhospital site from July 1 through December 31, 2004. (However, we note that family practice residents that train in nonhospital settings beginning January 1, 2005, and after are not subject to the moratorium provided under section 713 of Pub. L. 108–173.)

Because we are interpreting this moratorium to apply to prior period cost reports that are settled during calendar year (CY) 2004, and to cost reports that are settled after CY 2004 that cover training that occurred during the period of January 1, 2004 through December 31, 2004, a gap in applicability of the moratorium may result for family practice residents training in nonhospital settings. For example, a hospital might be permitted to count certain FTE family practice residents that are included in its FY 2001 cost report in accordance with the moratorium because that cost report is settled during CY 2004. However, the hospital might not be permitted to count certain FTE family practice residents in its FY 2002 and FY 2003 cost reports because these cost reports would not be settled during CY 2004 and the moratorium would not apply. The hospital then could be permitted to count certain FTE family practice residents in its FY 2004 cost report in accordance with the moratorium, because the FY 2004 cost report would contain family practice residents who actually trained in a nonhospital setting during CY 2004.

Regardless of whether the fiscal intermediaries are settling prior period cost reports during CY 2004, or settling cost reports after CY 2004 that cover training during the period of January 1, 2004 through December 31, 2004, we emphasize that the moratorium provided in section 713 of Public Law 108–173 only applies for purposes of counting FTE residents in allopathic and osteopathic general family practice programs that were in existence (that is, training residents) as of January 1, 2002 and where the requirement to incur the teaching physician compensation related to direct GME may not have been met. Therefore, for residents training in nonhospital settings, we are proposing that the moratorium applies only: (1) To FTE residents in general family practice programs (and not to dental, podiatric, or other allopathic or osteopathic specialty programs); (2) to family practice programs that were in existence as of January 1, 2002; and (3) with the exception of teaching physician compensation, to training in nonhospital settings that meet the requirements in the existing regulations at § 413.86(f)(4) (proposed to be redesignated as § 413.78(d)).

We are not proposing any regulation text changes to address this provision at this time. We note that section 713(b) of Public Law 108–173 directs the Inspector General of the Department of Health and Human Services to conduct a study of the appropriateness of alternative methodologies for payment of residency training in nonhospital settings and to submit a report to Congress on the results of the study, along with recommendations, as appropriate, by December 8, 2004. We will await the release of the Inspector General's report and may consider additional policy and regulation changes at that time if they are warranted.

c. Requirements for Written Agreements for Residency Training in Nonhospital Settings (Proposed redesignated § 413.78 (a proposed redesignation of existing § 413.86(f)).

As mentioned above, under section 1886(h)(4)(E) of the Act, a hospital may count residents training in nonhospital settings for direct GME purposes (and under section 1886(d)(5)(B)(iv) of the Act, for IME purposes), if the residents spend their time in patient care activities and if ''* * * the hospital incurs all, or substantially all, of the costs for the training program in that setting.'' We believe Congress intended to facilitate residency training in nonhospital settings by requiring hospitals to commit to incur, and actually incur, all or substantially all of the costs of the training programs in the nonhospital sites. Accordingly, in implementing section 1886(h)(4)(E) of the Act, first in the regulations at § 413.86(f)(3), effective July 1, 1987, and later at § 413.86(f)(4), effective January 1, 1999, we required that, in addition to incurring all or substantially all of the costs of the program at the nonhospital setting, there must be a written agreement between the hospital and the nonhospital site stating that the hospital will incur all or substantially all of the costs of training in the nonhospital setting. The later regulations further specify that the written agreement must indicate the amount of compensation provided by the hospital to the nonhospital site for supervisory teaching activities. (We note that, in this proposed rule, § 413.86(f)(3) is proposed to be redesignated as § 413.78(c), and § 413.86(f)(4) is proposed to be redesignated as § 413.78(d).)

We required the written agreements in regulations in order to provide an administrative tool for use by the fiscal intermediaries to assist in determining whether hospitals would incur all or substantially all of the costs of the training in the nonhospital setting in accordance with Congressional intent. Furthermore, CMS policy has required that the written agreement between the hospital and the nonhospital site be in place *prior* to the time that the hospital begins to count the FTE residents training in the nonhospital site. A written agreement signed before the time the residents begin training at the nonhospital site that states that the

hospital will incur the costs of the training program at the nonhospital site indicates the hospital's ongoing commitment to incur the costs of training at that site.

In settling cost reports where hospitals have included residents training at nonhospital sites in their FTE count, the fiscal intermediaries have encountered numerous situations where hospitals have complied with the requirement to incur all or substantially all of the costs of training in nonhospital settings. However, despite our longstanding regulations that state the requirement for a written agreement, these hospitals have not met the regulatory requirements related to written agreements. For example, some hospitals had no written agreement in place during the training in the nonhospital setting, or written agreements were not timely (that is, they were prepared after the residents began or, in some cases, finished training at the nonhospital site), or the agreements did not include a specific amount of compensation to be provided by the hospital to the nonhospital site for supervisory teaching activities. As a result, hospitals have faced disallowances of direct GME and IME payments relating to FTE residents training in nonhospital settings because the hospitals did not comply with the regulatory requirements concerning written agreements.

In retrospect, we believe the regulatory requirements concerning the written agreements may not have been the most efficient aid to fiscal intermediaries in determining whether hospitals would actually incur all or substantially all of the costs of the training programs in nonhospital settings. The fiscal intermediaries have been required to ensure that hospitals are complying with the regulations regarding written agreements, in addition to determining whether a hospital actually incurred the appropriate costs. We believe it would be more appropriate and less burdensome for both fiscal intermediaries and hospitals if we instead focus the fiscal intermediaries' reviews on the statutory requirement that hospitals must incur all or substantially all of the costs of the program in the nonhospital setting. Therefore, we are proposing to revise the regulations under proposed new § 413.78 (a proposed redesignation of existing § 413.86(f)) to remove the requirement for a written agreement between the hospital and the nonhospital setting as a precondition for a hospital to count residents training in nonhospital settings for purposes of direct GME and IME payments. However, consistent with our belief that Congress intended that hospitals commit to incur, and actually incur, all or substantially all of the costs of the training programs in the nonhospital sites in order to facilitate training at nonhospital sites, we are also proposing that, in order for the hospital to count residents training in a nonhospital setting, the hospital must pay for the nonhospital site training costs concurrently with the training that occurs during the cost reporting period.

We understand that residents' rotations, including those to nonhospital settings, are generally in discrete blocks of time (for example, 4-week or 6-week rotations). Therefore, to account for various rotation lengths, we are proposing under the new proposed § 413.78(e) that, in order to count residents training in a nonhospital setting, a hospital must pay all or substantially all of the costs of the training in a nonhospital setting(s) by the end of the month following a month in which the training in the nonhospital site occurred. If a hospital is counting residents training in a nonhospital setting for direct GME and IME purposes in any month of its cost reporting period, the hospital must make payment by the end of the following month to cover all or substantially all of the costs of training in that setting attributable to the preceding month. If the residents are employed by the hospital, and receive their salary payments (and fringe benefits) every 2 weeks, the hospital may continue to pay the residents' salaries every 2 weeks during the residents' rotation to the nonhospital setting. This should still result in payment being made for residents' time spent in nonhospital settings by the end of the following month. (We also note that the hospital must pay travel and lodging expenses, if applicable.) We are proposing that the hospital would be required to pay the nonhospital site for the portion of the cost of teaching physicians' salaries and fringe benefits attributable to direct GME by the end of the month following the month in which the training in the nonhospital setting occurred. We are proposing that if a hospital does not pay for all or substantially all of the costs of the program in the nonhospital setting by the end of the month following the month in which the training occurred, the hospital could not count those FTE residents in the month that the training occurred. Therefore, we are proposing to determine if residents training in nonhospital sites should be counted on a month-to-month basis, depending on whether a hospital paid for the training costs of those residents by the end of the month following the month in which the training occurred.

Following are examples of how a hospital that sends residents to train in nonhospital sites would make payments concurrently with the nonhospital site training:

Example 1. Hospital A, with a fiscal year end (FYE) of December 31, trains 10 internal medicine residents and 6 family practice residents. Each January, April, July, and October, Hospital A sends 5 internal medicine FTE residents to the Physicians' Clinic for 4 weeks. Each month, Hospital A sends 2 family practice FTE residents to the Family Clinic. The residents are employed by Hospital A, and the residents receive fringe benefits from and are paid every 2 weeks by Hospital A, regardless of whether they are training in Hospital A or at a nonhospital site. In order to make payments concurrently with the training that is occurring in the nonhospital sites, Hospital A must pay the Physicians' Clinic by the end of February, May, August, and November, respectively, of each cost reporting year, to cover the costs of teaching physician compensation and fringe benefits attributable to direct GME. Similarly, because residents are training at the Family clinic each month, Hospital A must pay the Family Clinic by the end of each month for the previous month's costs of teaching physician compensation and fringe benefits attributable to direct GME. There are no travel and lodging costs associated with these rotations to nonhospital sites.

Example 2. University A will sponsor an ophthalmology program with eight residents beginning on July 1, 2005. The residents will be on the payroll of the University, but they will train at Hospital B and at the University's Eye Clinic, which is a nonhospital setting. Hospital B has a June 30 FYE. Four of the residents will train in the Eye Clinic from August 1 to October 15, and the other four residents will train in the Eye Clinic from February 15 to April 30. Thus, residents are training in the Eye Clinic during the months of August, September, October, February, March, and April. If Hospital B wishes to count these FTE residents for IME and direct GME purposes in its cost reporting year ending June 30, 2006, and onward, it must pay the Eye Clinic at the end of September, October, November, March, April, and May, respectively, for the previous month's cost of the residents' salaries and fringe benefits, and the teaching physician compensation and fringe benefits attributable to direct GME.

Example 3. Hospital C sends a resident to train at a nonhospital site from January 28 to February 20. The resident was employed by the nonhospital site during this time. Hospital C paid the nonhospital site for the cost of the resident's salary and fringe benefits and the teaching physician compensation and fringe benefits attributable to direct GME by February 28 to account for the training that occurred from January 28 through January 31. However, Hospital C did not pay the nonhospital site by March 31 to

account for the training that occurred in February. Therefore, Hospital C could not count the resident's time in the nonhospital setting from February 1 through February 20 for direct GME and IME purposes.

We note that our proposal to require hospitals to pay for the nonhospital site training costs concurrently with the training that occurs in the nonhospital site is a departure from our current policy concerning the timeframe in which a hospital must make payment for the training costs. Currently, we apply the existing regulations at § 413.100(c)(2)(i), which state that a short-term liability (such as the hospital's obligation to pay the nonhospital site for the residency training costs) must be liquidated within 1 year after the end of the cost reporting period in which the liability is incurred. However, because we are proposing to no longer require that a written agreement between the hospital and the nonhospital site be in place prior to the time that the hospital begins to count the FTE residents training in the nonhospital site, we believe that a reasonable alternative to ensure that a hospital is facilitating the training at the nonhospital site through its ongoing commitment to incur all or substantially all of the costs is to require the hospital to make payments concurrently with the training that occurs in the nonhospital site in order to count the FTE residents for purposes of direct GME and IME payments.

We are aware that there are situations where, rather than providing direct financial compensation to the nonhospital site for supervisory teaching activities, the hospital is incurring all or substantially all of the teaching physician costs through nonmonetary, in-kind arrangements. We are proposing that, in order to be considered concurrent with the nonhospital site training, in-kind arrangements must be provided or made available to the teaching physician at least quarterly, to the extent that there are residents training in a nonhospital setting(s) in a quarter.

We are proposing to revise § 413.86(f) (proposed to be redesignated as § 413.78 in this proposed rule) to add a new paragraph (§ 413.78 (e)) to state that a hospital must incur all or substantially all of the costs of training in a nonhospital setting by the end of the month following a month in which the training in the nonhospital site occurred, to the extent that there are residents training in a nonhospital setting in a month. This proposed change would be effective for portions of cost reporting periods occurring on or after October 1, 2004. We would revise paragraph (d) of the proposed redesignated § 413.78 to reflect the effective cost reporting periods of the provisions under the new paragraph (e).

P. Rural Community Hospital Demonstration Program

[If you choose to comment on issues in this section, please include the caption ''Rural Community Hospital Demonstration'' at the beginning of your comment.]

Section 410A(a) of Public Law 108–173 requires the Secretary to establish a demonstration to test the feasibility and advisability of establishing ''rural community hospitals'' for Medicare payment purposes for covered inpatient hospital services furnished to Medicare beneficiaries. A rural community hospital, as defined in section 410A(f)(1), is a hospital that—

- Is located in a rural area (as defined in section 1886(d)(8)(E) of the Act) or treated as being so located under section 1886(d)(5)(F) of the Act;
- Has fewer than 51 beds (excluding beds in a distinct part psychiatric or rehabilitation unit) as reported in its most recent cost report;
- Provides 24-hour emergency care services; and
- Is not designated or eligible for designation as a CAH.

Section 410A(a)(3) of Public Law 108–173 specifies that the Secretary is to select for participation not more than 15 rural community hospitals in rural areas of States that the Secretary identifies as having low population densities. Using 2003 data from the U.S. Census Bureau, we have identified 10 States with the lowest population density in which rural community hospitals must be located to participate in the demonstration: Alaska, Idaho, Montana, Nebraska, Nevada, New Mexico, North Dakota, South Dakota, Utah, and Wyoming. (Source: U.S. Census Bureau Statistical Abstract of the United States: 2003)

Under the demonstration, participating hospitals will be paid the reasonable costs of providing covered inpatient hospital services (other than services furnished by a psychiatric or rehabilitation unit of a hospital that is a distinct part), applicable for discharges occurring in the first cost reporting period beginning on or after implementation of the demonstration program. For discharges occurring in subsequent cost reporting periods, payment is the lesser of reasonable cost or a target amount, which is the prior year's cost or, after the second cost reporting period, the prior year's target amount, adjusted by the inpatient prospective payment update factor. Covered inpatient hospital services means inpatient hospital services (defined in section 1861(b) of the Act) and includes extended care services furnished under an agreement under section 1883 of the Act.

Sections 410A(a)(5) and (a)(6) require the demonstration to be implemented not later than January 1, 2005, but not before October 1, 2004. The demonstration is to operate for 5 years. We intend to implement the payment change for a participating hospital under this demonstration with the hospital's first cost reporting period beginning on or after October 1, 2004.

Section 410A of Public Law 108–173 requires that ''in conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.'' Generally, when CMS implements a demonstration on a budget neutral basis, the demonstration is budget neutral in its own terms; in other words, aggregate payments to the participating providers do not exceed the amount that would be paid to those same providers in the absence of the demonstration. This form of budget neutrality is viable when, by changing payments or aligning incentives to improve overall efficiency, or both, a demonstration may reduce the use of some services or eliminate the need for others, resulting in reduced expenditures for the demonstration participants. These reduced expenditures offset increased payments elsewhere under the demonstration, thus ensuring that the demonstration as a whole is budget neutral or yields savings. However, the small scale of this demonstration, in conjunction with the payment methodology, makes it extremely unlikely that this demonstration could be viable under the usual form of budget neutrality. Specifically, cost-based payments to 15 small rural hospitals is likely to increase Medicare outlays without producing any offsetting reduction in Medicare expenditures elsewhere. Therefore, a rural community hospital's participation in this demonstration is unlikely to yield benefits to the participant if budget neutrality were to be implemented by reducing other payments for these providers.

In order to achieve budget neutrality, we are proposing to adjust national inpatient PPS rates by an amount sufficient to account for the added costs of this demonstration. In other words, we are proposing to apply budget neutrality across the payment system as

a whole rather than merely across the participants of this demonstration. We believe that the language of the statutory budget neutrality requirement permits the agency to implement the budget neutrality provision in this manner. This is because the statutory language refers merely to ensuring that ''aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration * * * was not implemented,'' and does not identify the range across which aggregate payments must be held equal. We invite public comment on this proposal. We discuss the payment rate adjustment that would be required to ensure the budget neutrality of this demonstration in the Addendum of this proposed rule.

To participate in this demonstration, a hospital must be located in one of the identified States and meet the criteria for a rural community hospital. Eligible hospitals that desire to participate in the demonstration must submit an application to CMS. Information about the demonstration and details on how to apply can be found on the CMS Web site: *www.cms.hhs.gov/researchers/demos/rch.asp.*

This demonstration has been approved by OMB under the title ''Medicare Waiver Demonstration Application,'' under OMB approval number 0938–0880, with a current expiration date of July 30, 2006.

Q. Special Circumstances of Hospitals Facing High Malpractice Insurance Rate Increases

[If you choose to comment on issues in this section, please include the caption ''Malpractice Insurance'' at the beginning of your comment.]

We have received comments from several hospitals about the effects of rapidly escalating malpractice insurance premiums on hospital financial performance and continued access for Medicare beneficiaries to high quality inpatient hospital services. We are aware that malpractice insurance premiums have increased at a high rate in some areas of the country during the last few years. While we are not aware of any specific situations in which malpractice premiums have created issues of access to inpatient hospital services for Medicare beneficiaries, some hospitals have expressed concern that they may be compelled to curtail their current operations by the rate of increase in their malpractice premiums. Therefore, we are inviting comments on the effect of increases in malpractice insurance premiums on hospitals participating in the Medicare program, and whether increasing malpractice costs may pose access problems for Medicare beneficiaries.

V. Proposed Changes to the PPS for Capital-Related Costs

[If you choose to comment on issues in this section, please include the caption ''Capital PPS'' at the beginning of your comment.]

A. Background

Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of inpatient acute hospital services ''in accordance with a PPS established by the Secretary.'' Under the statute, the Secretary has broad authority in establishing and implementing the PPS for capital-related costs. We initially implemented the PPS for capital-related costs in the August 30, 1991 IPPS final rule (56 FR 43358), in which we established a 10-year transition period to change the payment methodology for Medicare hospital inpatient capital-related costs from a reasonable cost-based methodology to a prospective methodology (based fully on the Federal rate).

Federal fiscal year (FY) 2001 was the last year of the 10-year transition period established to phase in the PPS for hospital inpatient capital-related costs. For cost reporting periods beginning in FY 2002, capital PPS payments are based solely on the Federal rate for the acute care hospitals (other than certain new hospitals and hospitals receiving certain exception payments). The basic methodology for determining capital prospective payments using the Federal rate is set forth in § 412.312. For the purpose of calculating payments for each discharge, the standard Federal rate is adjusted as follows:

(Standard Federal Rate) × (DRG Weight) x (Geographic Adjustment Factor (GAF)) × (Large Urban Add-on, if applicable) × (COLA Adjustment for hospitals located in Alaska and Hawaii) × (1 + Capital DSH Adjustment Factor + Capital IME Adjustment Factor, if applicable)

Hospitals also may receive outlier payments for those cases that qualify under the thresholds established for each fiscal year as specified in § 412.312(c) of the existing regulations.

The regulations at § 412.348(f) provide that a hospital may request an additional payment if the hospital incurs unanticipated capital expenditures in excess of $5 million due to extraordinary circumstances beyond the hospital's control. This policy was originally established for hospitals during the 10-year transition period, but as we discussed in the August 1, 2002 IPPS final rule (67 FR 50102), we revised the regulations at § 412.312 to specify that payments for extraordinary circumstances are also made for cost reporting periods after the transition period (that is, cost reporting periods beginning on or after October 1, 2001).

During the transition period, under §§ 412.348(b) through (e), eligible hospitals could receive regular exception payments. These exception payments guaranteed a hospital a minimum payment percentage of its Medicare allowable capital-related costs depending on the class of hospital (§ 412.348(c)), but were available only during the transition period. After the end of the transition period, eligible hospitals can no longer receive this exception payment. However, even after the transition period, hospitals receive additional payments under the special exceptions provisions at § 412.348(g), which guarantees all eligible hospitals a minimum payment of 70 percent of its Medicare allowable capital-related costs provided that special exceptions payments do not exceed 10 percent of total capital IPPS payments. Special exceptions payments may be made only for the 10 years from the cost reporting year in which the hospital completes its qualifying project, and the hospital must have completed the project no later than the hospital's cost reporting period beginning before October 1, 2001. Thus, an eligible hospital may receive special exceptions payments for up to 10 years beyond the end of the capital PPS transition period. Hospitals eligible for special exceptions payments were required to submit documentation to the intermediary indicating the completion date of their project. (For more detailed information regarding the special exceptions policy under § 412.348(g), refer to the August 1, 2001 IPPS final rule (66 FR 39911 through 39914) and the August 1, 2002 IPPS final rule (67 FR 50102).)

Under the PPS for capital-related costs, § 412.300(b) of the regulations defines a new hospital as a hospital that has operated (under current or previous ownership) for less than 2 years (56 FR 43418, August 30, 1991). During the 10-year transition period, a new hospital was exempt from the capital PPS for its first 2 years of operation and was paid 85 percent of its reasonable costs during that period. Originally, this provision was effective only through the transition period and, therefore, ended with cost reporting periods beginning in FY 2002. Because we believe that special protection to new hospitals is also appropriate even after the transition period, as discussed in the August 1, 2002 IPPS final rule (67 FR 50101), we revised the regulations at § 412.304(c)(2)

to provide that, for cost reporting periods beginning on or after October 1, 2002, a new hospital (defined under § 412.300(b)) is paid 85 percent of its allowable Medicare inpatient hospital capital-related costs through its first 2 years of operation, unless the new hospital elects to receive fully prospective payment based on 100 percent of the Federal rate. (Refer to the August 1, 2001 IPPS final rule (66 FR 39910) for a detailed discussion of the statutory basis for the system, the development and evolution of the system, the methodology used to determine capital-related payments to hospitals both during and after the transition period, and the policy for providing exception payments.)

B. Payments to Hospitals Located in Puerto Rico

As explained in section III.G. of this preamble, operating PPS and capital PPS payments to hospitals located in Puerto Rico are currently paid based on a blend of 50 percent of the Federal rate and 50 percent of the Puerto Rico rate. The Puerto Rico capital rate is derived from the costs of Puerto Rico hospitals only, while the capital Federal rate is derived from the costs of all acute care hospitals participating in the IPPS (including Puerto Rico). As also described in the section III.G. of this preamble, section 504 of Public Law 108–173 increases the national portion of the operating IPPS payment for Puerto Rico hospitals from 50 percent to 75 percent and decreases the Puerto Rico portion of the operating IPPS payments from 50 percent to 25 percent for discharges occurring on or after October 1, 2004. Under the broad authority of section 1886(g) of the Act, for the PPS, for capital-related costs we are proposing to revise the calculations of capital IPPS payments to hospitals located in Puerto Rico, as well, to parallel the change in operating IPPS payments to hospitals located in Puerto Rico, for discharges occurring on or after October 1, 2004. Accordingly, we are proposing to revise § 412.374 of the regulations to provide that, for discharges occurring on or after October 1, 2004, payments under the PPS for capital-related costs to hospitals located in Puerto Rico would be based on a blend of 25 percent of the Puerto Rico capital rate and 75 percent of the capital Federal rate. This proposed change would increase capital IPPS payments to hospitals located in Puerto Rico because the proposed Federal capital rate is higher than the proposed Puerto Rico capital rate. In addition, we note that this proposed change is similar to the change in capital IPPS payments made to hospitals located in Puerto Rico beginning in FY 1998 that had paralleled the statutory change in the Puerto Rico blended payment amount required for operating IPPS payments to hospitals located in Puerto Rico as mandated by section 4406 of Public Law 105–33 (62 FR 46012 and 46048, August 29, 1997).

C. Exception Payment for Extraordinary Circumstances

During the transition period, hospitals were guaranteed a minimum payment of a percentage of their Medicare allowable capital-related costs, depending on the class of hospital; that is, the minimum payment level for sole community hospitals was no greater than 90 percent, for urban hospitals with at least 100 beds meeting particular disproportionate share criteria, the minimum payment level was 80 percent, and for all other hospitals, the minimum payment level was 70 percent (§§ 412.348(c)(i) through (iii)). Regular exception payments provided the means to ensure that hospitals received the minimum levels of capital payment. However, any amount by which a hospital's cumulative capital payments exceeded its cumulative minimum payment levels was deducted from the additional exception payment the hospital was eligible to receive (§ 412.348(e)). This type of exception payment ended with the end of the transition period.

In the August 1, 2002 IPPS final rule (67 FR 50102), we specified that payments to hospitals that incur capital expenditures in excess of $5 million due to extraordinary circumstances beyond the hospital's control would be made for cost reporting periods after the transition period, that is, cost reporting periods beginning on or after October 1, 2001, as established at § 412.312(e). Generally, the exception payments for extraordinary circumstances are 85 percent of Medicare's share of allowable capital-related costs attributed to the extraordinary circumstances (100 percent for sole community hospitals). This amount is offset by any amount by which a hospital's cumulative payments exceed its cumulative minimum payment levels (adjusted for the extraordinary circumstances) under the PPS for capital-related costs. The minimum payment levels and the offsetting amounts were the same as those established for regular exceptions as indicated at § 412.348(f)(4). The regulation refers to the regular exception minimum payment levels at § 412.348(c)(1) and the offsetting amounts at § 412.348(e)(2).

Because the regulations governing the regular exception payments, which include the minimum payment levels regulations at § 412.348(c) and the offsetting amounts at § 412.348(e), were effective during the transition period only, we had not previously addressed whether or not the minimum payment levels under § 412.348(c) and the offsetting amounts at § 412.348(e) remain applicable for extraordinary circumstances exceptions in the post-transition period. In the August 1, 2002 IPPS final rule (67 FR 50102), we clarified our policy at a new § 412.312(e) that exception payments for extraordinary circumstances continued to apply to periods beginning on or after October 1, 2001. When we added § 412.312(e), we did not believe it was necessary to explain in the preamble that the minimum payment levels in § 412.348(c) or the offsetting amounts in § 412.348(e) were incorporated into § 412.312(e). However, in order to avoid any confusion, in this proposed rule, we are clarifying our current policy that although the minimum payment levels established at § 412.348(c)(1) are no longer in effect, they continue to be relevant in order to calculate the extraordinary circumstances exception payments after the end of the transition period. The extraordinary exception payment calculation incorporates the minimum payment levels as well as the offsetting deduction for cumulative payments. Thus, although the regular exception payments themselves have expired, it has always been our policy that the minimum payment levels will continue to be part of the formula for calculating extraordinary exception payments after the end of the transition period. In this proposed rule, we are proposing to amend § 412.312(e) to reflect our current policy that, for cost reporting periods beginning on or after October 1, 2001, the minimum payment levels established at § 412.348(c)(1) are part of the formula for calculating extraordinary circumstances exception payments.

Similarly, in this proposed rule, we clarify our current policy that the offsetting amounts established at § 412.348(e)(2) also are part of the formula for determining extraordinary circumstances exception payments after the end of the transition period, in spite of the fact that the regular exception payment provision that included the offsetting amounts at § 412.348(e)(2) expired at the end of the transition period. Accordingly, we are proposing to revise § 412.348(e) to clarify that, for cost reporting periods beginning on or after October 1, 2001, the offsetting

amounts established at § 412.348(e)(2) remain in effect for extraordinary circumstances exception payments.

In addition, we also are proposing to revise the period of time used to determine the offsetting amounts in § 412.348(e)(2). Under existing regulations, the additional payment for extraordinary circumstances is offset by any amount by which a hospital's cumulative payments exceed its cumulative minimum payment levels under the PPS for capital-related costs. In order to determine this offsetting amount, a hospital must keep a record of the difference between its cumulative capital payments and its cumulative minimum payment levels since it became subject to the PPS for capital-related costs. For instance, under existing regulations, if a hospital would be eligible for an additional payment for extraordinary circumstances in FY 2005 and the hospital had been subject to the PPS for capital-related cost since that PPS was implemented in FY 1992, the offsetting amount would be the difference in the hospital's cumulative capital payments and its cumulative minimum payment levels for the past 13 years. Similarly, under existing regulations, if a hospital would be eligible for an additional payment for extraordinary circumstances in FY 2012 and the hospital had been subject to the capital PPS since it was implemented in FY 1992, the offsetting amount would be the difference in the hospital's cumulative capital payments and its cumulative minimum payment levels for the past 20 years.

We believe that when the provisions for exception payments were originally implemented with the start of capital IPPS in FY 1992, it was anticipated that the offsetting amounts at § 412.348(e)(2) would be determined based on a period of no longer than 10 years. However, under existing regulations, exception payments for extraordinary circumstances are offset by the difference in the hospital's cumulative payments and its cumulative minimum payment levels since it became subject to the PPS for capital-related-costs, which for most hospitals is over 13 years. Therefore, in this proposed rule, for cost reporting periods beginning during FY 2005 and thereafter, we are proposing to revise § 412.312(e) to specify that the offsetting amounts in § 412.348(e)(2) would be based on the hospital's capital payments and minimum payment levels from the most recent 10 years rather than from the entire period of time the hospital has been subject to the PPS for capital-related costs. If a hospital has been paid under the PPS for capital-related costs for less than 10 years, the offsetting amounts would be based on the hospital's capital payments and minimum payment levels beginning with the date the hospital became subject to the PPS for capital-related costs. For example, if a hospital would be eligible for an additional payment for extraordinary circumstances in FY 2005 and the hospital had been subject to the PPS for capital-related costs since FY 1992 (13 years), the offsetting amounts used in the calculation of the extraordinary circumstances exception payment would be based on the hospital's cumulative capital PPS payments and cumulative minimum payment levels for the hospital's cost reporting period beginning during FY 1995 through FY 2004. Similarly, if a hospital would be eligible for an additional payment for extraordinary circumstances in FY 2005 and the hospital had only been subject to the PPS for capital-related costs since FY 2000 (5 years), the offsetting amounts used in the calculation of the extraordinary circumstances exception payment would be based on the hospital's cumulative capital PPS payments and cumulative minimum payment levels for the hospital's cost reporting periods beginning during FY 2000 through FY 2004.

D. Treatment of Hospitals Previously Reclassified for the Operating PPS Standardized Amounts

As we discussed in section IV.C. of this preamble, prior to April 1, 2003, the standardized amounts varied under the operating IPPS based on a hospital's geographic location (large urban versus other urban and rural areas). Furthermore, previously, a hospital could be reclassified to a large urban area by the MGCRB for the purpose of the standardized amount if certain criteria were met (as described in Part 412, Subpart L of the Medicare regulations).

Similarly, the standard capital Federal rate under the PPS for capital-related costs is adjusted to reflect the higher costs incurred by hospitals located in large urban areas (large urban add-on at § 412.316), as well as for hospitals in urban areas with at least 100 beds serving low-income patients (capital disproportionate share (DSH) adjustment at § 412.320). In the past, if a rural or other urban hospital was reclassified to a large urban area for purposes of the operating IPPS standardized amount under § 412.63, the hospital also was then eligible for a large urban add-on payment, as well as a DSH payment, under the PPS for capital-related costs.

Section 402(b) of the Consolidated Appropriations Resolution, 2003, Public Law 108–7, and section 402 of Public Law 108–89, (a Welfare Reform Act), provide that, for discharges occurring on or after April 1, 2003 and before March 31, 2004, under the operating IPPS, all hospitals are paid based on the large urban standardized amount, regardless of geographic location or MGCRB redesignation. Section 401(a) of Public Law 108–173 amended section 1886(d)(5)(A)(iv) by adding a subsection (II) that permanently equalizes the standardized amounts for large urban areas and for other urban and rural areas for discharges occurring on or after April 1, 2004.

In addition, under section 1886(d) of the Act, a hospital may reclassify under the operating IPPS only for the purpose of either its standardized amount or its wage index adjustment, or both. As further specified in regulations at § 412.230, a hospital may be reclassified for purposes of the standardized amount only if the area to which the hospital seeks redesignation has a higher standardized amount than the hospital currently receives. Because there are no longer differences in standardized amounts due to geographic classification as a result of the section 401 amendment, hospitals are no longer eligible to reclassify solely for standardized amount purposes. Accordingly, the MGCRB has denied all FY 2005 standardized amount reclassification requests. We note that although Public Law 108–7 and Public Law 108–89 also equalized the standardized amounts for all hospitals in FY 2004, because these laws were not enacted until after the MGCRB had already made its reclassification determinations for FY 2004, eligible hospitals received reclassification approval for the purposes of the standardized amount for FY 2004. However, in this case, Public Law 108–173 was enacted before the MGCRB issued its reclassification decisions for FY 2005. Therefore, no hospitals will be reclassified for the purpose of the standardized amounts in FY 2005.

The changes to the operating IPPS described above, has an effect on payments under the PPS for capital-related costs. Rural and other urban hospitals that were previously eligible to receive the large urban add-on and DSH payments under the PPS for capital-related costs if they reclassified to a large urban area for the purpose of the standardized amount under the operating IPPS, will no longer be reclassified, and therefore, will not be eligible to receive those additional

payments under the PPS for capital-related costs.

Our analysis indicates that rural and other urban hospitals will gain approximately $0.5 billion in FY 2005 in operating PPS payments due to the equalization of the standardized amounts compared to a relatively small adjustment to payments for capital-related costs under the IPPS. We understand that Congress was aware of the effect of the equalization of the standardized amounts on the rural and other urban hospitals' adjustments under the PPS for capital-related costs. This approach is consistent with section 4203 of the BBA, which prevented hospitals from reclassifying to a different area to get an additional payment solely for DSH purposes under the operating IPPS. The restriction at section 4203 clearly indicates Congress' intent to maintain the principle that reclassifications under section 1886(d) of the Act are only intended to be made for purposes of either the standardized amount or the wage index adjustment.

Therefore, in this proposed rule, we are clarifying that, beginning in FY 2005, only hospitals geographically located in a large urban area (as defined in proposed revised § 412.63(c)(6)) would be eligible for large urban add-on payments under the PPS for capital-related costs under § 412.312(b)(2)(ii) and § 412.316(b). Beginning in FY 2005, only hospitals serving low-income patients that are geographically located in an urban area (as defined in proposed new § 412.64 and discussed in section IV.D. of this preamble) with 100 or more beds (or that meet the criteria in § 412.106(c)(2)) would be eligible for DSH payments under the PPS for capital-related costs under § 412.320.

E. Geographic Classification and Definition of Large Urban Area

1. Core-Based Statistical Areas

As we discuss in greater detail in section III.B. of this preamble, we are proposing to adopt changes to the MSA criteria used to define hospital labor market areas based on the new Core-Based Statistical Areas (CBSA) definitions announced by OMB on June 6, 2003, which are based on 2000 Census data. We currently define hospital labor market areas based on the definitions of Metropolitan Statistical Areas (MSAs), Primary MSAs (PMSAs), and New England County Metropolitan Areas (NECMAs) under standards issued by OMB in 1990. In addition, OMB designates Consolidated MSAs (CMSAs). A CMSA is a metropolitan area with a population of one million or more, comprised of two or more PMSAs (identified by their separate economic and social character). Under the operating PPS, the wage index is calculated and assigned to hospitals on the basis of the labor market area in which the hospital is located. For purposes of the hospital wage index, we use the PMSAs rather than CMSAs because they allow a more precise breakdown of labor costs. However, if a metropolitan area is not designated as part of a PMSA, we use the applicable MSA.

As we discuss in sections III.B.3. and IV.C. of this preamble, we are proposing to adopt OMB's new CBSA designations to define labor market areas for discharges occurring on or after October 1, 2004, which would be set forth in regulations under a proposed new § 412.64. Currently, the large urban location adjustment under § 412.316(b) and the DSH adjustment for certain urban hospitals under § 412.320 for payments for capital related costs rely on the existing geographic classifications set forth at § 412.63. Because we are proposing to adopt OMB's new CBSA designations for FY 2005 and thereafter under proposed new § 412.64, we are proposing to revise § 412.316(b) and § 412.320(a)(1) to specify that, for discharges on or after October 1, 2004, the payment adjustments under these sections, respectively, would be based on the geographic classifications at proposed new § 412.64.

2. Metropolitan Divisions

Under the revised MSA criteria based on CBSAs, a Metropolitan Division is a county or group of counties located within an MSA with a core population of at least 2.5 million, representing an employment center, plus adjacent counties associated with the main county or counties through commuting ties (see section III.B.3.b. of this preamble for further details). Under the proposed changes to the MSA criteria discussed in section III.B. of this preamble, we are proposing to use the Metropolitan Divisions where applicable under the CBSA definitions. Thus, similar to our treatment of PMSAs as labor market areas where applicable, we would use the Metropolitan Divisions rather than MSAs to define labor market areas.

Currently, under the existing MSA criteria, a large urban area is defined at existing § 412.63(c)(6) as an MSA with a population of more than 1.000,000 or a NECMA with a population of more than 970,000 based on the most recent available population data published by the Bureau of the Census. As noted above, we currently use the PMSAs rather than CMSAs to define labor market areas. Accordingly, we currently determine large urban areas under existing § 412.63(c)(6) based on the most recent available population data for each PMSA rather than the CMSA. Similarly, because we are proposing to treat Metropolitan Divisions of MSAs as labor market areas, under the proposed changes based on CBSA designations, we would designate large urban areas based on the most recent available population data for each Metropolitan Division, rather than the MSA.

As discussed in section III.B.3.b., under the CBSA definitions, there are 11 MSAs containing Metropolitan Divisions: Boston; Chicago; Dallas; Detroit; Los Angeles; Miami; New York; Philadelphia; San Francisco; Seattle; and Washington, D.C. There are a total of 29 Metropolitan Divisions, which would be treated as MSAs. Of those 29 MSAs, 23 meet the definition of large urban area under § 412.63(c)(6) (as denoted in Tables 4A and 4B in the Addendum to this proposed rule). Under the proposed changes to the MSA criteria, there are a total of 62 large urban areas, including those 23 Metropolitan Divisions, as denoted in Tables 4A and 4B in the Addendum to this proposed rule.

In this section, we are proposing to clarify that the current definition of large urban area at existing § 412.63(c)(6) would remain in effect for the purpose of the large urban add-on adjustment to the Federal rate under the PPS for capital-related costs under §§ 412.312(b)(2)(ii) and 412.316(b). With the equalization of the operating standardized amounts (as discussed in section IV.D. of this preamble), we are proposing to revise the regulations under § 412.63(c), and making them effective for FYs 1984 through 2004, and to add a new § 412.64 that would be applicable for FYs 2005 and thereafter. Because CMS would compute a single standardized amount for hospitals located in all areas beginning in FY 2005, the term ''large urban area'' is no longer applicable under the operating PPS and therefore, a definition of large urban area would not be included under the proposed new § 412.64. However, the term ''large urban area'' continues to be applicable under the capital PPS for the large urban add-on adjustment at §§ 412.312(b)(2)(ii) and 412.316(b). Therefore, we are proposing to revise §§ 412.312(b)(2)(ii) and 412.316(b) to state that the definition of large urban area set forth at § 412.63(c)(6) would continue to be in effect under the capital PPS for discharges occurring on or after September 30, 2004.

VI. Proposed Changes for Hospitals and Hospital Units Excluded From the IPPS

A. Payments to Excluded Hospitals and Hospital Units (§§ 413.40(c), (d), and (f))

[If you choose to comment on issues in this section, please include the caption ''Excluded Hospitals and Units'' at the beginning of your comment.]

1. Payments to Existing Excluded Hospitals and Hospital Units

Section 1886(b)(3)(H) of the Act (as amended by section 4414 of Public Law 105–33) established caps on the target amounts for certain existing hospitals and hospital units excluded from the IPPS for cost reporting periods beginning on or after October 1, 1997 through September 30, 2002. For this period, the caps on the target amounts applied to the following three classes of excluded hospitals or units: psychiatric hospitals and units, rehabilitation hospitals and units, and LTCHs. In accordance with section 1886(b)(3)(H)(i) of the Act and effective for cost reporting periods beginning on or after October 1, 2002, payments to these classes of existing excluded hospitals or hospital units are no longer subject to caps on the target amounts.

In accordance with existing §§ 413.40(c)(4)(ii) and (d)(1)(i) and (ii), where applicable, excluded psychiatric hospitals and units continue to be paid on a reasonable cost basis, and payments are based on their Medicare inpatient operating costs, not to exceed the ceiling, up to the date that the inpatient psychiatric facility PPS described in section VII.A. of this preamble becomes effective. The ceiling is computed using the hospital's or unit's target amount from the previous cost reporting period, updated by the rate-of-increase specified in § 413.40(c)(3)(viii) of the regulations, and then multiplying this figure by the number of Medicare discharges.

Effective for cost reporting periods beginning on or after October 1, 2002, rehabilitation hospitals and units are paid in accordance with the IRF PPS at 100 percent of the Federal rate. In addition, effective for cost reporting periods beginning on or after October 1, 2002, LTCHs are no longer paid on a reasonable cost basis, but are paid under a DRG-based PPS. However, as part of the PPS for LTCHs, we have established a 5-year transition period from reasonable cost-based reimbursement to a fully Federal PPS. Under the LTCH PPS, a LTCH that is subject to the blend methodology may elect to be paid based on a 100 percent of the Federal prospective rate. We have proposed, but not finalized, an inpatient psychiatric facility (IPF) prospective payment system under which psychiatric hospitals and psychiatric units would no longer be paid on a reasonable cost basis but would be paid on a prospective per diem basis. (Sections VI.A.3, 4, and 5 of this preamble contain a more detailed discussion of the IRF PPS and the LTCH PPS and the proposed IPF PPS.)

2. Updated Caps for New Excluded Hospitals and Units

Section 1886(b)(7) of the Act established a payment limitation for new hospitals and units that fell within one of three classes of hospitals or units-psychiatric, rehabilitation, and long-term care that first receives payment as a hospital or unit excluded from the IPPS on or after October 1, 1997. A discussion of how the payment limitation was calculated can be found in the August 29, 1997 final rule with comment period (62 FR 46019); the May 12, 1998 final rule (63 FR 26344); the July 31, 1998 final rule (63 FR 41000); and the July 30, 1999 final rule (64 FR 41529). Under the statute, a ''new'' hospital or unit is a hospital or unit that falls within one of the three classes of hospitals or units (psychiatric, rehabilitation or long-term care) that first receives payment as a hospital or unit excluded from the IPPS on or after October 1, 1997.

The amount of payment for a ''new'' psychiatric hospital or unit (as defined at 42 CFR 413.40(f)(2)(ii) would be determined as follows:

- Under existing § 413.40(f)(2)(ii), for the first two 12-month cost reporting periods, the amount of payment is the lesser of: (1) The operating costs per case; or (2) 110 percent of the national median (as estimated by the Secretary) of the target amounts for the same class of hospital or unit for cost reporting periods ending during FY 1996, updated by the hospital market basket increase percentage to the fiscal year in which the hospital or unit first receives payments under section 1886 of the Act, as adjusted for differences in area wage levels.
- Under existing § 413.40(c)(4)(v), for cost reporting periods following the hospital's or unit's first two 12-month cost reporting periods, the target amount is equal to the amount determined under section 1886(b)(7)(A)(i) of the Act for the preceding cost reporting period, updated by the applicable hospital market basket increase percentage to the third cost reporting period.

The proposed amounts included in the following table reflect the proposed updated 110 percent of the national median target amounts of new excluded psychiatric hospitals and units for cost reporting periods beginning during FY 2005. These figures are updated with the most recent data available to reflect the proposed projected market basket increase percentage of 3.3 percent. This projected percentage change in the market basket reflects the average change in the price of goods and services purchased by hospitals to furnish inpatient hospital services (as projected by the Office of the Actuary of CMS based on its historical experience with the IPPS). For a new provider, the labor-related share of the target amount is multiplied by the appropriate geographic area wage index, without regard to IPPS reclassifications, and added to the nonlabor-related share in order to determine the per case limit on payment under the statutory payment methodology for new providers.

Class of excluded hospital or unit	Proposed FY 2005 labor-related share	Proposed FY 2005 nonlabor-related share.
Psychiatric	$7,534.70	$2,994.67

Effective for cost reporting periods beginning on or after October 1, 2002, this payment limitation was no longer applicable to new LTCHs because they are paid 100 percent of the Federal rate. Accordingly, it is no longer necessary to publish an updated cap for new LTCHs.

Effective for cost reporting periods beginning on or after October 1, 2002, this payment limitation is also no longer applicable to new rehabilitation hospitals and units because they are paid 100 percent of the Federal prospective rate under the IRF PPS. Therefore, it is also no longer necessary to update the payment limitation for new rehabilitation hospitals or units.

3. Implementation of a PPS for IRFs

Section 1886(j) of the Act, as added by section 4421(a) of Public Law 105–33, provided for the phase-in of a case-mix adjusted PPS for inpatient hospital services furnished by a rehabilitation hospital or a rehabilitation hospital unit (referred to in the statute as rehabilitation facilities) for cost reporting periods beginning on or after October 1, 2000, and before October 1, 2002, with a fully implemented PPS for cost reporting periods beginning on or after October 1, 2002. Section 1886(j) of the Act was amended by section 125 of Public Law 106–113 to require the Secretary to use a discharge as the payment unit under the PPS for inpatient hospital services furnished by rehabilitation facilities and to establish classes of patient discharges by functional-related groups. Section 305 of Public Law 106–554 further amended section 1886(j) of the Act to allow rehabilitation facilities, subject to the blend methodology, to elect to be paid the full Federal prospective payment rather than the transitional period payments specified in the Act.

On August 7, 2001, we issued a final rule in the **Federal Register** (66 FR 41316) establishing the PPS for inpatient rehabilitation facilities, effective for cost reporting periods beginning on or after January 1, 2002. There was a transition period for cost reporting periods beginning on or after January 1, 2002 and ending before October 1, 2002. For cost reporting periods beginning on or after October 1, 2002, payments are based entirely on the Federal prospective payment rate determined under the IRF PPS.

4. Implementation of a PPS for LTCHs

In accordance with the requirements of section 123 of Public Law 106–113, as modified by section 307(b) of Public Law 106–554, we established a per discharge, DRG-based PPS for LTCHs as described in section 1886(d)(1)(B)(iv) of the Act for cost reporting periods beginning on or after October 1, 2002, in a final rule issued on August 30, 2002 (67 FR 55954). The LTCH PPS uses information from LTCH hospital patient records to classify patients into distinct LTC-DRGs based on clinical characteristics and expected resource needs. Separate payments are calculated for each LTC-DRG with additional adjustments applied.

We published in the **Federal Register** on May 7, 2004, a final rule (69 FR 25673) that updated the payment rates for the LTCH PPS and made policy changes effective for a new LTCH PPS rate year of July l, 2004 through June 30, 2005. The 5-year transition period from reasonable cost-based reimbursement to the fully Federal prospective rate will end with cost reporting periods beginning on or after October 1, 2005 and before October 1, 2006.

5. Development of a PPS for IPFs

Section 124 of the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 (BBRA) requires the development of a per diem prospective payment system (PPS) for payment of inpatient hospital services furnished in psychiatric hospitals and psychiatric units of acute care hospitals (inpatient psychiatric facilities (IPFs)). We published a proposed rule to implement the IPF PPS on November 28, 2003 (68 FR 66920). On January 30, 2004, we published a proposed rule to implement the IPF PPS on November 28, 2003 (68 FR 66920). On January 30, 2004, we published a notice to extend the comment period for 30 additional days (69 FR 4464). The comment period closed on March 26, 2004.

Under the proposed rule, we would compute a Federal per diem base rate to be paid to all IPFs based on the sum of the average routine operating, ancillary, and capital costs for each patient day of psychiatric care in an IPF adjusted for budget neutraility. The Federal per diem base rate would be adjusted to reflect certain characteristics such as age, specified DRGs, and selected high-cost comorbidities, and certain facility characteristics such as wage index adjustment, rural location, and indirect teaching costs.

The November 28, 2003 proposed rule assumed an April 1, 2004 effective date for the purpose of ratesetting and calculating impacts. However, we are still in the process of analyzing public comments and developing a final rule for publication. The effective date of the IPF PPS would occur 5 months following publication of the final rule.

6. Technical Changes Related to Establishment of Payments for Excluded Hospitals

We have become aware of a number of technical errors in the existing regulations governing how we determine payments to hospitals that are excluded from the IPPS. The existing regulations under § 413.40 set forth requirements for establishing the ceiling on the rate of increase in operating costs per case for hospital inpatient services furnished to Medicare beneficiaries that will be recognized as reasonable for purposes of determining the amount of Medicare payments. The rate-of-increase ceiling applicable to cost reporting periods has been adjusted a number of times since it was first applied for hospital cost reporting periods beginning on or after October 1, 1982. In revising the regulations over the years to reflect the different applicable adjustments for cost reporting periods for specific providers, we have inadvertently overlooked updating or conforming § 413.40 to reflect various statutory changes. We note that, although we erroneously omitted the technical changes in the regulation text, we did, in fact comply with the changes required by the statute when determining the rate-of-increase ceiling. Therefore, we are proposing to make several changes to § 413.40(c)(4)(iii) in order to conform it to section 1886(b)(3)(J) of the Act. These proposed changes are as follows: (1) In § 413.40(c)(4)(iii)(A)(*1*) and (c)(4)(iii)(B)(*4*)(*i*), the phrase ''on or after October 1, 2001'', should read ''during FY 2001''; and in § 413.40(c)(4)(iii)(A)(*2*), the phrase ''on or after October 1, 2000'' should read ''during FY 2001''. In order to include pertinent changes that were erroneously omitted from the regulatory text and to conform the text to section 1886(b)(*2*)(A) of the Act, we are proposing to delete the phrase ''and ending before October 1, 2000'' in § 413.40(d)(4)(i) because, in section 1886(b)(2)(A) of the Act, there is no ending date for the continuous improvement bonus payment. In addition, at § 413.40(d)(4)(ii), we propose to delete the word ''ending'' from the introductory phrase so that the phrase would read, ''For cost reporting periods beginning on or after October 1, 2000 and before September 30, 2001.'' The word ''ending'' in the existing language at best limits the provision to cost reporting periods beginning on October 1, 2000. The provision was intended to apply to cost reporting periods beginning during all of FY 2001.

B. Criteria for Classification of Hospitals-Within-Hospitals

[If you choose to comment on the issues in this section, please include the caption ''Hospitals-Within-Hospitals'' at the beginning of your comment.]

Existing regulations at § 412.22(e) define a hospital-within-a-hospital as a hospital that occupies space in a building as another hospital, or in one or more separate buildings located on the same campus as buildings used by another hospital. Moreover, existing § 412.22(f) provides for the grandfathering of hospitals-within-hospitals that were in existence on or before September 30, 1995.

One of the goals of our hospital-within-hospital regulations at § 412.22(e) has been to prevent a LTCH

co-located with an acute care hospital to function as a unit of that hospital, a situation precluded under section 1886(d)(1)(B) of the Act. This policy protects the integrity of the IPPS by ensuring that costly, long-stay patients who could reasonably continue treatment in that setting would not be unnecessarily discharged to an onsite LTCH, a behavior that would skew and undermine the Medicare IPPS DRG system. Further, there is concern that the hospital-within-hospital configuration could result in patient admission, treatment, and discharge patterns that are guided more by attempts to maximize Medicare payments than by patient welfare. We believe that the unregulated linking of an IPPS hospital and a hospital excluded from the IPPS could lead to two Medicare payments for what was essentially one episode of patient care.

In the September 1, 1994 IPPS final rule (59 FR 45389), we first discussed hospitals-within-hospitals, describing them as entities that were manipulating the conditions of participation (COPs) for hospitals under Medicare, set forth in regulations at 42 CFR Part 482, to permit them to receive exclusion from the prospective payment systems. Specifically, these hospitals have begun to organize what they themselves refer to as the ''hospital-within-a-hospital'' model. Under this model, an entity may operate in space leased from a hospital, and have most or all services furnished under arrangements by employees of the lessor hospital. The newly organized entity may be operated by a corporation formed and controlled by the lessor hospital, or by a third entity that controls both. In either case, the new entity seeks State licensure and Medicare participation as a hospital, demonstrates that it has an average length of stay of over 25 days, and obtains an exclusion from the IPPS. The effect of this process is to extend the long-term care hospital exclusion to what is, for all practical purposes, a ''long-term care unit.'' We noted that the averaging concept that underlies the IPPS recognizes that some patients will stay longer and consume more resources than expected, while others will have shorter, less costly stays. We envisioned that abuse of the PPSs could result if an acute care hospital under the IPPS ''diverted all long-stay cases to the excluded unit, leaving only shorter, less costly cases to be paid for under the IPPS. In such cases, hospitals would profit inappropriately from prospective payments.'' Further, we stated that we believed that the ''exclusion of long-term care 'units' was inconsistent with the statutory scheme.'' Section 1886(d)(1)(B) of the Act clearly provides for an exclusion of LTCHs from the acute care IPPS. While the statute also provides for an exclusion for psychiatric units and rehabilitation units, it does not provide for an exclusion of long-term care units. (59 FR 45389)

In addition, in that September 1, 1994 final rule, we proceeded to establish ''separateness and control'' regulations at (then) § 412.23(e) that required the two hospitals to have separate medical and administrative governance and decisionmaking and also ensured that each hospital operated as a separate facility. We believed at that time that such rules were sufficient solutions to our concerns about these new entities and, therefore, we did not preclude common ownership of the host and the LTCH at that time.

In the ensuing decade, we have revisited the issue of hospitals-within-hospitals several times (for example, 60 FR 45836, September 1, 1995; 62 FR 46012, August 29, 1997; 67 FR 56010, August 30, 2002; 67 FR 45463, August 1, 2003) during which we clarified and amplified the separateness and control requirements. In the August 29, 1997 IPPS final rule, we extended the application of these rules beyond LTCHs to include other classes of facilities that might seek exclusion from the IPPS as hospitals-within-hospitals, such as IRFs. In addition, in the August 29, 1997 final rule, we also established a ''grandfathering'' provision for hospitals-within-hospitals in existence prior to September 30, 1995, at § 412.22(f), and in the August 1, 2003 IPPS final rule, we clarified and codified the requirements for ''grandfathered'' hospitals-within-hospitals (68 FR 45463).

As stated earlier, presently, a hospital-within-a-hospital must meet the separateness and control criteria set forth at § 412.22(a). In order to be excluded from the IPPS, the hospital-within-a-hospital must have a separate governing body, a separate chief medical officer, a separate medical staff, and a separate chief executive officer. Regarding the performance of basic hospital functions (§ 412.22(e)(5)), currently, the hospital must meet at least one of the following criteria: (i) The hospital performs the basic functions through the use of employees or under contracts or other agreements with entities other than the hospital occupying space in the same building or on the same campus, or a third entity that controls both hospitals; (ii) for the same period of at least 6 months immediately preceding the first cost reporting period for which exclusion is sought, the cost of the services that the hospital obtained under contracts or other agreements with the hospital occupying space in the same building or on the same campus, or with a third entity that controls both hospitals, is no more than 15 percent of the hospital's total inpatient operating costs, as defined in § 412.2(c) (that is, inpatient operating costs include operating costs for routine services, such as costs of room, board, and routine nursing services; operating costs for ancillary services such as laboratory or radiology; special care unit operating costs; malpractice insurance costs related to serving inpatients; and preadmission services); or (iii) for the same period of at least 6 months immediately preceding the first cost reporting period for which exclusion is sought, the hospital has an inpatient population of whom at least 75 percent were referred to the hospital from a source other than another hospital occupying space in the same building or on the same campus or with a third entity that controls both hospitals.

It is our experience that the vast majority of hospitals-within-hospitals have elected to meet the second of the three criteria at § 412.22(e)(5), that is, the cost of the services that the hospital obtained from the co-located hospital or with a third entity that controls both hospitals is no more than 15 percent of its total inpatient operating costs. In establishing the 15-percent rule, we originally believed that we would be able to detect a true corporate identity and actual function and to guard against an arrangement that could undermine the statutory preclusion of long-term care units. We sought to distinguish admissions to independently operating facilities from what were, in effect, transfers of patients from one unit of the corporation to another unit of the corporation without a truly distinct and separate corporate identity. Our underlying policy rationale was that, if an entity could not be separately identified, it effectively would be functioning as a mere unit of the parent entity in violation of the statutory prohibition on long-term care units. We explained in the September 1, 1994 rule (59 FR 45390) that ''if an entity is effectively part of another hospital and the principles of the prospective payment system do apply well to the organization as a whole, then it would not be appropriate to exclude part of that organization from the prospective payment system.''

Although we have periodically revisited the phenomenon of hospitals-within-hospitals in our rules and we have revised or clarified some related

issues, we have not proposed significant changes in our policies in this area for some time. This is despite the significant changes that have been made in the payment systems for Medicare-certified, excluded hospitals and units. Medicare payments to two types of IPPS-excluded hospitals, LTCHs and IRFs, are now made on a prospective basis. We believe that, in part, the new LTCH PPS is one of the reasons for the rapidly increasing number of LTCH hospitals-within-hospitals. In its June 2003 Report to the Congress, MedPAC identified hospitals-within-hospitals as the fastest growing type of LTCHs, and specified that the number had grown from 10 in 1993 to 114 in 2002, an average annual increase of approximately 30 percent (p. 85). In the August 30, 2002 final rule that implemented the PPS for LTCHs, we noted that ''* * * we remain extremely concerned about rapid growth in LTCH hospitals-within-hospitals and will be collecting data on the relationship among host hospitals, hospitals-within-hospitals, and parent corporations in order to determine the need for additional regulation'' (67 FR 56010). We indicated that if, as a consequence of these monitoring activities, we determine the need to revisit existing regulations dealing with ownership and control of hospitals-within-hospitals, we would follow the notice and comment rulemaking process (67 FR 56011).

The LTCH PPS was implemented for cost reporting periods beginning on or after October 1, 2002. We have gathered considerable anecdotal information from inquiries from the provider community, fiscal intermediaries, and, particularly, from the survey and certification divisions of our CMS Regional Offices.

We believe that existing policies regarding hospitals-within-hospitals do not sufficiently protect the Medicare program from the problems that we envisioned in the September 1, 1994 final rule. We also question the effectiveness of the ''separateness and control'' requirements alone because entities have used complex arrangements among corporate affiliates, and obtained services from those affiliates, thereby impairing or diluting the separateness of the corporate entity. While technically remaining within the parameters of the rule, these arrangements have intermingled corporate interests so that the corporate distinctness has been lost.

In corporate law, several standards are used to determine how much separateness is sufficient for a corporate autonomy to be recognized. The courts have applied a number of tests and considered a number of factors in determining when a parent corporate autonomy is liable for the acts of its subsidiary, including the parent corporate autonomy's exercise of control over the decisionmaking of the subsidiary; the subsidiary's actions as an alter ego of the parent corporate autonomy, such that recognition of a distinct corporate entity would lead to fraud or an injustice or would defeat public policy and the interrelatedness of operations. While we do not believe that it is necessary to apply any single test that might be used in the context of assigning liability, we believe that some of the same considerations apply when trying to determine whether there is functional separateness among related or affiliated organizations.

The requirement for separate governing bodies, separate medical boards, separate medical officers, and separate chief executive officers in co-located hospitals under the same ownership does not prevent, on a practical level, the establishment of admission, treatment, and discharge policies that maximize payments. Some of these co-located facilities are under common ownership, either nonprofit or for profit, and, therefore, the payments generated from care delivered at both settings affect their mutual interests.

Even when the hospital-within-a-hospital and the host hospital are separately owned, we believe that there may be incentives to prematurely discharge patients to a postacute care setting in spite of the fact that the acute care hospital could continue to provide the appropriate level of care. We find this situation even more troubling regarding LTCHs, in particular, because LTCHs are certified as acute care hospitals and the sole statutory and regulatory distinction between LTCHs and acute care hospitals is the greater than 25-day average length of stay criterion at § 412.23(e)(2). In many parts of the country, there are no LTCHs and appropriate care for patients who could otherwise be treated in LTCHs is being delivered in acute care hospitals, often followed by postacute care at SNFs. Because a similar level of care is often available in either an acute care hospital or a LTCH, we believe that, when an acute care hospital and a LTCH are co-located, there are significant inducements for patients to be moved to the provider setting that generates the highest Medicare payments.

This movement of patients is facilitated by the fact of co-location because, rather than arranging for the patient to be admitted to another offsite facility and transporting the patient by ambulance to another hospital, all that may actually be required to ''discharge'' the patient from one hospital and admit the patient to another is wheeling the patient down the hall or on and off an elevator.

Although co-location of Medicare providers, at best, may embody the positive economic benefits of sharing expensive medical equipment and provide a measure of convenience for patient families, at worst, co-location and patient-shifting can serve to undermine the basic premise of the IPPS DRG classification system and generate inappropriate Medicare payments. This is the case because payment for specific diagnoses is determined by setting DRG weights that represent a national averaging of hospital costs for each diagnosis. In addition, the Federal standardized payment amount was based on the average cost of a patient across all hospitals. This assumes that, on average, both high-cost and low-cost patients are treated at a hospital. Although Medicare might pay a hospital less than was expended for a particular case, over a period of time, the hospital would also receive more than was expended for other cases. However, an acute care hospital that consistently discharges a higher cost patient to a postacute care setting for the purpose of lowering its costs undercuts the foundation of the IPPS DRG system, which is based on averages. In this circumstance, the hospital would recoup larger payments from the Medicare system than is intended under the DRG system because the course of acute treatment has not been completed. At the same time, the patient, still under active treatment for an acute illness, will be admitted to a LTCH, thereby generating a second admission and Medicare payment that would not have taken place but for the fact of co-location.

We believe that the 15-percent policy is being sidestepped through creative corporate reconfigurations. Therefore, if the LTCH is nominally complying with the 15-percent requirement, it has not been required to meet the basic hospital function requirements at existing § 412.22(e)(5)(iii). Thus, it is free to accept even 100 percent of patients from the onsite host, and share the same basic hospital functions as the host. Reliance on meeting the 15-percent criterion has enabled the creation of LTCH hospitals-within-hospitals that rely upon affiliated entities both for their operations and for their patient referrals. This results in a situation very similar to the hospital-within-hospital serving as a LTCH unit of the acute care hospital, which is precluded by the statute.

One of the reasons we are proposing revisions to the existing criteria for hospitals-within-hospital is because we believe that determining whether a hospital has complied with the 15-percent criterion is burdensome for a fiscal intermediary on an ongoing basis. Presently, review of corporate arrangements represents a snapshot in time that may assess a particular set of business transactions but does not provide relevant details to reveal the extent of the unity of interests between the parties over time. Further, the widespread existence of such complex configurations, as well as the ongoing creation of new business arrangements, convinces us that a hospital-within-a-hospital's compliance with § 412.22(e)(5)(ii) may be fluid, unreliable, or, in some cases, nonexistent.

Another reason we are proposing revisions to the existing criteria for hospitals-within-hospitals because the concerns that we expressed in 1994 and 1995, when excluded hospitals were paid under the reasonable cost-based TEFRA system, are even more compelling with the implementation of PPSs for LTCHs and IRFs, because now one episode of care for a beneficiary could generate two full Medicare prospective payments, one under the IPPS, and another under the applicable excluded hospital PPS. In addition, the substantial increase in the number of hospitals-within-hospitals adds further urgency to reevaluation of the existing hospital-within-a-hospital policies. Therefore, it is incumbent upon us to revise our regulations in order to offer the greatest possible protection against potential abuses.

Accordingly, for qualification purposes, we are proposing to delete the 15-percent criterion at § 412.22(e)(5)(i) and the rarely elected criterion at § 412.22(e)(5)(i) that requires the hospital-within-a-hospital to perform basic hospital functions, which includes nursing services, medical records, pharmacy services, radiology, laboratory services, infection control, and discharge planning, through the use of employees or under contracts or other agreements with entities other than the host hospital or a third entity that controls them both. Because we believe that efficient use of excess space at a hospital and the sharing of medical facilities and services may represent the strongest argument for the existence of hospitals-within-hospitals, from the standpoint of efficiency and cost reduction, we do not believe that these criteria should be maintained.

We are proposing that all hospitals-within-hospitals would be required to comply only with the criterion set forth at the existing § 412.22(e)(5)(iii), which requires that at least 75 percent of the admissions to the hospital-within-a-hospital be referred from a source other than the host hospital. We believe that this ''functional separateness'' test (62 FR 46014, August 29, 1997) directly addresses our concern that the excluded hospital not function either as a vehicle to generate more favorable Medicare reimbursement for each provider or as a de facto unit. Compliance with the 75-percent criterion is a requirement that we can verify without the involvement of corporate attorneys and a yearly reevaluation of corporate documents and transactions. The goal of the proposed provisions is to diminish the possibility that a hospital-within-a-hospital could actually be functioning as a unit of an acute care hospital and generating unwarranted payments under the much more costly LTCH PPS.

Therefore, under our proposed policy, a hospital must demonstrate that it has a separate governing body, a separate chief medical officer, and a separate chief executive officer, and that at least 75 percent of its admissions originate from a source other than its host hospital, in order to be totally excluded from the IPPS. Fiscal intermediaries would reevaluate compliance with these regulations annually. In implementing our belief that separation and control can best be objectively determined by limiting compliance to the 75-percent criterion as the single ''performance of hospital functions'' test, we are proposing several policy options that are detailed below that, if not met, notwithstanding compliance with the separate governance and control requirements under existing § 412.22(e)(1) through (4), could result in the either total discontinuance of IPPS-exclusion payment status or Medicare payment adjustments for hospital-within-a-hospital patients from the host hospitals.

As noted above, DRG weights and hence payments under the IPPS are established annually based on the average concept that recognizes that, for patients with a particular diagnosis, some will stay longer and consume more hospital resources than expected, while others will have shorter, less costly stays. Under the IPPS, a full DRG payment is triggered on the first day of admission to the acute care hospital. Medicare adopted an IPPS transfer policy at § 412.4(b) in order to pay appropriately for cases that were discharged to other IPPS hospitals prior to the hospitals delivering full treatment to a beneficiary. We also promulgated the postacute care transfer policy at §§ 412.4(c) and (d) to discourage premature transfers or discharges from IPPS hospitals for particular DRGs to postacute care settings, including LTCHs (63 FR 40977, July 31, 1998, 68 FR 45469, August 1, 2003). The issues that we addressed in formulating the acute and postacute care transfer policies are similar to those we are raising as our present concerns: that the incentives of the IPPS could result in acute care hospitals shifting a portion of the cost of services that should reasonably be treated in that setting to other providers; that the acute care hospitals would still collect a full DRG payment under the IPPS for less than a full course of treatment; and that an additional and unnecessary Medicare payment would be made to the second provider. We believe that the potential for linking clinical decisions to the highest Medicare payments is even stronger when the acute care hospital and a postacute care provider are co-located and, even more so, if they are also under common ownership.

Therefore, we are also proposing to revise § 412.22(e), effective October 1, 2004, to preclude common ownership (wholly or in part) of hospitals-within-hospitals and host hospitals (proposed new § 412.22(e)(2)(ii)). However, we are also proposing to ''grandfather'' those hospitals-within-hospitals that were under common ownership with their host hospitals prior to June 30, 2004, and to continue to pay them as hospitals excluded from the IPPS, as long as they comply with the existing control criteria at § 412.22(e)(1) through (4) (as set forth in proposed new § 412.22(e)(2)(i)) and with the proposed mandatory 75-percent criterion (as set forth in proposed new § 412.22(e)(2)(iii)).

In addition, in this proposed rule, we are presenting, for public comment, three payment options that we believe would diminish the possibility of a hospital-within-a-hospital actually functioning as a unit of an acute care hospital and at the same time generating unwarranted payments under the more costly LTCH PPS.

Option 1. Under the first option, as discussed earlier, in order for a hospital-within-a-hospital to receive payment as an IPPS-excluded hospital, we are proposing to retain as the only qualifying criterion that the hospital-within-a-hospital have at least 75 percent of its admissions from a source other than the host hospital (existing § 412.22(e)(5)(iii)). The hospital-within-a-hospital would still be required to demonstrate that it meets the separateness and control criteria at § 412.22(a). Under this option, a hospital-within-hospital that admitted

more than 25 percent of its patients from the host hospital would not be paid as an IPPS-excluded hospital for any of its patients. The hospital or unit that does not meet the criteria under this option would receive payment as an acute care hospital for all of its patients.

As stated earlier, we believe that compliance with the 75-percent criterion under this option is a requirement that fiscal intermediaries would be able to evaluate annually in an efficient manner without the involvement of corporate attorneys and a yearly reevaluation of corporate documents and transactions. Further, we believe that this option would ensure increased protections to the Medicare program and greatly diminish opportunities for maximizing Medicare payments under the PPS.

Option 2. Under the second option, as proposed earlier, we would require the hospital to meet the existing qualifying 75-percent criterion under § 412.22(e)(5)(iii). However, under this option, we would allow a hospital-within-a-hospital that failed to meet the 75-percent criterion to be excluded from the IPPS to be paid as a PPS-excluded hospital only for the patients admitted to the hospital-within-a-hospital from providers other than the host hospital. For example, no payments would be made to a LTCH for those patients that had been transferred to the LTCH from the host hospital because it failed to meet this criterion. Payments for patients referred from the host acute care hospital would only be paid to the host under the IPPS. We would treat services provided by the hospital-within-a-hospital as services furnished ''under arrangement.'' Therefore, in keeping with our existing policy at § 411.15(m) that restricts separate Medicare payment to hospital services furnished under arrangements, we would make payment only to the acute care hospital from which the patients were referred for ''under arrangements'' furnished by the hospital-within-a-hospital.

Option 3. Under the third option, as proposed earlier, we would require that the hospital-within-a-hospital must meet the existing qualifying 75-percent criterion under § 412.22(e)(iii). However, under this option, we would pay the hospital-within-a-hospital directly for services, even for services provided to patients admitted to the hospital-within-a-hospital from the co-located acute care hospital. However, the payment to the hospital-within-a-hospital for those patients would be the lesser of what would be paid under the IPPS for that DRG, or what would be paid to the hospital-within-a-hospital under the applicable excluded hospital payment system. Payments to the hospital-within-a-hospital for patients admitted to the hospital-within-a-hospital from another hospital that was not the co-located hospital would be made under the hospital-within-a-hospital payment system with no adjustment. Therefore, for example, a LTCH that was a hospital-within-a-hospital and failed to meet the 75-percent criterion would be paid the lesser of the IPPS payment or the LTCH PPS payment for its patients that were admitted from its host hospital. However, for patients admitted from other hospitals, the LTCH hospital-within-a-hospital would be paid under the LTCH PPS with no adjustment.

We believe that adoption of any of these three options is within the broad discretion conferred on the Secretary by section 123 of Public Law 106–113 (BBRA) and by section 307 of Public Law 106–554 (BIPA), which grant the Secretary the authority to develop a per discharge PPS for payment of inpatient hospital services by LTCHs and to provide for appropriate adjustments to the LTCH PPS.

We are proposing to revise the existing separateness and control regulations at § 412.22(e) for hospitals-within-hospitals and to require that in order to be excluded from the IPPS, all hospitals-within-hospitals must admit no more than 25 percent of their patients from the onsite host hospital. We are also proposing to preclude common ownership of host hospitals and excluded hospitals, while grandfathering existing hospitals-within-hospitals and hosts that are under common ownership, as long as they comply with the proposed mandatory 75-percent criterion. We are further seeking comments on the options presented if the hospital-within-a-hospital fails to meet the 75-percent criterion that would either require that all of the hospital's Medicare payment would be made under the IPPS or, alternatively, to allow a hospital-within-a-hospital to still be paid as an excluded hospital for its admissions from onsite providers while applying specific payment adjustments for patients admitted from the host hospital.

We are soliciting comments on the three options presented and whether they provide sufficient protection against the phenomenon of inadequate separateness and control as described in this proposed rule. We want to emphasize that, under any of the options, nowhere is a change in physician clinical decisionmaking or a change in the manner in which a physician or hospital practices medicine intended. The policy options outlined in this proposed rule would simply address the appropriate level of payments once those decisions have been made.

Technical Change. In § 412.22(e) of our regulations, we refer to a hospital-within-a-hospital as a hospital that ''occupies space in a building also used by another hospital, or in one or more *entire* buildings located on the same campus as buildings used by another hospital'' (emphasis added). The reference to ''entire'' buildings is incorrect. We should have referred to ''separate'' buildings. Therefore, we are proposing to correct this error.

C. Critical Access Hospitals (CAHs)

[If you choose to comment on issues in this section, please include the caption ''Critical Access Hospitals'' at the beginning of your comment.]

1. Background

Section 1820 of the Act provides for the establishment of Medicare Rural Hospital Flexibility Programs, under which individual States may designate certain facilities as critical access hospitals (CAHs). Facilities that are so designated and meet the CAH conditions of participation in 42 CFR Part 485, Subpart F, will be certified as CAHs by CMS. Regulations governing payments to CAHs for services to Medicare beneficiaries are located in 42 CFR Part 413.

2. Payment Amounts for Inpatient CAH Services (Section 405(a) of Public Law 108–173 and §§ 413.70 and 413.114 of the Regulations)

Prior to the enactment of Public Law 108–173, section 1814(l) of the Act provides that the Medicare payment amount for inpatient services furnished by a CAH is the reasonable costs of the CAH in providing the services. Section 1834(g)(1) of the Act provides that the Medicare amount of payment for outpatient services furnished by a CAH is made on a reasonable cost basis, unless the CAH makes an election, under section 1834(g) of the Act, to receive a payment amount that is the sum of the reasonable cost of hospital outpatient facility services plus 115 percent of the amount otherwise paid for professional services. Section 1883(a)(3) of the Act provides for payment to a CAH for covered skilled nursing facility services furnished under an agreement entered into under section 1883 of the Act on the basis of the reasonable costs of such services. Regulations implementing these provisions are set forth in § 413.70(a), for inpatient CAH services; in

§ 413.70(b), for payment under the standard method for the reasonable costs of facility services, and outpatient CAH services; in § 413.70(b)(3), for the optional method of payment for outpatient services (reasonable costs for facility services plus fee schedule for professional services); and in § 413.114, for SNF services of a CAH with a swing-bed agreement.

Section 405(a) of Public Law 108–173 amended sections 1814(l), 1834(g)(1), and 1883(a)(3) of the Act to provide that, effective for services furnished during cost reporting periods beginning on or after January 1, 2004, the amount of the payment for inpatient, outpatient, and SNF services, respectively, furnished by a CAH is equal to 101 percent of the reasonable cost of the CAH in providing these services.

We are proposing to revise §§ 413.70(a)(1), (b)(2), and (b)(3) and § 413.114 of our regulations to incorporate the change in the payment percentage made by section 405(a) of Public Law 180–173. We also are proposing to make a technical correction to § 413.70(b)(2)(i) to remove paragraphs (b)(2)(i)(C) and (D). We are proposing to delete these paragraphs to conform the regulations to provisions of the outpatient hospital PPS.

We note that in the IPPS final rule published in the **Federal Register** on August 1, 2001 (66 FR 39936), we added a new paragraph (a)(1)(iv) to § 413.70. However, when the change was incorporated into the Code of Federal Regulations, paragraphs (a)(1)(i), (a)(1)(ii), and (a)(1)(iii) were inadvertently omitted. Our proposed revision of § 413.70(a)(1) would correct the omission of these three paragraphs.

3. Condition for Application of Special Professional Service Payment Adjustment (Section 405(d) of Public Law 108–173 and § 413.70(b) of the Regulations)

As stated earlier, section 1834(g) of the Act provides for two methods of payment for outpatient CAH services. Under the provisions of section 1834(g) of the Act, a CAH will be paid under a reasonable cost method unless it elects payment under an optional method. Under the reasonable cost payment method, facility services are paid on a reasonable cost payment basis by the fiscal intermediary to the CAH, and physician and other professional services to CAH outpatients are paid for under the physician fee schedule, with payments being made by the carrier. Under the optional method (frequently referred to as ''method 2''), CAHs submit bills for both facility and professional services to the fiscal intermediary. If a CAH elects the optional method of billing for outpatient services, Medicare payment for its facility services are made at the same level as would apply under the reasonable cost reimbursement method, but services of professionals to outpatients are paid for at 115 percent of the amounts that would otherwise be paid for under the physician fee schedule. To make the optional method election feasible and to help prevent possible duplicate billing, we require practitioners furnishing services to outpatients of a CAH to agree to reassign to the CAH their rights to bill the Medicare program for those services.

Existing regulations at § 413.70(b) set forth these payment options and specify that an election of the optional method, once made for a cost reporting period, remains in effect for all of that period and applies to all services furnished to CAH outpatients during that period. This means that, under existing regulations, a CAH may elect the optional method payment only if all of its practitioners agree to reassign their billing rights for outpatient services to the CAH.

Section 405(d)(1) of Public Law 108–173 amended section 1834(g)(2) of the Act by adding a sentence after paragraph (B) to specify that the Secretary may not require, as a condition for a CAH to make an election of the optional method of payment, that each physician or other practitioner providing professional services in the CAH must assign billing rights with respect to the services. However, the optional payment method does not apply to those physicians and practitioners who have not assigned such billing rights. In other words, section 405(d) amended the Medicare law to authorize CAHs to elect the optional payment method even if some practitioners do not reassign to the CAH their rights to bill for professional services to CAH outpatients. However, it also specifies that the 15-percent increase in payment for those services is not available for professional services for which billing rights are not reassigned.

The provisions of section 405(d)(1) of Public Law 108–173 are effective for cost reporting periods beginning on or after July 1, 2004. However, section 405(d)(2)(B) also states, in a special rule of application, that in the case of a CAH that made an election before November 1, 2003, the provisions of section 405(d)(1) are effective for cost periods beginning on or after July 1, 2001.

Consistent with section 405(d)(2)(B), we do not intend to attempt recovery of certain amounts paid improperly in the past to CAHs for professional services that the CAHs billed under the optional payment method, even though the CAHs had not obtained reassignments of billing rights from all physicians and other practitioners furnishing professional services to their outpatients, as required by § 413.70 as in effect at that time. However, we are proposing to clarify that the special rule of application in section 405(d)(2)(B) is not to be interpreted to permit a CAH to obtain payment under the optional payment method for any cost reporting period based on an election made for a prior period or on an optional payment method election that was withdrawn or revoked prior to the start of the cost reporting period for which it was made.

To illustrate the application of section 405(d)(2)(B), assume that on October 1, 2002, a CAH elected method 2 for its cost reporting period starting on January 1, 2003, but did not obtain reassignments from all physicians treating its outpatients, as required by regulations in effect at that time. Under section 405(d)(2)(B), CMS would not recover any amounts from the CAH for payments for services furnished during that cost reporting period (January 1, 2003, through December 31, 2004) that are attributable to that election, even though the election was inappropriate at the time it was made. Assume further that the same CAH recognized its error and did not make a method 2 election for its cost reporting period beginning January 1, 2004, thus receiving payment under method 1. The fact that the election of October 1, 2002, was made prior to November 1, 2003, is not material in this case and cannot be interpreted to justify method 2 payment for the cost reporting period beginning January 1, 2004, because that method 2 election related to an earlier cost reporting period and not to the cost reporting period beginning January 1, 2004. The same result would occur if the CAH had elected method 2 on October 1, 2003, but subsequently revoked that election on October 15, 2004.

We are proposing to revise §§ 413.70(b)(3)(i) to reflect the changes made by section 405(d) of Public Law 108–173. We would specify in § 413.70(b)(3)(i) that a CAH may elect to be paid for outpatient services in any cost reporting period beginning on or after July 1, 2004, under the method described in §§ 413.70(b)(3)(ii) and (b)(3)(iii). In § 413.70(b)(3)(i)(A), we would clarify that such an election is to be made at least 30 days before the start of the cost reporting period for which the election is made. In § 413.70(b)(3)(i)(B), we would specify

that the provision applies to all services furnished to outpatients during that cost reporting period by a physician or other practitioner who has reassigned his or her rights to bill for those services to the CAH in accordance with the reassignment regulations under 42 CFR part 424, Subpart F. In that paragraph, we also would specify that if a physician or other practitioner does not reassign his or her billing rights to the CAH in accordance with 42 CFR Part 424, Subpart F, payment for the physician's or practitioner's services to CAH outpatients will be made on a fee schedule or other applicable basis specified in 42 CFR Part 414, Subpart B. We would also add a new paragraph (C) to § 413.70(b)(3)(i) to state that, in case of a CAH that made an election under § 413.70(b)(3) before November 1, 2003, for a cost reporting period beginning before December 1, 2004, the rules in paragraph (b)(3)(i)(B) are effective for cost reporting periods beginning on or after July 1, 2001. We are also proposing in § 413.70(b)(3)(i)(B) to clarify that an election effective only for any cost reporting period for which it was made for the optional method does not apply to an election that was withdrawn or revoked before the start of the cost reporting period for which it was made.

4. Coverage of Costs for Certain Emergency Room On-Call Providers (Section 405(b) of Public Law 108–173 and §§ 413.70(b)(4) and 485.618 of the Regulations)

Under existing regulations at § 413.70(b)(4), which implement section 1834(g)(5) of the Act, Medicare payments to a CAH may include the costs of compensation and related costs of on-call emergency room physicians who are not present on the premises of a CAH, are not otherwise furnishing services, and are not on-call at any other provider or facility when determining the reasonable cost of outpatient CAH services.

Section 405(b) of Public Law 108–173 amended section 1834(g)(5) of the Act to expand the reimbursement of on-call emergency room providers beyond physicians to include physician assistants, nurse practitioners, and clinical nurse specialists for the costs associated with covered Medicare services furnished on or after January 1, 2005.

We are proposing to revise § 413.70(b)(4)(i) and (ii) to include the expanded list of emergency room on-call providers for whom reimbursement for reasonable compensation and related costs in a CAH would be available. We also are making a conforming change to § 485.618(d) governing the standard for emergency room personnel who are on call under the CAH conditions of participation.

5. Authorization of Periodic Interim Payments for CAHs (Section 405(c) of Public Law 108–173 and Proposed § 413.64(h)(2)(vi) and § 413.70(d) of the Regulations)

Section 1815(e)(2) of the Act provides that payments may be made on a periodic interim payment (PIP) basis for specified covered Medicare services. Section 405(c)(1) of Public Law 108–173 amended section 1815(e)(2) by adding a new subsection (E) to provide for payments for inpatient services furnished by CAHs on a PIP basis, effective for payments made on or after July 1, 2004. Section 405(c)(2) of Public Law 108–173 directs the Secretary to develop alternative methods for the timing of the payments under the PIP method.

We have already established in existing regulations under § 413.64(h) provisions for making payments under the PIP method to providers for certain Medicare covered services. The principles and rules of § 413.64 have been incorporated into regulations governing payment on a PIP basis to acute care IPPS hospitals as well as to other providers, such as SNFs and LTCHs, that are paid on a prospective basis. We believe these principles and rules could be equally applied to CAHs. Therefore, in this proposed rule, to implement the provisions of section 405(c) of Public Law 108–173, we are proposing to add a new § 413.64(h)(2)(vi) to specify inpatient services furnished by CAHs as an additional type of covered service for which PIP is available, effective for payments made on or after July 1, 2004.

It has been our longstanding policy under § 413.64(h)(6) that payment will be made biweekly under the PIP method, unless the provider requests a longer fixed interval (not to exceed 1 month) between payments. We believe that this provision grants adequate flexibility for the timing of payments under the PIP method to all qualifying providers, including CAHs. Under our proposed policy for CAHs, if a CAH chooses to receive its payments less frequently than biweekly, it could inform its Medicare fiscal intermediary. Section 413.64(h)(6) does not provide for the payments to be made more frequently than biweekly to providers for which PIP is currently available. We believe this is equally appropriate for the payments for inpatient services furnished by CAHs.

In summary, we are proposing to apply the same rules and procedures for payments under the PIP method that we apply to acute care hospitals and certain other Medicare providers. Therefore, CAHs, in applying for and receiving payments for inpatient services under the PIP provision, would be operating under the same rules as other providers for which PIP is available under § 413.64(h), including the flexibility discussed above of the timing of their payments as provided for under § 413.64(h)(6). We also are proposing to establish a new paragraph (d) under § 413.70 to provide that, for payments on or after July l, 2004, a CAH may elect to receive PIP for inpatient services furnished by CAHs, subject to the provisions of § 413.64(h). The new § 413.70(d) summarizes the application of the PIP provisions under § 413.64(h)(6) for CAH inpatient services and notes the availability of accelerated payments for CAHs that are not receiving PIPs.

Technical Changes to § 413.64. We are proposing to use this opportunity to remove §§ 413.64(h)(3)(iv) and 413.64(h)(4), which contain an outdated requirement that a provider must repay any outstanding current financing payments before being permitted to be paid under the PIP method. Current financing payments have not been available since 1973.

6. Revision of the Bed Limit for CAHs (Section 405(e) of Public Law 108–173 and §§ 485.620(a) and 485.645(a)(2) of the Regulations)

Prior to the enactment of Public Law 108–173, sections 1820(c)(2)(B)(iii) and 1820(f) of the Act restricted CAHs to 15 acute care beds and a total of 25 beds if the CAH had been granted swing-bed approval. The number of beds used at any time for acute care inpatient services could not exceed 15 beds.

Section 405(e) of Public Law 108–173 amended sections 1820(c)(2)(B)(iii) and 1820(f) of the Act to allow CAHs a maximum of 25 acute care beds for inpatient services, regardless of the swing-bed approval. This amendment is effective on January 1, 2004 and applies to CAHs designated before, on, or after this date. However, section 405(e)(3) of Public Law 108–173 also notes that any election made in accordance with the regulations promulgated to carry out the bed size amendments only applies prospectively.

We interpret this provision to mean that the increased bed size limitation is to be applied prospectively after April 1, 2004, regardless of when the CAH was designated. Accordingly, we implemented this provision via a survey and certification letter on January 1, 2004. (See Survey and Certification

Letter No. 0414, issued December 11, 2003.) Therefore, effective January 1, 2004, this provision allows any currently participating CAH, or applicant for CAH approval, to maintain up to 25 inpatient beds. If swing-bed approval has been granted, all 25 beds can be used interchangeably for acute care or swing-bed services. However, no CAH will be considered to have had 25 acute care beds prior to January 1, 2004. We are proposing to amend our regulations at §§ 485.620(a) and 485.645(a)(2) to reflect the increase in the number of beds permitted in a CAH, in accordance with the amendments made by section 405(e) of Public Law 108–173.

7. Authority To Establish Psychiatric and Rehabilitation Distinct Part Units of CAHs (Section 405(g)(1) of Public Law 108–173 and Proposed New § 485.646 of the Regulations)

As stated earlier, sections 1820(c)(2)(B) and 1861(mm) of the Act set forth the criteria for designating a CAH. Under this authority, the Secretary has established in regulations the minimum requirements a CAH must meet to participate in Medicare (42 CFR Part 485, Subpart F). The CAH designation is targeted to small rural hospitals with a low patient census and short patient stays.

Under the law in effect prior to Public Law 108–173, CAHs are excluded from operating distinct part units (that is, separate sections of hospitals that are dedicated to providing inpatient rehabilitation or psychiatric care and are paid under payment methods different from those used for the acute care areas of the hospitals). The statute (section 1886(d)(l)(B) of the Act) and implementing regulations under 42 CFR Part 412, Subpart B require distinct part units to be units of ''subsection (d) hospitals,'' which are hospitals paid under the IPPS. Because CAHs are not ''subsection (d) hospitals'' paid under IPPS, but instead are paid for inpatient care on a reasonable cost basis under section 1814(l) of the Act, they are effectively prohibited from having distinct part units.

Section 405(g)(1) of Public Law 108–173 modified the statutory requirements for CAHs under section 1814(l) and section 1820(c)(2) of the Act to allow CAHs to establish distinct part rehabilitation and psychiatric units of up to 10 beds each, which will not be included in the revised total 25 CAH bed count under section 405(e) of Public Law 108–173 (discussed in detail in section VI.D.6. of this preamble. In addition, as explained more fully below, the average 96-hour stay does not apply to the 10 beds in the distinct part units and inpatient admissions; days of inpatient care in these distinct part units are not taken into account in determining the facility's compliance with the requirement for a facility-wide average length of stay that does not exceed 96 hours.

Section 405(g)(1) of Public Law 108–173 provides under section 1820(c)(2)(E)(i) of the Act that a distinct part rehabilitation or psychiatric unit of a CAH must meet the conditions of participation that would otherwise apply to the distinct part unit of a hospital if the distinct part unit were established by a subsection (d) hospital in accordance with the matter following clause (v) of section 1886(d)(1)(B) of the Act, including any applicable regulations adopted by the Secretary. CAHs will now be permitted to operate distinct-part psychiatric and rehabilitation units, and it is clear that the law, consistent with this change, requires the same level of health and safety protection for patients in distinct part units of a CAH that is currently required for patients in distinct part units operated by an acute care hospital.

The amendments to section 405(g)(1) are effective for the cost reporting periods beginning on or after October 1, 2004.

As CAHs were excluded from operating distinct part units prior to the enactment of section 405(g), the CAH conditions of participation did not address the necessary requirements and standards for operating such units. As noted previously, section 1820(c)(2)(E)(i) of the Act makes it clear that the requirements, including conditions of participation, for operating these units in a CAH are to be the same as is currently required for these units operated by an acute care hospital. Accordingly, we are proposing that, in accordance with the requirements of section 405(g), a rehabilitation or psychiatric distinct part unit of a CAH must meet all of the hospital conditions of participation at 42 CFR Part 482, Subparts A, B, C, and D and the criteria for exclusion from the IPPS at 42 CFR Part 412 as described below. These requirements will only apply to the services provided in the distinct part unit of a CAH and not the entire CAH.

Currently, psychiatric distinct part units of hospitals are subject to specific Medicare regulations established in 42 CFR 412.27 regarding the types of patients admitted, the scope of services furnished, and the qualifications of staff. For example, psychiatric distinct part units may admit only patients whose condition requires inpatient hospital care for a psychiatric principal diagnosis. The regulations at § 412.27(b) further requires a hospital that wishes to establish a psychiatric distinct part unit to furnish, through the use of qualified personnel, psychological services, social work services, psychiatric nursing, and occupational and recreational therapy. The hospital must maintain medical records for the unit that permit determination of the degree and intensity of services to individuals treated in the unit. Inpatient psychiatric services must be under the supervision of a clinical director, service chief, or equivalent who is qualified to provide the leadership required for an intensive treatment program, and who is board certified in psychiatry (42 CFR 412.27(d)(2)). The distinct part unit must have a director of social services, a qualified director of psychiatric nursing services who is a registered nurse with a master's degree in psychiatric or mental health nursing, or its equivalent from an accredited school of nursing, or is qualified by education and experience in the care of individuals with mental illness. There must also be an adequate number of registered nurses to provide 24-hour coverage as well as licensed practical nurses and mental health workers. These and other applicable requirements are set forth in greater detail in § 412.27.

Rehabilitation distinct part units of hospitals are currently subject to criteria in 42 CFR 412.29. This section specifies that such a unit must meet either the requirements for new units (§ 412.30(a)) or those for existing units (§ 412.30(c)). In addition, the units must furnish through qualified personnel rehabilitation nursing, physical and occupational therapy, and as needed, speech therapy and social services or psychological services, and orthotics and prosthetics. The unit must have a director of rehabilitation services who is trained or experienced in medical management of inpatients who require rehabilitation services and is a doctor of medicine or a doctor of osteopathy. Rehabilitation distinct part units may treat only patients likely to benefit significantly from an intensive inpatient program, utilizing services such as physical, occupational, or speech therapy. These and other applicable requirements are set forth in greater detail in §§ 412.29 and 412.30.

To implement the requirements of section 1820(c)(2)(E)(i) of the Act, as added by section 405(g)(1) of Public Law 108–173, we are proposing to add a new § 485.647 to 42 CFR Part 485, Subpart F. In proposed § 485.647(a)(1), we would specify that if a CAH provides

inpatient psychiatric services in a distinct part unit, the services provided in that unit must comply with the hospital requirements specified in Subparts A, B, C, and D of Part 482, with the common requirements for IPPS-excluded units in § 412.25(a)(2) through (f), and with the additional requirements of § 412.27 for psychiatric units excluded from the IPPS. In proposed § 485.647(a)(2), we would specify that if a CAH provides inpatient rehabilitation services in a distinct part unit, the services provided in that unit must comply with the hospital requirements specified in Subparts A, B, C, and D of Part 482, with the common requirements for IPPS-excluded units in § 412.25(a)(2) through (f), and with the additional requirements of §§ 412.29 and 412.30, which relate specifically to rehabilitation units excluded from the IPPS. To provide for consistent application of section 405(g)(1) and avoid any confusion, we also are proposing to revise § 412.22, which contains the common requirements for excluded hospital units, to state that, for purposes of 42 CFR Part 412, Subpart B, the term ''hospital'' includes a CAH.

As noted earlier, sections 1820(c)(2)(E)(ii) and (c)(2)(E)(iii) of the Act, as added by section 405(g)(1) of the MMA, provide that each distinct part unit of a CAH may have up to 10 beds and that, in determining the number of beds a CAH has for purposes of compliance with the 25-bed limit described earlier, the beds in a distinct part unit are not to be taken into account. We interpret the exclusion of these beds from consideration for purposes of the 25-bed limit as also indicating that the admissions and lengths of stay in distinct part unit beds are not to be considered in determining the facility-wide average length stay of a CAH for purposes of the 96-hour limitation on CAH's average length of inpatient stay. These rules would be codified in paragraphs (b)(1) through (b)(3) of proposed § 485.647.

Section 1820(c)(2)(E)(iv) of the Act, as added by section 405(g)(1) of Public Law 108–173, imposes severe sanctions on CAHs that fail to operate their distinct part units in compliance with applicable requirements. That section states that if a psychiatric or rehabilitation unit of a CAH does not meet the requirements of section 1820(c)(2)(E)(i) with respect to a cost reporting period, no payment may be made to the CAH for services furnished in that unit for that period. Payment to the CAH for services in the unit may resume only after the unit has demonstrated to CMS that the unit meets the requirements of § 485.645. We are proposing to codify this requirement by adding a new paragraph (g) to § 412.25.70, which contains the common requirements for excluded units.

Section 405(g)(1) of Public Law 108–173 amended section 1814(l) of the Act by adding a new paragraph (2) to that provision. New section 1814(l)(2) states that, in the case of a distinct-part psychiatric or rehabilitation unit of a CAH, the amount of payment for inpatient CAH services of such a unit is to equal the amount that would be paid if these services were inpatient hospital services of a psychiatric or rehabilitation unit, respectively, of the kind described in the matter following clause (v) of section 1886(d)(1)(B) of the Act. To implement the requirements of section 1814(1)(2) of the Act, we are proposing that, for CAHs that establish rehabilitation or psychiatric distinct part units, or both, in their facility, Medicare payment for inpatient services provided in those units would be made under the applicable existing payment methodology described below for IRFs and IPFs.

Presently, IRFs are paid under a per discharge PPS that became effective for cost reporting periods beginning on or after January 1, 2002. The regulations governing the IRF PPS are located under 42 CFR Part 412, Subpart P (§§ 412.600 through 412.632).

At this time psychiatric hospitals and units that are excluded from the IPPS are paid for their inpatient operating costs on a reasonable cost basis, subject to a hospital-specific limit. However, as required by statute, a per diem PPS for Medicare payments for inpatient hospital services furnished in psychiatric hospitals and units (referred to as inpatient psychiatric facilities (IPFs)) was proposed in the **Federal Register** on November 28, 2003 (68 FR 66920). We are in the process of developing the final rule for this proposed rule. When finalized, the IPF PPS will replace the reasonable cost based payment system currently in effect.

To clarify the requirements of section 1814(1)(2) of the Act regarding payment for inpatient CAH services of a distinct part psychiatric or rehabilitation unit of a CAH, we are proposing to revise the title and first sentence of paragraph (a)(1) of § 413.70, and to add a new paragraph (a)(4) to that section, to clarify that payment for inpatient services of a CAH distinct part unit is not made in accordance with the otherwise applicable rules for payment for inpatient CAH services, but under other rules described in new § 413.70(e). We propose also in new paragraph § 413,70(e), that payment for inpatient services of distinct part rehabilitation units of CAHs is made in accordance with regulations governing the IRF PPS at 42 CFR Part 412, Subpart F (§§ 412.600 through 412.632). We also would state that payment for inpatient services of distinct part psychiatric units of CAHs is made in accordance with regulations governing IPPS-excluded psychiatric units of hospitals at 42 CFR 413.40.

8. Waiver Authority for Designation of a CAH as a Necessary Provider

Section 405(h) of Public Law 108–173 amended section 1820(c)(B)(i)(II) of the Act by adding language that terminates a State's authority to waive the location requirement for a CAH by designating the CAH as a necessary provider, effective January 1, 2006. Currently, a CAH is required to be located more than a 35-mile drive (or in the case of mountainous terrain or secondary roads, a 15-mile drive) from a hospital or another CAH, unless the CAH is certified by the State as a necessary provider of health care services to residents in the area. Under this provision, after January 1, 2006, States will no longer be able to designate a CAH based upon a determination it is a necessary provider of health care.

In addition, section 405(h) of Public Law 108–173 amended section 1820(h) of the Act to include a grandfathering provision for CAHs that are certified as necessary providers prior to January 1, 2006. Under this provision, any CAH that is designated as a necessary provider in its State's rural health plan prior to January 1, 2006, will be permitted to maintain its necessary provider designation.

In this proposed rule, we are proposing to revise our regulations at § 485.610(c) to incorporate the amendments made by section 405(h) of Public Law 108–173.

9. Payment for Clinical Diagnostic Laboratory Tests

Medicare payment for clinical diagnostic laboratory tests provided to the outpatients of CAHs was established through the regulatory process and published in the **Federal Register** as part of the FY 2004 IPPS final rule (68 FR 45346, August 1, 2003). Payment to a CAH for clinical diagnostic laboratory tests for outpatients is made on a reasonable cost basis only if the individuals for whom the tests are performed are outpatients of the CAH and are physically present at the CAH at the time specimens are collected. Otherwise, payment for these tests is made on a fee schedule basis.

We published this final rule to clarify our policy in this area and ensure that all relevant issues were publicly noted. For reasons which are set forth in detail in the FY 2004 IPPS final rule, we do not agree that providing reasonable cost payment to individuals who are not present at the CAH when the specimen is collected is appropriate. We believe that extending reasonable cost payment in these instances is inconsistent with Medicare law and regulations and duplicates existing coverage. It also creates confusion for beneficiaries and others by blurring the distinction between CAHs and other types of providers (for example, SNFs and HHAs) and increases the costs of providing care to Medicare patients without enhancing either the quality or the availability of that care.

Following publication of the FY 2004 IPPS final rule, we received a number of letters and statements in Open Door Calls indicating that some commenters continue to believe that this policy will impose a hardship on Medicare beneficiaries in rural areas. Several of these commenters argued that it might cause frail elderly nursing home patients to have to be moved to a CAH to have blood drawn or other specimen collection performed instead of sending a laboratory technician to the patient's bedside for the same purpose. We agree with the commenters that this would not be an appropriate result. However, we would note that there are also alternative ways in which specimen collection and travel are payable under Medicare (for example, the laboratory benefit under Part B or HAAs that have laboratory provider numbers). Therefore, we do not expect beneficiaries to face reduced access to services under this policy.

In response to continuing claims of potential access problems, we invited commenters to submit further, more specific comments that provide specific information on actual, rather than merely potential or anticipated access problems. In response, we received many communications asserting that these problems would occur, but no credible documentation that they actually are occurring. As a result of these responses, we are not proposing any further change in policy on this issue at this time. We would like to renew our request for specific, verifiable documentation as to any actual access problems being generated by this policy, and will review carefully any such documentation we receive to determine whether current policy should be reconsidered.

10. Proposed Technical Changes in Part 489

In several sections of Part 489, we have discovered a need to update cross-references to conform them to the redesignation of the Medicare transfer rules from § 489.24(d) to § 489.24(d). Specifically, we are proposing to correct the cross-reference to ''§ 489.24(d)'' in §§ 489.20(m) and 489.53(b)(2) to read ''§ 489.24(e)''.

VII. Proposed Changes to the Disclosure of Information Requirements for Quality Improvement Organizations (QIOs)

[If you choose to comment on issues in this section, please include the caption ''Quality Improvement Organizations'' at the beginning of your comment.]

A. Background

Section 1152 of the Act defines a utilization and quality control peer review organization (now referred to as a quality improvement organization (QIO)). Section 1153 provides for contracts with such organizations to review items and services furnished by physicians, other practitioners, and providers to Medicare patients to verify that the items and services are reasonable, medically necessary, and allowable under the Act; meet professionally recognized standards of health care; and are furnished in the appropriate setting. Section 1154 of the Act outlines the functions of a QIO, which include responsibility for: (1) Collecting and maintaining information necessary to carry out its responsibilities; (2) examining pertinent records maintained by the practitioner or provider verifying the medical necessity and quality of services provided by any practitioner or provider of health care services to Medicare patients; (3) ensuring that health care practitioners and providers maintain evidence of medical necessity and quality of health care services provided to Medicare patients; and (4) exchanging information with intermediaries, carriers, and other public or private review organizations as appropriate. Section 1160 of the Act provides that information acquired by QIOs in the exercise of their duties and functions must be held in confidence. Information cannot be disclosed except as allowed under section 1160 of the Act and the existing regulations governing the release of QIO peer review information in 42 CFR Part 480. Specifically, Part 480 sets forth the policies and procedures for disclosure of information collected, acquired, or generated by a QIO (or the review component of a QIO subcontractor) in the performance of its responsibilities under the Act and the Medicare regulations, as well as the acquisition and maintenance of information needed by a QIO to comply with its responsibilities under the Act.

QIOs assist institutions and practitioners seeking to improve the quality of care given to Medicare beneficiaries. CMS aims to ensure that adequate protections of information collected by QIOs are in place and, at the same time, to ensure that the quality improvement activities of these institutions and practitioners are not unnecessarily hindered by regulations. It has come to our attention that the existing regulations omit information disclosure procedures that would allow for the effective and efficient exchange of information that is an essential part of quality improvement activities. In addition, it has come to our attention that, although the QIO does not need the consent of the institution to release nonconfidential information, the existing 30-day advance notice requirement to an institution prior to releasing public information or any other nonconfidential information that identifies an institution, when an institution consents to or requests the release of information, impedes the ability of QIOs to conduct quality improvement work. If the institution requests or consents to the release of the information, the institution is already aware of the QIO's intention to disclose the nonconfidential information. Therefore, we see no reason to require the additional 30-day advance notice. Likewise, there is no reason to require a 30-day notice for practitioners who request the release of information for quality improvement activities or other permissible releases under the regulations.

B. Provisions of the Proposed Regulations

We are proposing to make several changes in the regulations in Part 480 to expedite the exchange of information and minimize delays and expenditures currently required of QIOs, institutions, and practitioners as discussed below.

Existing § 480.105(a) requires that a QIO must notify an identified institution of its intent to disclose nonconfidential information about the institution and provide a copy of the information at least 30 calendar days before the disclosure. Section 480.105 also includes certain notice requirements a QIO must meet before disclosing confidential information that identifies practitioners and physicians. Section 480.106 presently includes several exceptions to these notice

requirements. We are proposing to revise § 480.106 to establish additional exceptions to the notice requirements in § 480.105(a) and (b)(2). We are proposing to specify that the notice requirements in § 480.105(a) and (b)(2) would not apply if (1) the institution or practitioner has requested, in writing, that the QIO make the disclosure; (2) the institution or practitioner has provided written consent for the disclosure; or (3) the information is public information as defined in § 480.101 and specified in § 480.120.

Existing § 480.133(a)(2)(iii) specifies that a QIO may disclose to any person, agency, or organization confidential information on a particular practitioner or reviewer with the consent of that practitioner or reviewer, provided that the information does not identify other individuals. We are proposing to revise § 480.133(a)(2)(iii) to allow for the release of information at the written request of the practitioner or reviewer, in addition to information releasable with the consent of the practitioner or reviewer under the existing provision. Specifically, the proposed revised § 480.133(a)(2)(iii) would provide that a QIO may disclose confidential information about a particular practitioner or reviewer at the written request of, or with the written consent of that practitioner or reviewer. The recipient of the information would have the same redisclosure rights and responsibilities as the requesting or consenting practitioner or reviewer would, under the authority of Subpart B of Part 480. We are proposing a similar revision to § 480.140 relating to the release of quality review study information. Specifically, we are proposing to revise § 480.140 by adding a new paragraph (d) (the existing paragraphs (d) and (e) would be redesignated as paragraphs (e) and (f), respectively) to provide that a QIO may disclose quality review study information with identifiers of particular practitioners or institutions at the written request of, or with the written consent of, the identified practitioner(s) or institution(s). The recipient of the information would have the same redisclosure rights and responsibilities as the requesting or consenting practitioner or reviewer would, under the authority of Subpart B of Part 480. We believe that these proposed revisions would reduce the existing burden on practitioners, institutions, and QIOs and, at the same time, ensure that necessary protections on information remain in place. These proposed revisions would allow QIOs, institutions, and practitioners to share vital information in an effective manner and further our efforts to ensure the highest quality of care possible for Medicare beneficiaries.

C. Technical Changes

We are proposing to revise the title of Part 480 under Subchapter F of Chapter IV of 42 CFR to conform it to a previous regulatory change in the name of the organization conducting medical reviews under Medicare from a peer review organization to a quality improvement organization. The proposed new title is ''Part 480—Acquisition, Protection, and Disclosure of Quality Improvement Organization Information''.

In a final rule published in the **Federal Register** on November 24, 1999 (64 FR 66279), we redesignated Part 476 as Part 480. However, as part of the redesignation process, we inadvertently failed to make appropriate changes to the cross-references in various sections under the redesignated Part 480. In this proposed rule, we are proposing to correct those cross-references.

VIII. Proposed Policy Changes Relating to Medicare Provider Agreements for Compliance With Bloodborne Pathogens Standards, Hospital Conditions of Participation, and Fire Safety Requirements for Certain Health Care Facilities

A. Conditions of Participation for Discharge Planning

[If you choose to comment on issues in this section, please include the caption ''Discharge Planning'' at the beginning of your comment.]

1. Background

As part of the definition of ''hospital,'' sections 1861(e)(1) through (e)(8) of the Act set forth specific requirements that a hospital must meet to participate in the Medicare program. Section 1861(e)(9) of the Act specifies that a hospital also must meet other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in hospitals. Implementing regulations for section 1861(c) of the Act, setting forth the conditions of participation (CoPs) that a hospital must meet to participate in the Medicare program, are located in 42 CFR Part 482.

The purposes of these CoPs are to protect patient health and safety and to ensure that high quality care is furnished to all patients in Medicare-participating hospitals. In accordance with section 1864 of the Act, State survey agencies conduct surveys of hospitals to determine compliance with the Medicare CoPs, using interpretive guidelines and survey procedures found in the State Operations Manual (SOM), CMS Publication No. 7. In accordance with section 1865 of the Act and the implementing regulations at 42 CFR 488.5 and 488.6, hospitals accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the American Osteopathic Association (AOA), or other national accreditation organizations are not routinely surveyed by States for compliance with the CoPs, but are deemed to meet most of the hospital CoPs based on their accreditation. However, all hospitals that participate in the Medicare program are required to be in compliance with the CoPs, regardless of their accreditation status. Under section 1905(a) of the Act, the hospital CoPs also apply to hospitals participating in Medicaid (§ 440.10(a)(3)(iii) and § 482.1(a)(5)).

Under § 489.10(d), a Medicare provider agreement is subject to the State survey agency's determination of whether a hospital meets the CoPs. The State survey agency makes corresponding recommendations to CMS about the hospital's certification; that is, whether the hospital has met the standards or requirements necessary to provide Medicare and Medicaid services and receives Federal and State reimbursement.

Section 4321(a) of Public Law 105–33 (BBA) amended section 1861(ee)(2) of the Act to require that Medicare-participating hospitals, as part of the discharge planning process, share with each patient, as appropriate, a list of available home health services through individuals and entities, including Medicare-certified home health agencies (HHAs) that participate in Medicare, serve the geographic area in which the patient resides, and request to be listed by the hospital as available. In addition, section 4321(a) prohibits hospitals from limiting or steering patients to any specific HHA or qualified provider that may provide posthospital home health services and requires hospitals to identify (in a form and manner specified by the Secretary) any HHA or other entity to whom the individual is referred in which the hospital has a disclosable financial interest consistent with section 1866(a)(1)(S) of the Act or which has a financial interest in the hospital if the patient is referred to that entity.

Congress enacted section 4321 of Public Law 105–33 to protect patient choice and enable Medicare beneficiaries to make more informed choices about the providers from which

they receive certain Medicare services. We believe that this provision was intended to address concerns that some hospitals were referring patients only to HHAs in which they had a financial interest, and that shared financial relationships were influencing referrals to other entities. Hospitals essentially have a captive patient population and, through the discharge planning process, can influence a patient's choice regarding who provides posthospitalization services.

Congress also enacted section 926 of Public Law 108–173 (MMA) to improve the administration of the Medicare program by protecting patient choice and enabling Medicare beneficiaries to make more informed choices about the providers from which they receive Medicare services. Section 926(a) of Public Law 108–173 requires the Secretary to publicly provide information that enables hospital discharge planners, Medicare beneficiaries, and the public to identify SNFs that are participating in the Medicare program. Section 926(b) of Public Law 108–173 amended section 1861(ee)(2)(D) of the Act to require Medicare-participating hospitals, as part of the discharge planning process, to include a discharge planning evaluation of a patient's likely need for posthospital extended care services and the availability of these services through facilities that participate in the Medicare program and that serve the geographic area in which the patient resides. The amendments to the Act made by section 926(b) of Public Law 108–173 apply to discharge plans made on or after a date specified by the Secretary, which may be no later than 6 months after the Secretary provides for the availability of information required by section 926(a) of Public Law 108–173.

2. Implementation

We implemented the requirements of section 4321(a) of Public Law 105–33 relating to information on HHAs through a HCFA (now CMS) directive that was issued to the Regional Offices and State survey agencies on October 31, 1997. Enforcement has been carried out through the State agency survey and certification process. We note that even though it was not a requirement under section 4321(a) to provide currently available information on HHAs to the public (as now required under section 1861(ee)(2)(D) of the Act, as amended), we have established a ''Home Health Compare'' link on the CMS Web site, *www.medicare.gov,* that identifies HHAs that are currently participating in the Medicare or Medicaid program.

We are now proposing to incorporate in our regulations under § 482.43 the requirements of section 4321(a) of Public Law 105–53 relating to providing information on HHAs to hospital patients as part of the discharge planning process. We note that we had previously issued a proposed rule on December 19, 1997 (62 FR 66726) to implement the provisions of section 4321(a) of Public Law 105–33. However, section 902 of Public Law 108–173 now requires us to finalize rules within 3 years after publication of the proposed rule, except under ''exceptional circumstances.'' While it is not clear whether Congress intended this policy to apply retroactively, out of an abundance of caution, we are issuing a new proposed rule because of the length of time that has elapsed since the issuance of the 1997 proposed rule. Moreover, the provisions of Public Law 108–173 contain information requirements for SNFs substantially similar to the ones required for HHAs. In developing this second proposed rule, we have taken into consideration the issues raised in the public comments we received on the December 19, 1997 proposed rule relating to HHAs.

Information on SNFs related to the requirement imposed by section 926(a) of Public Law 108–173 is currently available to the public and can be accessed at the CMS Web site, *www.medicare.gov,* by clicking on the ''Nursing Home Compare'' link or by calling 1–800–MEDICARE (800–633–4227). Nursing Home Compare, launched in November 2002, meets the statutory requirement of section 926(a) by enabling hospital discharge planners, Medicare beneficiaries, and the public to identify the 17,000 nursing homes that participate in the Medicare or Medicaid program. Nursing Home Compare can be used to locate a nursing home by State and county, by proximity (city or zip code), or by name. In addition, Nursing Home Compare provides detailed information about the past performance of every Medicare-certified and Medicaid-certified nursing home in the country. The data on this Web site describe nursing home characteristics, quality measures, inspection results, and nursing staff information. The Nursing Home Compare tool received 9.3 million page views in 2003 and was the most popular tool on *www.medicare.gov.* If an interested individual does not have access to the Internet, the individual can call 1–800–MEDICARE (800–633–4227) and request a printout of the nursing homes in a designated area.

We are proposing to amend the regulations at § 482.43 to incorporate the provisions of section 4321(a) of Public Law 105–33 and section 926(b) of Public Law 108–173 into the hospital CoPs. Specifically, we are proposing to add new paragraphs (c)(6), (c)(7), and (c)(8) to include the requirement for hospitals to provide lists of Medicare-certified HHAs and SNFs as part of the discharge planning process. The discharge planning evaluation would be required to include a list of Medicare-certified HHAs that have requested to be placed on the list as available to the patient and that serve the geographic area in which the patient resides. We are proposing to require the SNF list to include Medicare-certified SNFs located in the geographic area in which the patient requests. We are not requiring that the list of Medicare-certified SNFs contain those SNFs that are just located in the area in which the patient resides. Because many available Medicare-certified SNFs are not located in proximity to where the patient resides, especially in rural areas, we believe that a requirement that restricts a patient to SNFs in areas where the patient resides is too restrictive and would limit the availability of posthospital extended care services to Medicare beneficiaries.

Section 4321(a) of Public Law 105–33 requires listing the availability of home health services through individuals and entities. We have received inquiries regarding the identity of those individuals and entities. We are proposing that, because section 1861(m) of the Act identifies home health services as ''specific items or services furnished to an individual, who is under the care of a physician, by an HHA, or by others under arrangements with an HHA,'' section 4321(a) is referring to Medicare-participating HHAs.

We are proposing that the hospital present the list of HHAs or SNFs only to patients for whom home health care or posthospital extended care services are indicated as appropriate, as determined by the discharge planning evaluation. We do not expect that patients without a need for home health care or posthospital extended care services would receive the list. In addition, we are proposing to require the hospital to document in the patient's medical record that a list of HHAs or SNFs was presented to the patient or an individual acting on the patient's behalf. Hospitals would not have to duplicate the list in the patient's medical record. The information in the medical record would serve as documentation that the requirement was met. The hospital would have the flexibility to determine

exactly how and where in the patient's medical record this information would be documented.

We are proposing that a hospital have the flexibility to implement the requirement to present the lists in a manner that is most efficient and least burdensome in its particular setting. A hospital can simply print a list from the Home Health Compare or Nursing Home Compare site on the CMS Web site, *www.medicare.gov* or develop and maintain its own list of HHAs and SNFs. When the patient requires home health services, the CMS Web site list would be printed based on the geographic area in which the patient resides. When the patient requires posthospital extended care services, the CMS Web site list would be printed based on the geographic area requested by the patient. Or, in the rare instance when a hospital does not have Internet access, the hospital can call 1–800–MEDICARE (1–800–633–4227) to request a printout of a list of HHAs or SNFs in the desired geographic area. Information on this Web site should not be construed as an endorsement or advertisement for any particular HHA or SNF.

If a hospital chooses to develop its own list of HHAs or SNFs, the hospital would have the flexibility of designing the format of the list. However, the list should be utilized neither as a recommendation nor endorsement by the hospital of the quality of care of any particular HHA or SNF. If a HHA or SNF does not meet all of the criteria, (Medicare-certified and is located in the geographic area in which the patient resides or in the geographic area requested by the patient) for inclusion on the list, we are not proposing to require the hospital to place that HHA or SNF on the list. In addition, in accordance with the provisions of the Act, we are proposing that HHAs must request to be listed by the hospital as available. Also, we are proposing that the list must be legible and current (updated at least annually), and that the listed information be shared with the patient or an individual acting on the patient's behalf at least once during the discharge planning process. However, we would specify that information regarding the availability of HHAs or SNFs may need to be presented more than once during the discharge planning process to meet the patient's need for additional information or as the patient's needs and condition change.

We are proposing to require that, as part of the discharge planning process, the hospital must inform the patient or the patient's family of their freedom to choose among participating Medicare providers of posthospital services and must, when possible, respect patient and family preferences when they are expressed (proposed § 482.43(c)(7)). In addition, the hospital may not use the discharge plan to specify or otherwise limit the patient's choice of qualified providers that may provide home health care or posthospital extended care services. The intent of this proposed provision is to provide the patient with the freedom of choice to determine which HHA or SNF will provide care in accordance with section 1802 of the Act, which states that beneficiaries may obtain health services from any Medicare-participating provider.

Finally, we are proposing to require the hospital to identify in each discharge plan those HHAs or SNFs to which the patient is referred that the hospital has a disclosable financial interest or HHAs or SNFs that have a financial interest in the hospital (proposed § 482.43(c)(8)). For the purposes of implementing section 4321(a) of Public Law 105–33, we are proposing to define a disclosable ''financial interest'' as any financial interest that a hospital is required to report according to the provider enrollment process, which is governed by section 1124 of the Act and implementing regulations located in 42 CFR Part 420, Subpart C, and manual provisions. If a hospital refers patients about to be discharged and in need of posthospital services only to entities it owns or controls, the hospital would be infringing on the rights of the patient to choose the facility he or she would like to go to for services. The proposed disclosable financial interest requirement is an effort to increase the beneficiary's awareness of the actual or potential financial incentives for a hospital as a result of the referral. To allow hospitals the flexibility of determining how these financial interests are disclosed to the patient, we are not requiring a specific form or manner in which the hospital must disclose financial interest. The hospital could simply highlight or otherwise identify those entities in which a financial interest exists directly on the HHA and SNF lists. Or, the hospital could choose to maintain a separate list of those entities in which a financial interest exists.

Hospitals and managed care organizations (MCOs) have expressed concern as to whether the change made by section 4321(a) of Public Law 105–33 was intended to apply to patients in managed care plans. MCO members are limited as to what services they may obtain from sources other than through the MCO. We believe that providing MCO members with a standardized list of all HHAs or SNFs in the requested geographic area could be misleading and potentially financially harmful because MCO enrollees may be liable for services that they obtain from providers other than the MCO, and patients may interpret a list of HHAs or SNFs that are not available to them under their health plan to mean that they are authorized by the MCO. This does not mean that Medicare MCO members in particular are denied the freedom of choice they are entitled to under section 1802 of the Act. Medicare beneficiaries exercise their freedom of choice when they voluntarily enroll in the MCO and agree to adhere to the plan's coverage provisions.

The list provided to MCO patients should include available and accessible HHAs or SNFs in a network of the patient's MCO. Hospitals also have the option, in the course of discussing discharge planning with patients, to determine whether the beneficiary has agreed to excluded services or benefits or coverage limitations through enrollment in a MCO. If this is the case, the hospital could inform the patient of the potential consequences of going outside the plan for services.

We also have received many inquiries about how the requirements contained in section 4321(a) of Public Law 105–33 are monitored and enforced. Once codified in the hospital CoPs, a hospital's obligations under both section 4321(a) of Public Law 105–33 and section 926(b) of Public Law 108–173 would be monitored as part of the hospital survey and certification process. Anyone aware of instances in which patients are inappropriately influenced or steered toward a particular HHA or SNF in a way that violated the regulation would have the opportunity to file a complaint with the State survey agency. The State survey agency would then investigate and follow up with the complainant. Noncompliance with the hospital CoPs may result in a hospital losing its ability to participate in the Medicare program.

Requiring hospitals to provide a list of Medicare-certified HHAs or SNFs would provide patients with more options and assist them in making informed decisions about the providers from which they receive Medicare services. Specifically, the intent of the proposed modifications to the discharge planning CoPs is to provide the patient with the freedom of choice to determine which HHA or SNF available in the geographic area in which the patient resides or the geographic area requested by the patient, would provide them care in accordance with section 1802 of the Act,

which states that beneficiaries may obtain health services from any Medicare participating provider.

B. Compliance With Bloodborne Pathogens Standards

[If you choose to comment on issues in this section, please include the caption ''Bloodborne Pathogens Standards'' at the beginning of your comment.]

Section 1866(a)(1) of the Act sets forth provider agreement requirements that Medicare-participating hospitals must meet. Implementing regulations for these requirements are set forth at 42 CFR 489.20.

Section 947 of Public Law 108–173 amended section 1866(a)(1) of the Act to require that, by July 1, 2004, hospitals not otherwise subject to the Occupational Safety and Health Act (OSHA) (or a State occupational safety and health plan that is approved under section 18(b) of that Act) must comply with the OSHA bloodborne pathogens (BBP) standards at 29 CFR 1910.1030 as part of their Medicare provider agreements. These OSHA standards can be found on OSHA's Web site at *http://www.osha.gov/SLTC/bloodbornepathogens/*. Section 947, which applies to hospitals participating in Medicare as of July 1, 2004, was enacted to ensure that all hospital employees who may come into contact with human blood or other potentially infectious materials in the course of their duties are provided proper protection from bloodborne pathogens. Section 947 further provides that a hospital that fails to comply with OSHA's BBP standards may be subject to a civil money penalty. The civil money penalty will be imposed and collected in the same manner that civil money penalties are imposed and collected under section 1128A(a) of the Act. However, failure to comply with the BBP standards will not lead to termination of a hospital's provider agreement.

Currently, most hospitals are subject either to the OSHA BBP standards or to other BBP standards (generally, State standards) that meet or exceed the OSHA standards. However, non-Federal public hospitals located in States that do not have their own BBP standards are not subject to OSHA standards, including the OSHA BBP standards. Twenty-six States and the District of Columbia, and Guam do not have their own BBP standards under an OSHA-approved State plan. Therefore, an estimated 600,000 employees of hospitals located in those 26 States, the District of Columbia, and Guam are not afforded the same protections from BBPs as employees of all other hospitals in the United States. The States and territories that would be affected by the change made by section 947 of Public Law 108–173 are Alabama, Arkansas, Colorado, Delaware, Florida, Georgia, Idaho, Illinois, Kansas, Louisiana, Maine, Massachusetts, Mississippi, Missouri, Montana, Nebraska, New Hampshire, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Texas, West Virginia, Wisconsin, District of Columbia, and Guam.

We are proposing to incorporate the provisions of Public Law 108–173 in § 489.20 of the Medicare regulations governing provider agreements by adding a new paragraph (t). Paragraph (t) would specify that hospitals not otherwise subject to the OSHA BBP standards must comply with the OSHA BBP standards at 29 CFR 1910.1030 as part of their Medicare provider agreement. The proposed regulations would further specify that if a hospital fails to comply with OSHA's BBP standards, the hospital may be subject to a civil money penalty. The civil money penalty would be imposed and collected in the same manner that civil money penalties are imposed and collected under section 1128A(a) of the Act. However, failure to comply with the BBP standards would not lead to termination of a hospital's provider agreement. The proposed regulations would also refer to the Federal Civil Penalties Inflation Adjustment Act. This reference is intended to alert the reader that the civil money penalty amounts under section 1128A(a) of the Act may, under the Federal Civil Penalties Inflation Adjustment Act, be increased to adjust for inflation.

C. Fire Safety Requirements for Certain Health Care Facilities

[If you choose to comment on issues in this section, please include the caption ''Life Safety Code'' at the beginning of your comment.]

1. Background

On January 10, 2003, we published a final rule in the **Federal Register** (68 FR 1374) that adopted the 2000 edition of the Life Safety Code (LSC) published by the National Fire Protection Association (NFPA) as the fire safety requirements (with specified exceptions) that we are applying to the following types of providers participating in the Medicare and Medicaid programs: long-term care facilities, hospitals, intermediate care facilities for the mentally retarded (ICF/MRs), ambulatory surgical centers (ASCs), hospices that provide inpatient services, religious nonmedical health care institutions, CAHs, and Programs of All-Inclusive Care for the Elderly (PACE).

In addition to adopting the 2000 edition of the LSC, we stated our intent to delete references to all previous editions of the LSC. However, as a result of a technical error, the reference to previous editions of the LSC in § 483.70(a)(1) of the regulations for long-term care facilities was not deleted. Allowing long-term care facilities to comply with the 1967, 1973, and 1981 editions of the LSC would not adequately protect long-term care facility patients from the threat of fire and other emergencies. These editions do not recognize newer technology, nor the advances in fire safety that have been developed in the ensuing years. In addition, the existing conflicting regulatory language is confusing and contrary to the best interests of long-term care facilities and their patients. Therefore, in this proposed rule, we are proposing to correct this technical error. We are not proposing to make any substantive policy change.

In the January 10, 2003 final rule, we also specified that we were not adopting the provisions of Chapter 19.3.6.3.2, exception number 2 of the LSC regarding the use of roller latches for application to religious nonmedical health care institutions, hospices, hospitals, long-term care facilities, PACE programs, ICF/MRs and CAHs. We prohibit the use of roller latches in existing and new buildings, except for ASCs under Chapter 20 and Chapter 21 of the LSC, and provide for the replacement of existing roller latches, phased in over a 3-year period beginning March 11, 2003. We indicated that allowing health care facilities to continue using roller latches would not adequately protect patients in those facilities. Through fire investigations, roller latches have proven to be an unreliable door latching mechanism requiring extensive on-going maintenance to operate properly. Many roller latches in fire situations failed to provide adequate protection to patients in their room during an emergency. Roller latches that are not maintained pose a threat to the health and safety of patients and staff. We added that we had found through our online survey, certification, and reporting (OSCAR) system data that doors that include roller latches are consistently one of our most cited deficiencies. In fact, in SNFs, roller latches in corridor doors are consistently the number one cited deficiency under the life safety requirements.

We have learned that the language regarding the date when these facilities must be in compliance with the

prohibition on the use of roller latch may be misinterpreted and needs to be clarified. In this proposed rule, we are proposing to clarify our intent by revising the regulations as discussed under section VIII.C.2. of this preamble. We are not proposing to make any substantive policy changes.

The flexibility of the January 10, 2003 final rule would remain the same. The Secretary has broad authority to grant waivers to facilities under section 1819(d)(2)(B) and section 1919(d)(2)(B) of the Act. The proposed amendments in this proposed rule would continue to allow the Secretary to grant waivers on a case-by-case basis if the safety of the patients would not be compromised and if specific provisions of the LSC would result in unreasonable hardship on the provider. The Secretary also may accept a State's fire and safety code instead of the LSC if the State's fire and safety code adequately protects patients. Further, the NFPA's Fire Safety Evaluation System (FSES), an equivalency system, provides alternatives to meeting various provisions of the LSC, thereby achieving the same level of fire protection as the LSC.

2. Proposed Changes to the Regulations

We are proposing to revise § 483.70(a) to delete references to the 1967, 1973, and 1981 editions of the LSC.

We are proposing to revise the following regulations applicable to the specified facilities to clarify that the facility must be in compliance with Chapter 19.2.9, Emergency Lighting, beginning March 13, 2006. In addition, we would also specify that, beginning March 13, 2006, Chapter 19.3.6.3.2, exception number 2 (concerning roller latches), does not apply to the facility.

a. For religious nonmedical health care institutions: § 403.744(a) and (c).

b. For hospices, § 418.100(d)(1), (d)(4), and new (d)(5).

c. For PACE programs, § 460.72(b)(1)(i), (b)(3), and new (b)(4).

d. For hospitals, § 482.41(b).

e. For long-term care facilities, § 483.70(a).

f. For ICF/MRs, § 483.470(j).

g. For CAHs, § 485.623(d)(1), (d)(5), and new (d)(6).

IX. MedPAC Recommendations

[If you choose to comment on issues in this section, please include the caption ''MedPAC Recommendations'' at the beginning of your comment.]

We are required by section 1886(e)(4)(B) of the Act to respond to MedPAC's IPPS recommendations in our annual proposed IPPS rule. We have reviewed MedPAC's March 1, 2004 ''Report to the Congress: Medicare Payment Policy'' and have given it careful consideration in conjunction with the proposals set forth in this document. For further information relating specifically to the MedPAC report or to obtain a copy of the report, contact MedPAC at (202) 653–7220, or visit MedPAC's Web site at: *www.medpac.gov.*

We note that MedPAC's recommendations in its March 1, 2004 report included only one recommendation concerning Medicare inpatient hospital payment policies. MedPAC's Recommendation 3A–1 states that Congress should increase payment rates for the IPPS by the projected rate of increase in the hospital market basket for FY 2005. We note that section 501(a)(3) of Public Law 108–173 requires that the payment rates for the IPPS be increased by the market basket percentage increase for all hospitals during FYs 2005, 2006, and 2007, except that it also provides for reducing the update by 0.4 percentage points for any hospital that fails to submit data on a list of 10 quality indicators. We discuss this recommendation further in Appendix B of this proposed rule in the context of our recommendation concerning the update factor for inpatient hospital operating costs and for hospitals and hospital distinct-part units excluded from the IPPS.

X. Other Required Information

A. Requests for Data From the Public

In order to respond promptly to public requests for data related to the prospective payment system, we have established a process under which commenters can gain access to raw data on an expedited basis. Generally, the data are available in computer tape or cartridge format; however, some files are available on diskette as well as on the Internet at *http://www.hcfa.gov/stats/pufiles.htm.* Data files and the cost for each file, if applicable, are listed below. Anyone wishing to purchase data tapes, cartridges, or diskettes should submit a written request along with a company check or money order (payable to CMS–PUF) to cover the cost to the following address: Centers for Medicare & Medicaid Services, Public Use Files, Accounting Division, P.O. Box 7520, Baltimore, MD 21207–0520, (410) 786–3691. Files on the Internet may be downloaded without charge.

1. CMS Wage Data

This file contains the hospital hours and salaries for FY 2001 used to create the proposed FY 2005 prospective payment system wage index. The file will be available by the beginning of February for the NPRM and the beginning of May for the final rule.

Processing year	Wage data year	PPS fiscal year
2004	2001	2005
2003	2000	2004
2002	1999	2003
2001	1998	2002
2000	1997	2001
1999	1996	2000
1998	1995	1999
1997	1994	1998
1996	1993	1997
1995	1992	1996
1994	1991	1995
1993	1990	1994
1992	1989	1993
1991	1988	1992

These files support the following:

- NPRM published in the **Federal Register**.
- Final Rule published in the **Federal Register**.

Media: Diskette/most recent year on the Internet.

File Cost: $165.00 per year.

Periods Available: FY 2005 PPS Update.

2. CMS Hospital Wages Indices (Formerly: Urban and Rural Wage Index Values Only)

This file contains a history of all wage indices since October 1, 1983.

Media: Diskette/most recent year on the Internet.

File Cost: $165.00 per year.

Periods Available: FY 2005 PPS Update.

3. PPS SSA/FIPS MSA State and County Crosswalk

This file contains a crosswalk of State and county codes used by the Social Security Administration (SSA) and the Federal Information Processing Standards (FIPS), county name, and a historical list of Metropolitan Statistical Areas (MSAs).

Media: Diskette/Internet.

File Cost: $165.00 per year.

Periods Available: FY 2005 PPS Update.

4. Reclassified Hospitals New Wage Index (Formerly: Reclassified Hospitals by Provider Only)

This file contains a list of hospitals that were reclassified for the purpose of assigning a new wage index. Two versions of these files are created each year. They support the following:

- NPRM published in the **Federal Register**.
- Final Rule published in the **Federal Register**.

Media: Diskette/Internet.

File Cost: $165.00 per year.
Periods Available: FY 2005 PPS Update.

5. PPS–IV to PPS–XII Minimum Data Set

The Minimum Data Set contains cost, statistical, financial, and other information from Medicare hospital cost reports. The data set includes only the most current cost report (as submitted, final settled, or reopened) submitted for a Medicare participating hospital by the Medicare fiscal intermediary to CMS. This data set is updated at the end of each calendar quarter and is available on the last day of the following month.
Media: Tape/Cartridge.
File Cost: $770.00 per year.

	Periods beginning on or after	and before
PPS–IV	10/01/86	10/01/87
PPS–V	10/01/87	10/01/88
PPS–VI	10/01/88	10/01/89
PPS–VII	10/01/89	10/01/90
PPS–VIII	10/01/90	10/01/91
PPS–IX	10/01/91	10/01/92
PPS–X	10/01/92	10/01/93
PPS–XI	10/01/93	10/01/94
PPS–XII	10/01/94	10/01/95

(**Note:** The PPS–XIII, PPS–XIV, PPS–XV, PPS–XVI, PPS–XVII, PPS–XVIII, and PPS–XIX Minimum Data Sets are part of the PPS–XIII, PPS–XIV, PPS–XV, PPS–XVI, PPS–XVII, PPS–XVIII, and PPS–XIX Hospital Data Set Files (refer to item 7 below).)

6. PPS–IX to PPS–XII Capital Data Set

The Capital Data Set contains selected data for capital-related costs, interest expense and related information and complete balance sheet data from the Medicare hospital cost report. The data set includes only the most current cost report (as submitted, final settled or reopened) submitted for a Medicare certified hospital by the Medicare fiscal intermediary to CMS. This data set is updated at the end of each calendar quarter and is available on the last day of the following month.
Media: Tape/Cartridge.
File Cost: $770.00 per year.

	Periods beginning on or after	and before.
PPS–IX	10/01/91	10/01/92.
PPS–X	10/01/92	10/01/93.
PPS–XI	10/01/93	10/01/94.
PPS–XII	10/01/94	10/01/95

(**Note:** The PPS–XIII, PPS–XIV, PPS–XV, PPS–XVI, PPS–XVII, PPS–XVIII, and PPS–XIX Capital Data Sets are part of the PPS–XIII, PPS–XIV, PPS–XV, PPS–XVI, PPS–XVII, PPS–XVIII, and PPS–XIX Hospital Data Set Files (refer to item 7 below).)

7. PPS–XIII to PPS–XIX Hospital Data Set

The file contains cost, statistical, financial, and other data from the Medicare Hospital Cost Report. The data set includes only the most current cost report (as submitted, final settled, or reopened) submitted for a Medicare-certified hospital by the Medicare fiscal intermediary to CMS. The data set is updated at the end of each calendar quarter and is available on the last day of the following month.
Media: Diskette/Internet.
File Cost: $2,500.00.

	Periods beginning on or after	and before.
PPS–XIII	10/01/95	10/01/96.
PPS–XIV	10/01/96	10/01/97.
PPS–XV	10/01/97	10/01/98.
PPS–XVI	10/01/98	10/01/99.
PPS–XVII	10/01/99	10/01/00.
PPS–XVIII ...	10/01/00	10/01/01.
PPS–XIX	10/01/01	10/01/02

8. Provider-Specific File

This file is a component of the PRICER program used in the fiscal intermediary's system to compute DRG payments for individual bills. The file contains records for all prospective payment system eligible hospitals, including hospitals in waiver States, and data elements used in the prospective payment system recalibration processes and related activities. Beginning with December 1988, the individual records were enlarged to include pass-through per diems and other elements.
Media: Diskette/Internet.
File Cost: $265.00.
Periods Available: FY 2005 PPS Update.

9. CMS Medicare Case-Mix Index File

This file contains the Medicare case-mix index by provider number as published in each year's update of the Medicare hospital inpatient prospective payment system. The case-mix index is a measure of the costliness of cases treated by a hospital relative to the cost of the national average of all Medicare hospital cases, using DRG weights as a measure of relative costliness of cases. Two versions of this file are created each year. They support the following:
- NPRM published in the **Federal Register**.
- Final rule published in the **Federal Register**.

Media: Diskette/most recent year on Internet.
Price: $165.00 per year/per file.
Periods Available: FY 1985 through FY 2005.

10. DRG Relative Weights (Formerly Table 5 DRG)

This file contains a listing of DRGs, DRG narrative descriptions, relative weights, and geometric and arithmetic mean lengths of stay as published in the **Federal Register**. The hard copy image has been copied to diskette. There are two versions of this file as published in the **Federal Register:**
- NPRM.
- Final rule.

Media: Diskette/Internet.
File Cost: $165.00.
Periods Available: FY 2005 PPS Update.

11. PPS Payment Impact File

This file contains data used to estimate payments under Medicare's hospital inpatient prospective payment systems for operating and capital-related costs. The data are taken from various sources, including the Provider-Specific File, Minimum Data Sets, and prior impact files. The data set is abstracted from an internal file used for the impact analysis of the changes to the prospective payment systems published in the **Federal Register**. This file is available for release 1 month after the proposed and final rules are published in the **Federal Register**.
Media: Diskette/Internet.
File Cost: $165.00.
Periods Available: FY 2005 PPS Update.

12. AOR/BOR Tables

This file contains data used to develop the DRG relative weights. It contains mean, maximum, minimum, standard deviation, and coefficient of variation statistics by DRG for length of stay and standardized charges. The BOR tables are ''Before Outliers Removed'' and the AOR is ''After Outliers Removed.'' (Outliers refers to statistical outliers, not payment outliers.)

Two versions of this file are created each year. They support the following:
- NPRM published in the **Federal Register**.
- Final rule published in the **Federal Register**.

Media: Diskette/Internet.
File Cost: $165.00.
Periods Available: FY 2005 PPS Update.

13. Prospective Payment System (PPS) Standardizing File

This file contains information that standardizes the charges used to

calculate relative weights to determine payments under the prospective payment system. Variables include wage index, cost-of-living adjustment (COLA), case-mix index, disproportionate share, and the Metropolitan Statistical Areas (MSAs). The file supports the following:

- NPRM published in the **Federal Register**.
- Final rule published in the **Federal Register**.

Media: Internet.

File Cost: No charge.

Periods Available: FY 2005 PPS Update.

For further information concerning these data tapes, contact the CMS Public Use Files Hotline at (410) 786–3691.

Commenters interested in obtaining or discussing any other data used in constructing this rule should contact James Hart at (410) 786–9520.

B. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to evaluate fairly whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

Therefore, we are soliciting public comments on each of these issues for the information collection requirements discussed below.

The following information collection requirements in this proposed rule and the associated burdens are subject to the PRA.

Section 412.22 Excluded Hospitals and Hospital Units: General Rules

In summary, this section outlines the requirements for excluded hospitals and hospital units. This section states that a LTCH that occupies space in a building used by another hospital, or in one or more separate buildings located on the same campus as buildings used by another hospital must notify its fiscal intermediary and CMS in writing of its co-location.

The collection requirement has not changed. While this requirement is subject to the PRA, this requirement is currently approved in OMB No. 0938–0897, with a current expiration date of July 31, 2006.

Section 412.25 Excluded Hospital Units: Common Requirements

In summary, this section proposes to apply the excluded hospital unit requirements to psychiatric or rehabilitation CAH units that are now permitted under the provisions of Public Law 108–173. This section states that if a psychiatric rehabilitation unit of a CAH does not meet the applicable requirements, payment will not be made and will resume only after the unit has demonstrated to CMS that it meets the applicable requirements.

We believe the collection requirements are exempt as defined in 5 CFR 1320.4, information collections conducted or sponsored during the conduct of a criminal or civil action, or during the conduct of an administrative action or investigation, or audit. We also believe the collection requirements to be exempt as defined in 5 CFR 1320.3(c)(4) because we believe this would affect less than 10 persons.

Section 412.64 Federal Rates for Inpatient Operating Costs for Federal Fiscal Years 2005 and Subsequent Fiscal Years

In summary, this section outlines the proposed requirements and process for determining the adjustment of the wage index to account for the commuting patterns of hospital workers. This section states that a hospital may waive the application of the wage index adjustment by notifying CMS in writing within 45 days after the publication of the annual notice of proposed rulemaking for the IPPS.

The burden associated with this requirement is the time and effort for the hospital to prepare a written notice asking to waive the application of the wage index adjustment and send the notice to CMS.

The burden associated with this requirement is estimated to be 30 minutes per hospital. Therefore, we estimate it would take 5 total annual hours (30 minutes × 10 hospitals seeking a waiver).

Section 412.103 Special Treatment: Hospitals Located in Urban Areas and That Apply for Reclassification as Rural

In summary, this section outlines the requirements and process for a rural hospital to become reclassified. This section states that a prospective payment hospital that is located in an urban area may be reclassified as a rural hospital if it submits an application in accordance with this section.

We are proposing to revise this section; however, the collection requirement remains the same. While this requirement is subject to the PRA, this requirement is currently approved in OMB No. 0938–0573, with a current expiration date of October 31, 2005.

Section 412.101 Special Treatment: Inpatient Hospital Payment Adjustment for Low-Volume Hospitals

In summary, this section outlines the proposed requirements for determining a payment adjustment for low-volume hospitals. This section states that in order to qualify for the higher incremental costs adjustment, the hospital must provide its fiscal intermediary with evidence that it meets the distance requirement to make a determination that the hospital meets the distance requirement specified in this section.

The burden associated with this requirement is the time and effort for the hospital to provide the fiscal intermediary with evidence that it meets the specified distance requirement.

The burden associated with this requirement is estimated to be 1 hour per hospital. Therefore, we estimate it would take 500 total annual hours (1 hour × 500 hospitals seeking the incremental costs adjustment).

Section 412.211 Puerto Rico Rates for Federal Fiscal Year 2004 and Subsequent Fiscal Years

In summary, this section outlines the requirements and process for determining the adjusted prospective payment rate for inpatient hospital services in Puerto Rico. This section states that a hospital may waive the application of the proposed wage index adjustment for commuting hospital employees by notifying CMS in writing within 45 days after the publication of the annual notice of proposed rulemaking for the inpatient prospective payment system.

The burden associated with this requirement is the time and effort for the hospital to prepare a written notice asking to waive the application of the wage index adjustment and send the notice to CMS.

The burden associated with this requirement is estimated to be 30 minutes per hospital. Therefore, we estimate it would take 5 total annual hours (30 minutes × 10 hospitals seeking a waiver).

Section 412.234 Criteria for All Hospitals in an Urban County Seeking Redesignation to Another Urban Area

In summary, this section outlines the requirements for determining an urban hospital's redesignation to another urban area. This section states that hospitals must submit appropriate wage data to the fiscal intermediary as outlined.

We are proposing to revise this section. However, the collection requirement remains the same. While this requirement is subject to the PRA, this requirement is currently approved in OMB No.0938–0907, with a current expiration date of December 31, 2005.

Section 413.70 Payment for Services of a CAH

In summary, this section outlines the requirements for a CAH to make an election to be paid for outpatient facility services plus the fee schedule for professional services under an optional single payment method. This section states that a CAH may make this election in any cost reporting period. This election must be made in writing, made on an annual basis, and delivered to the fiscal intermediary servicing the CAH at least 30 days before the start of each affected cost reporting period.

We are proposing to revise this section. However, the collection requirement remains the same. While this requirement is subject to the PRA, this requirement is currently approved in OMB No. 0938–0050, with a current expiration date of November 30, 2005.

Section 413.78 Direct GME Payments: Determinations of the Total Number of FTE Residents

In summary, this section outlines the requirements for the determination of the total number of FTE residents in determining direct GME payments to hospitals. Currently, this section states that, for residents who spend time in nonprovider settings, there must be a written agreement between the hospital and the outside entity that states that the resident's compensation for training time spent outside of the hospital setting is to be paid by the hospital. This section proposes to remove the written agreement requirement.

This requirement is exempt from the PRA in accordance with Public Law 99–272 or Public Law 108–173, or both.

Section 413.79 Direct GME Payments: Determination of the Weighted Number of FTE Residents

In summary, this section outlines the requirements for the determination of the weighted number of FTE residents for direct GME payments to hospitals. This section proposes that a hospital seeking an adjustment to the limit on its unweighted resident count under section 422 of Public Law 108–173 must provide documentation justifying the adjustment. In addition, the section states that a hospital wishing to receive a temporary adjustment to its FTE resident cap because it is participating in a Medicare GME affiliated group must submit the Medicare GME affiliation agreement to the CMS fiscal intermediary and to CMS's Central Office. This section specifies the information that a request must contain.

These requirements are exempt from the PRA in accordance with Public Law 99–272 or Public Law 108–173, or both.

Section 413.80 Determination of Weighting Factors for Foreign Medical Graduates

In summary, this section specifies the information that a hospital must submit to the fiscal intermediary to include foreign medical graduates in its FTE count for a particular cost reporting period.

This requirement is exempt from the PRA in accordance with Public Law 99–272 or Public Law 108–173, or both.

Section 413.83 Adjustment of a Hospital's Target Amount or Prospective Payment Hospital-Specific Rate

In summary, this section outlines the requirements for seeking an adjustment to the hospital's target amount or hospital-specific rate. This section states that a hospital may request that the intermediary review the classification of operating costs that were previously misclassified for purposes of adjusting the hospital's target amount or hospital-specific rate. A hospital's request for review must include sufficient documentation demonstrating that an adjustment is warranted. This section also specifies the terms in which the information should be provided.

This requirement is exempt from the PRA in accordance with Public Law 99–272 or Public Law 108–173, or both.

Section 480.106 Exceptions to QIO Notice Requirements

In summary, we are proposing to revise this section to add exceptions to the notice requirements for disclosure of QIO information to any person, agency, or organization. The notice requirements would not apply if the institution or practitioner has requested, in writing, that the QIO make the disclosure; the institution or practitioner has provided, in writing, consent for the disclosure; or the information is public information.

The burden associated with these requirements is the time and effort for the institution or practitioner to provide a written request that the QIO make the disclosure or consent to the disclosure.

We believe the collection requirements are exempt as defined in 5 CFR 1320.4, information collections conducted or sponsored during the conduct of a criminal or civil action, or during the conduct of an administrative action or investigation, or audit. We also believe the collection requirements to be exempt as defined in 5 CFR 1320.3(c)(4) because we believe this would affect less than 10 persons.

Section 480.133 Disclosure of Information about Practitioners, Reviewers and Institutions

In summary, this section outlines the requirements concerning the disclosure of QIO information about practitioners, reviewers, and institutions. This section states that a QIO may disclose information on a particular practitioner or reviewer at the written request of or with the written consent of that practitioner or reviewer, with the recipient subject to the same rights and responsibilities on redisclosure as the requesting or consenting practitioner or reviewer.

We believe the collection requirements are exempt as defined in 5 CFR 1320.4, information collections conducted or sponsored during the conduct of a criminal or civil action, or during the conduct of an administrative action or investigation, or audit. We also believe the collection requirements to be exempt as defined in 5 CFR 1320.3(c)(4) because we believe this would affect less than 10 persons.

Section 480.140 Disclosure of Quality Review Study Information

In summary, this section outlines the requirements concerning the disclosure of quality review study information. This section states that a QIO may disclose quality review study information with identifiers of particular practitioners or institutions, or both, at the written request of, or with the written consent of, the identified practitioner(s) or institution(s). The consent or request must specify the information that is to be disclosed and the intended recipient of the information. The recipient would be subject to the same rights and responsibilities on redisclosure as the requesting or consenting practitioner or institution.

We believe the collection requirements are exempt as defined in 5 CFR 1320.4, information collections conducted or sponsored during the

conduct of a criminal or civil action, or during the conduct of an administrative action or investigation, or audit. We also believe the collection requirements to be exempt as defined in 5 CFR 1320.3(c)(4) because we believe this would affect less than 10 persons.

Section 482.43 Condition of Participation: Discharge Planning

In summary, this section outlines the requirements of the discharge planning process. This section states that the hospital must include in the discharge plan, a list of HHAs or SNFs that are available to the patient, that participate in the Medicare program, that serve the geographic area, and that request to be listed by the hospital as available and to maintain documentation. This section also specifies other information that the discharge plan must contain.

The burden associated with these requirements is the time and effort for the hospital to provide a list to beneficiaries, for whom home health care or posthospital extended care services are necessary, and document the patient's medical record.

The burden associated with these requirements is estimated to be 5 minutes per hospital per discharge. Therefore, we estimate the total national burden to be 327,684 hours annually to comply with these requirements (652 discharges per hospital per year × 6,031 hospitals × 5 minutes each).

We have submitted a copy of this proposed rule to OMB for its review of the information collection requirements described above. These requirements are not effective until they have been approved by OMB.

If you comment on any of these information collection and record keeping requirements, please mail copies directly to the following:

Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Regulations Development and Issuances Group, Attn: Dawn Willinghan, CMS–1428–P, Room C5–14–03, 7500 Security Boulevard, Baltimore, MD 21244–1850; and Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Brenda Aguilar, CMS Desk Officer.

Comments submitted to OMB may also be e-mailed to the following address: e-mail: *baguilar@omb.eop.gov,* or faxed to OMB at (202) 395–6974.

C. Public Comments

Because of the large number of items of correspondence we normally receive on a proposed rule, we are not able to acknowledge or respond to them individually. However, in preparing the final rule, we will consider all comments concerning the provisions of this proposed rule that we receive by the date and time specified in the **DATES** section of this preamble and respond to those comments in the preamble to that rule.

CROSSWALK OF CONTENTS OF § 413.86

Existing section	Proposed new section.
§ 413.86(a)	§ 413.75(a).
§ 413.86(a)(1)	§ 413.75(a)(1).
§ 413.86(a)(2)	§ 413.75(a)(2).
§ 413.86(b)	§ 413.75(b).
§ 413.86(c)	§ 413.75(c).
§ 413.86(d)	§ 413.76.
§ 413.86(d), introductory text	§ 413.76, introductory text.
§ 413.86(d)(1)	§ 413.76(a).
§ 413.86(d)(2)	§ 413.76(b).
§ 413.86(d)(3)	§ 413.76(c).
§ 413.86(d)(3)(i)	§ 413.76(c)(1).
§ 413.86(d)(3)(ii)	§ 413.76(c)(2).
§ 413.86(d)(3)(iii)	§ 413.76(c)(3).
§ 413.86(d)(3)(iv)	§ 413.76(c)(4).
§ 413.86(d)(3)(v)	§ 413.76(c)(5).
§ 413.86(d)(4)	§ 413.76(d).
§ 413.86(d)(5)	§ 413.76(e).
§ 413.86(d)(5)(i)	§ 413.76(e)(1).
§ 413.86(d)(5)(ii)	§ 413.76(e)(2).
§ 413.86(d)(6)	§ 413.76(f).
§ 413.86(e)	§ 413.77.
§ 413.86(e)(1)	§ 413.77(a).
§ 413.86(e)(1)(i)	§ 413.77(a)(1).
§ 413.86(e)(1)(i)(A)	§ 413.77(a)(1)(i).
§ 413.86(e)(1)(i)(B)	§ 413.77(a)(1)(ii).
§ 413.86(e)(1)(ii)	§ 413.77(a)(2).
§ 413.86(e)(1)(ii)(A)	§ 413.77(a)(2)(i).
§ 413.86(e)(1)(ii)(B)	§ 413.77(a)(2)(ii).
§ 413.86(e)(1)(ii)(C)	§ 413.77(a)(2)(iii).
§ 413.86(e)(1)(iii)	§ 413.77(a)(3).
§ 413.86(e)(1)(iv)	§ 413.77(a)(4).
§ 413.86(e)(1)(v)	§ 413.77(a)(5).
§ 413.86(e)(2), introductory text	§ 413.77(b), introductory text.
§ 413.86(e)(2)(i)	§ 413.77(b)(1).
§ 413.86(e)(2)(ii)	§ 413.77(b)(2).
§ 413.86(e)(3), introductory text	§ 413.77(c), introductory text.
§ 413.86(e)(3)(i)	§ 413.77(c)(1).
§ 413.86(e)(3)(ii)	§ 413.77(c)(2).
§ 413.86(e)(4), introductory text	§ 413.77(d), introductory text—NEW.
§ 413.86(e)(4)(i), introductory text	§ 413.77(d)(1), introductory text.
§ 413.86(e)(4)(i)(A), introductory text	§ 413.77(d)(1)(i), introductory text.
§ 413.86(e)(4)(i)(A)(*1*)	§ 413.77(d)(1)(i)(A).

CROSSWALK OF CONTENTS OF § 413.86—Continued

Existing section	Proposed new section.
§ 413.86(e)(4)(i)(A)(*2*)	§ 413.77(d)(1)(i)(B).
§ 413.86(e)(4)(i)(A)(*3*)	§ 413.77(d)(1)(i)(C).
§ 413.86(e)(4)(i)(B)	§ 413.77(d)(1)(ii).
§ 413.86(e)(4)(ii), introductory text	§ 413.77(d)(2), introductory text—NEW.
§ 413.86(e)(4)(ii)(A)	§ 413.77(d)(2)(i).
§ 413.86(e)(4)(ii)(B)	§ 413.77(d)(2)(ii).
§ 413.86(e)(4)(ii)(C), introductory text	§ 413.77(d)(2)(iii), introductory text.
§ 413.86(e)(4)(ii)(C)(*1*)	§ 413.77(d)(2)(iii)(A).
§ 413.86(e)(4)(ii)(C)(*1*)(*i*)	§ 413.77(d)(2)(iii)(A)(*1*).
§ 413.86(e)(4)(ii)(C)(*1*)(*ii*)	§ 413.77(d)(2)(iii)(A)(*2*).
§ 413.86(e)(4)(ii)(C)(*1*)(*iii*)	§ 413.77(d)(2)(iii)(A)(*3*).
§ 413.86(e)(4)(ii)(C)(*2*), introductory text	§ 413.77(d)(2)(iii)(B), introductory text—NEW.
§ 413.86(e)(4)(ii)(C)(*2*)(*i*)	§ 413.77(d)(2)(iii)(B)(*1*).
§ 413.86(e)(4)(ii)(C)(*2*)(*ii*)	§ 413.77(d)(2)(iii)(B)(*2*).
§ 413.86(e)(4)(ii)(C)(*2*)(*iii*)	§ 413.77(d)(2)(iii)(B)(*3*)—NEW.
§ 413.86(e)(4)(ii)(C)(*2*)(*iv*)	§ 413.77(d)(2)(iii)(B)(*4*)—NEW.
	§ 413.77(d)(2)(iiii)(B)(*5*)—NEW.
§ 413.86(e)(4)(ii)(C)(*3*)	§ 413.77(d)(2)(iii)(C)—NEW.
§ 413.86(e)(5)	§ 413.77(e).
§ 413.86(e)(5)(i)	§ 413.77(e)(1).
§ 413.86(e)(5)(i)(A)	§ 413.77(e)(1)(i).
§ 413.86(e)(5)(i)(B), introductory text	§ 413.77(e)(1)(ii), introductory text.
§ 413.86(e)(5)(i)(B)(*1*)	§ 413.77(e)(1)(ii)(A).
§ 413.86(e)(5)(i)(B)(*2*)	§ 413.77(e)(1)(ii)(B).
§ 413.86(e)(5)(i)(C)	§ 413.77(e)(1)(iii).
§ 413.86(e)(5)(ii)	§ 413.77(e)(2).
§ 413.86(e)(5)(iii)	§ 413.77(e)(3).
	§ 413.77(f)—NEW.
§ 413.86(f)	§ 413.78.
§ 413.86(f), introductory text	§ 413.78, introductory text.
§ 413.86(f)(1)	§ 413.78(a).
§ 413.86(f)(2)	§ 413.78(b).
§ 413.86(f)(3), introductory text	§ 413.78(c), introductory text.
§ 413.86(f)(3)(i)	§ 413.78(c)(1).
§ 413.86(f)(3)(ii)	§ 413.78(c)(2).
§ 413.86(f)(4), introductory text	§ 413.78(d), introductory text.
§ 413.86(f)(4)(i)	§ 413.78(d)(1).
§ 413.86(f)(4)(ii)	§ 413.78(d)(2).
§ 413.86(f)(4)(iii)	§ 413.78(d)(3).
§ 413.86(f)(4)(iv)	§ 413.78(d)(4).
	§ 413.78(e), introductory text—NEW.
	§ 413.78(e)(1)—NEW.
	§ 413.78(e)(2)—NEW.
	§ 413.78(e)(3)—NEW.
§ 413.86(g), introductory text	§ 413.79.
§ 413.86(g), introductory text	§ 413.79, introductory text.
§ 413.86(g)(1)	§ 413.79(a).
§ 413.86(g)(1)	§ 413.79(a) introductory text—NEW.
§ 413.86(g)(1)	§ 413.79(a)(1)—NEW.
§ 413.86(g)(1)	§ 413.79(a)(2)—NEW.
§ 413.86(g)(1)	§ 413.79(a)(3)—NEW.
§ 413.86(g)(1)	§ 413.79(a)(4)—NEW.
§ 413.86(g)(1)	§ 413.79(a)(5)—NEW.
§ 413.86(g)(1)(i)	§ 413.79(a)(6).
§ 413.86(g)(1)(ii)	§ 413.79(a)(7).
§ 413.86(g)(1)(iii), introductory text	§ 413.79(a)(8), introductory text.
§ 413.86(g)(1)(iii)(A)	§ 413.79(a)(8)(i).
§ 413.86(g)(1)(iii)(B)	§ 413.79(a)(8)(ii).
§ 413.86(g)(1)(iv)	§ 413.79(a)(9).
§ 413.86(g)(2)	§ 413.79(b)(1).
§ 413.86(g)(3)	§ 413.79(b)(2).
	§ 413.79(c)(1), introductory text—NEW.
	§ 413.79(c)(1)(i) through (iii)—NEW.
§ 413.86(g)(4), introductory text	§ 413.79(c)(2), introductory text.
§ 413.86(g)(4)(i)	§ 413.79(c)(2)(i).
§ 413.86(g)(4)(ii)	§ 413.79(c)(2)(ii).
§ 413.86(g)(4)(iii)	§ 413.79(c)(2)(iii).
§ 413.86(g)(4)(iv)	§ 413.79(c)(2)(iv).
§ 413.86(g)(4)(v)	§ 413.79(c)(2)(v).
	§ 413.79(c)(3)(i) through (ii)—NEW.
	§ 413.79(c)(4)—NEW.
	§ 413.79(c)(5)—NEW.

CROSSWALK OF CONTENTS OF § 413.86—Continued

Existing section	Proposed new section.
§ 413.86(g)(5), introductory text	§ 413.79(d), introductory text.
§ 413.86(g)(5)(i)	§ 413.79(d)(1).
§ 413.86(g)(5)(ii)	§ 413.79(d)(2).
§ 413.86(g)(5)(iii)	§ 413.79(d)(3).
§ 413.86(g)(5)(iv)	§ 413.79(d)(4).
§ 413.86(g)(5)(v)	§ 413.79(d)(5).
§ 413.86(g)(5)(vi)	§ 413.79(d)(6).
§ 413.86(g)(5)(vii)	§ 413.79(d)(7).
§ 413.86(g)(6), introductory text	§ 413.79(e), introductory text.
§ 413.86(g)(6)(i)	§ 413.79(e)(1).
§ 413.86(g)(6)(i)(A)	§ 413.79(e)(1)(i).
§ 413.86(g)(6)(i)(B)	§ 413.79(e)(1)(ii).
§ 413.86(g)(6)(i)(C)	§ 413.79(e)(1)(iii).
§ 413.86(g)(6)(i)(D)	§ 413.79(e)(1)(iv).
§ 413.86(g)(6)(i)(E)	§ 413.79(e)(1)(v).
§ 413.86(g)(6)(ii), introductory text	§ 413.79(e)(2), introductory text.
§ 413.86(g)(6)(ii)(A)	§ 413.79(e)(2)(i).
§ 413.86(g)(6)(ii)(B)	§ 413.79(e)(2)(ii).
§ 413.86(g)(6)(iii)	§ 413.79(e)(3).
§ 413.86(g)(6)(iv)	§ 413.79(e)(4).
§ 413.86(g)(7)	§ 413.79(f).
§ 413.86(g)(7)(i)	§ 413.79(f)(1).
§ 413.86(g)(7)(ii)	§ 413.79(f)(2).
§ 413.86(g)(7)(iii)	§ 413.79(f)(3).
§ 413.86(g)(7)(iv)	§ 413.79(f)(4).
§ 413.86(g)(7)(v)	§ 413.79(f)(5).
§ 413.86(g)(8), introductory text	§ 413.79(g), introductory text.
§ 413.86(g)(8)(i), introductory text	§ 413.79(g)(1), introductory text.
§ 413.86(g)(8)(i)(A)	§ 413.79(g)(1)(i).
§ 413.86(g)(8)(i)(B)	§ 413.79(g)(1)(ii).
§ 413.86(g)(8)(ii)	§ 413.79(g)(2).
§ 413.86(g)(8)(iii)	§ 413.79(g)(3).
§ 413.86(g)(8)(iv)	§ 413.79(g)(4).
§ 413.86(g)(8)(v)	§ 413.79(g)(5).
§ 413.86(g)(9)	§ 413.79(h).
§ 413.86(g)(9)(i), introductory text	§ 413.79(h)(1), introductory text.
§ 413.86(g)(9)(i)(A)	§ 413.79(h)(1)(i).
§ 413.86(g)(9)(i)(B)	§ 413.79(h)(1)(ii).
§ 413.86(g)(9)(ii), introductory text	§ 413.79(h)(2), introductory text.
§ 413.86(g)(9)(ii)(A)	§ 413.79(h)(2)(i).
§ 413.86(g)(9)(ii)(B)	§ 413.79(h)(2)(ii).
§ 413.86(g)(9)(iii), introductory text	§ 413.79(h)(3), introductory text.
§ 413.86(g)(9)(iii)(A), introductory text	§ 413.79(h)(3)(i), introductory text.
§ 413.86(g)(9)(iii)(A)(*1*)	§ 413.79(h)(3)(i)(A).
§ 413.86(g)(9)(iii)(A)(*2*)	§ 413.79(h)(3)(i)(B).
§ 413.86(g)(9)(iii)(B), introductory text	§ 413.79(h)(3)(ii), introductory text.
§ 413.86(g)(9)(iii)(B)(*1*)	§ 413.79(h)(3)(ii)(A).
§ 413.86(g)(9)(iii)(B)(*2*)	§ 413.79(h)(3)(ii)(B).
§ 413.86(g)(10), introductory text	§ 413.79(i), introductory text.
§ 413.86(g)(10)(i)	§ 413.79(i)(1).
§ 413.86(g)(10)(ii)	§ 413.79(i)(2).
§ 413.86(g)(10)(iii)	§ 413.79(i)(3).
§ 413.86(g)(11), introductory text	§ 413.79(j), introductory text.
§ 413.86(g)(11)(i)	§ 413.79(j)(1).
§ 413.86(g)(11)(ii)	§ 413.79(j)(2).
§ 413.86(g)(11)(iii)	§ 413.79(j)(3).
§ 413.86(g)(12), introductory text	§ 413.79(k), introductory text.
§ 413.86(g)(12)(i), introductory text	§ 413.79(k)(1), introductory text.
§ 413.86(g)(12)(i)(A)	§ 413.79(k)(1)(i).
§ 413.86(g)(12)(i)(B)	§ 413.79(k)(1)(ii).
§ 413.86(g)(12)(ii), introductory text	§ 413.79(k)(2), introductory text.
§ 413.86(g)(12)(ii)(A)	§ 413.79(k)(2)(i).
§ 413.86(g)(12)(ii)(B), introductory text	§ 413.79(k)(2)(ii), introductory text.
§ 413.86(g)(12)(ii)(B)(*1*), introductory text	§ 413.79(k)(2)(ii)(A), introductory text.
§ 413.86(g)(12)(ii)(B)(*1*)(*i*)	§ 413.79(k)(2)(ii)(A)(*1*).
§ 413.86(g)(12)(ii)(B)(*1*)(*ii*)	§ 413.79(k)(2)(ii)(A)(*2*).
§ 413.86(g)(12)(ii)(B)(*2*)	§ 413.79(k)(2)(ii)(B).
§ 413.86(g)(12)(iii)	§ 413.79(k)(3).
§ 413.86(g)(12)(iv), introductory text	§ 413.79(k)(4), introductory text.
§ 413.86(g)(12)(iv)(A)	§ 413.79(k)(4)(i).
§ 413.86(g)(12)(iv)(B), introductory text	§ 413.79(k)(4)(ii), introductory text.
§ 413.86(g)(12)(iv)(B)(*1*)	§ 413.79(k)(4)(ii)(A).

CROSSWALK OF CONTENTS OF § 413.86—Continued

Existing section	Proposed new section.
§ 413.86(g)(12)(iv)(B)(*2*)	§ 413.79(k)(4)(ii)(B).
§ 413.86(g)(12)(v), introductory text	§ 413.79(k)(5), introductory text.
§ 413.86(g)(12)(v)(A)	§ 413.79(k)(5)(i).
§ 413.86(g)(12)(v)(B)	§ 413.79(k)(5)(ii).
§ 413.86(g)(12)(v)(C)	§ 413.79(k)(5)(iii).
§ 413.86(g)(12)(vi)	§ 413.79(k)(6).
§ 413.86(g)(13)	§ 413.79(l).
§ 413.86(h)	§ 413.80.
§ 413.86(h)(1), introductory text	§ 413.80(a), introductory text.
§ 413.86(h)(1)(i)	§ 413.80(a)(1).
§ 413.86(h)(1)(ii)	§ 413.80(a)(2).
§ 413.86(h)(2)	§ 413.80(b).
§ 413.86(h)(3)	§ 413.80(c).
§ 413.86(h)(4)	§ 413.80(d).
§ 413.86(h)(5)	§ 413.80(e).
§ 413.86(h)(6)	§ 413.80(f).
§ 413.86(i)	§ 413.81.
§ 413.86(i)(1), introductory text	§ 413.81(a), introductory text.
§ 413.86(i)(1)(i)	§ 413.81(a)(1).
§ 413.86(i)(1)(ii)	§ 413.81(a)(2).
§ 413.86(i)(2)	§ 413.81(b).
§ 413.86(i)(3)(i)	§ 413.81(c)(1).
§ 413.86(i)(3)(ii)	§ 413.81(c)(2).
§ 413.86(j), introductory text	§ 413.80(g), introductory text.
§ 413.86(j)(1)	§ 413.80(g)(1).
§ 413.86(j)(2)	§ 413.80(g)(2).
§ 413.86(j)(3)	§ 413.80(g)(3).
§ 413.86(j)(4)	§ 413.80(g)(4).
§ 413.86(j)(5)	§ 413.80(g)(5).
§ 413.86(j)(6)	§ 413.80(g)(6).
§ 413.86(j)(7)	§ 413.80(g)(7).
§ 413.86(k)	§ 413.82.
§ 413.86(k)(1)	§ 413.82(a).
§ 413.86(k)(2)	§ 413.82(b).
§ 413.86(k)(3)	§ 413.82(c).
§ 413.86(l)	§ 413.83.
§ 413.86(l)(1)	§ 413.83(a).
§ 413.86(l)(1)(i)	§ 413.83(a)(1).
§ 413.86(l)(1)(ii)	§ 413.83(a)(2).
§ 413.86(l)(2)(iii)	§ 413.83(a)(3).
§ 413.86(l)(2)	§ 413.83(b).
§ 413.86(l)(2)(i)	§ 413.83(b)(1).
§ 413.86(l)(2)(ii)	§ 413.83(b)(2).
§ 413.86(l)(2)(iii)	§ 413.83(b)(3).

Note to Readers: Proposed redesignated §§ 413.77, 413.78 and 413.79 are the only three sections of the proposed redesignated §§ 413.75 through 413.83 that contain proposed policy changes, as discussed in section IV. O. of the preamble of this proposed rule. Therefore, we will only consider public comments on the following paragraphs of the proposed redesignated sections:

- Sections 413.77(d) introductory text, (d)(2), (d)(2)(iii)(B), (d)(2)(iii)(B)(*3*), (d)(2)(iii)(B)(*4*), (d)(2)(iii)(B)(*5*), (d)(2)(iii)(C), and (f).
- Sections 413.78(e), (e)(1), (e)(2), and (e)(3).
- Section 413.79(a), (c)(1), (c)(2), (c)(3), (c)(4), and (c)(5).

The remaining portions of the proposed redesignated §§ 413.75 through 413.83 contain only coding, cross-reference, and conforming redesignation changes. For these remaining portions, we will consider comments on redesignation, coding, and cross-reference changes only.

List of Subjects

42 CFR Part 403

Health insurance, Hospitals, Incorporation by reference, Intergovernmental relations, Medicare, Reporting and recordkeeping requirements.

2 CFR Part 412

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

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 418

Health facilities, Hospice care, Incorporation by reference, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 460

Aged, Health, Incorporation by reference, Medicare, Medicaid, Reporting and recordkeeping requirements.

42 CFR Part 480

Medicare Program; Utilization and quality control, Quality Improvement Organizations (QIOs).

42 CFR Part 482

Grant program-health, Hospitals, Medicaid, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 483

Grant program-health, Health facilities, Health professions, Health records, Medicaid, Medicare, Nursing

homes, Nutrition, Reporting and recordkeeping requirements, Safety.

42 CFR Part 485

Grant programs-health, Health facilities, Medicaid, Medicare, Reporting and record keeping requirements.

42 CFR Part 489

Health facilities, Medicare, Reporting and record keeping requirements.

For the reasons stated in the preamble of this proposed rule, the Centers for Medicare & Medicaid Services is proposing to amend 42 CFR chapter IV as follows:

A. Part 403 is amended as follows:

PART 403—SPECIAL PROGRAMS AND PROJECTS

1. The authority citation for part 403 continues to read as follows:

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

2. Section 403.744 is amended by—

A. Revising paragraph (a)(1).

B. Revising paragraph (c).

C. Removing paragraph (c)(1) and paragraph (c)(2).

The revision reads as follows:

§ 403.744 Condition of Participation: Life safety from fire.

(a) *General.* An RNHCI must meet the following conditions:

(1) Except as otherwise provided in this section—

(i) The RNHCI must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101® 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD and at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: *http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.* Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the **Federal Register** to announce the changes.

(ii) Chapter 19.3.6.3.2, exception number 2 of the adopted Life Safety Code does not apply to an RNHCI.

* * * * *

(c) *Phase-in period.* Beginning March 13, 2006, an RNHCI must be in compliance with Chapter 19.2.9, Emergency Lighting. Beginning March 13, 2006, Chapter 19.3.6.3.2, exception number 2 does not apply to RNHCIs.

B. Part 412 is amended 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 412.2 is amended by adding a new paragraph (b)(3) to read as follows:

§ 412.2 Basis for payment.

* * * * *

(b) *Payment in full.*

* * * * *

(3) If a patient is admitted to an acute care hospital and then the acute care hospital meets the criteria at § 412.23(e) to be paid as a LTCH, during the course of the patient's hospitalization, Medicare considers all the days of the patient stay in the facility (days prior to and after the designation of LTCH status) to be a single episode of LTCH care. Medicare will not make payment under subpart H for any part of the hospitalization. Payment for the entire patient stay (days prior to and after the designation of LTCH status) will be made in accordance with the requirements specified in § 412.521. The requirements of this paragraph (b)(3) apply only to a patient stay in which a patient is in an acute care hospital and that hospital is designated as a LTCH on or after October 1, 2004.

* * * * *

3. Section 412.4 is amended by revising paragraph (d) to read as follows:

§ 412.4 Discharges and transfers.

* * * * *

(d) *Qualifying DRGs.*

(1) For purposes of paragraph (c) of this section, and subject to the provisions of paragraph (d)(2) of this section, the qualifying DRGs must meet the following criteria for both of the 2 most recent fiscal years for which data are available:

(i) The DRG must have a geometric mean length of stay of at least 3 days.

(ii) The DRG must have at least 14,000 cases identified as postacute care transfer cases.

(iii) The DRG must have at least 10 percent of the postacute care transfers occurring before the geometric mean length of stay for the DRG.

(iv) If the DRG is one of a paired DRG based on the presence or absence of a comorbidity or complication, one of the DRGs meets the criteria specified under paragraphs (d)(1)(i) through (d)(1)(iii) of this section.

(v) To initially qualify, the DRG must meet the criteria specified in paragraphs(d)(1)(i) through (d)(1)(iv) of this section and must have a decline in the geometric mean length of stay for the DRG during the most recent 5-year period of at least 7 percent. Once a DRG initially qualifies, the DRG is subject to the criteria specified under paragraphs (d)(1)(i) through (d)(1)(iv) of this section for each subsequent fiscal year.

(2) Effective October 1, 2004, if a DRG fails to meet the qualifying criteria under paragraph (d)(1) of this section, the qualifying DRG must meet the following criteria for both of the 2 most recent fiscal years for which data are available:

(i) The DRG must have a geometric mean length stay of at least 3 days.

(ii) The DRG must have at least 5,000 cases identified as postacute care transfer cases.

(iii) The DRG must have a percentage of the postacute care transfer cases occurring before the geometric mean length of stay of at least 2 standard deviations above the geometric mean length of stay across all DRGs.

(iv) If the DRG is one of a paired DRG based on the presence or absence of a comorbidity or complication, one of the DRGs meets the criteria specified under paragraph (d)(2)(i) through (d)(2)(iii) of this section.

(v) To initially qualify, the DRG meets the criteria specified in paragraph (d)(2)(i) through (d)(2)(iv) of this section and must either have experienced a decline in its geometric mean length of stay during the most recent 5-year period of at least 7 percent, or contain only cases that would have been included in a DRG to which the policy applied in the prior year. Once a DRG initially qualifies, the DRG is subject to the criteria specified under paragraphs (d)(2)(i) through (d)(2)(iv) for each subsequent fiscal year.

* * * * *

4. Section 412.22 is amended by—

A. Adding a sentence at the end of paragraph (a).

B. Revising paragraph (e).

The addition and revision read as follows:

§ 412.22 Excluded hospitals and hospital units: General rules.

(a) *Criteria.* * * * For purposes of this subpart, the term ''hospital'' includes a critical access hospital (CAH).

* * * * *

(e) *Hospitals-within-hospitals.* Except as provided in paragraph (f) of this section, a hospital that occupies space in a building also used by another hospital, or in one or more separate buildings located on the same campus as buildings used by another hospital, must meet the following criteria in order to be excluded from the prospective payment systems specified in § 412.1(a)(1):

(1) For cost reporting periods beginning on or after October 1, 1987, and before October 1, 2004—

(i) *Separate governing body.* The hospital has a governing body that is separate from the governing body of the hospital occupying space in the same building or on the same campus. The hospital's governing body is not under the control of the hospital occupying space in the same building or on the same campus, or of any third entity that controls both hospitals.

(ii) *Separate chief medical officer.* The hospital has a single chief medical officer who reports directly to the governing body and who is responsible for all medical staff activities of the hospital. The chief medical officer of the hospital is not employed by or under contract with either the hospital occupying space in the same building or on the same campus or any third entity that controls both hospitals.

(iii) *Separate medical staff.* The hospital has a medical staff that is separate from the medical staff of the hospital occupying space in the same building or on the same campus. The hospital's medical staff is directly accountable to the governing body for the quality of medical care provided in the hospital, and adopts and enforces by laws governing medical staff activities, including criteria and procedures for recommending to the governing body the privileges to be granted to individual practitioners.

(iv) *Chief executive officer.* The hospital has a single chief executive officer through whom all administration authority flows, and who exercises control and surveillance over all administrative activities of the hospital. The chief executive officer is not employed by, or under contract with, either the hospital occupying space in the same building or on the same campus or any third entity that controls both hospitals.

(v) *Performance of basic hospital functions.* The hospital meets one of the following criteria:

(A) The hospital performs the basic functions specified in §§ 482.21 through 482.27, 482.30, 482.42, 482.43, and 482.45 of this chapter through the use of employees or under contracts or other agreements with entities other than the hospital occupying space in the same building or on the same campus, or a third entity that controls both hospitals. Food and dietetic services and housekeeping, maintenance, and other services necessary to maintain a clean and safe physical environment could be obtained under contracts or other agreements with the hospital occupying space in the same building or on the same campus, or with a third entity that controls both hospitals.

(B) For the same period of at least 6 months used to determine compliance with the criterion regarding the age of patients in § 412.23(d)(2) or the length-of-stay criterion in § 412.23(e)(2), or for hospitals other than children's or long-term care hospitals, for a period of at least 6 months immediately preceding the first cost reporting period for which exclusion is sought, the cost of the services that the hospital obtains under contracts or other agreements with the hospital occupying space in the same building or on the same campus, or with a third entity that controls both hospitals, is no more than 15 percent of the hospital's total inpatient operating costs, as defined in § 412.2(c). For purposes of this paragraph (e)(1)(v)(B), however, the costs of preadmission services are those specified under § 413.40(c)(2) rather than those specified under § 412.2(c)(5).

(C) For the same period of at least 6 months used to determine compliance with the criterion regarding the age of inpatients in § 412.23(d)(2) or the length-of-stay criterion in § 412.23(e)(2), or for hospitals other than children's or long-term care hospitals, for the period of at least 6 months immediately preceding the first cost reporting period for which exclusion is sought, the hospital has an inpatient population of whom at least 75 percent were referred to the hospital from a source other than another hospital occupying space in the same building or on the same campus.

(2) Effective for cost reporting periods beginning on or after October 1, 2004, the hospital must meet the following:

(i) *Governance and control requirements.* The hospital meets the criteria under paragraphs (e)(1)(i) through (e)(1)(iv) of this section.

(ii) *Ownership interest and control.* The hospital must not be owned, wholly or in part, by a person or party that has any ownership interest in the hospital occupying space in the same building or on the same campus, or of any third party entity that controls both hospitals. However, hospitals that were excluded from the prospective payment systems specified in § 412.1(a) as of June 30, 2004, will be deemed to these criteria.

(iii) *Admissions criteria.* For the same period of at least 6 months used to determine compliance with the criterion regarding the age of inpatients in § 412.23(d)(2) or the length-of-stay criterion in § 412.23(e)(2), or for hospitals other than children's or long-term care hospitals, for the period of at least 6 months immediately preceding the first cost reporting period for which exclusion is sought, the hospital has an inpatient population of whom at least 75 percent were referred to the hospital from a source other than another hospital occupying space in the same building or on the same campus.

(3) *Notification of co-located status.* A long-term care hospital that occupies space in a building used by another hospital, or in one or more separate buildings located on the same campus as buildings used by another hospital that meets the criteria of (e)(1) or (e)(2) of this section must notify its fiscal intermediary and CMS in writing of its co-location within 60 days of its first cost reporting period that begins on or after October 1, 2002.

* * * * *

5. Section 412.25 is amended by adding a new paragraph (g), to read as follows:

§ 412.25 Excluded hospital units: Common requirements.

* * * * *

(g) *CAH units not meeting applicable requirements.* If a psychiatric or rehabilitation unit of a CAH does not meet the requirements of § 485.645 with respect to a cost reporting period, no payment may be made to the CAH for services furnished in that unit for that period. Payment to the CAH for services in the unit may resume only after the unit has demonstrated to CMS that the unit meets the requirements of § 485.645.

6. Section 412.63 is amended by—

A. Revising the heading of the section.

B. Revising paragraph (a).

C. Adding introductory text to paragraph (b).

D. Revising paragraph (c)(1), (c)(5), and (c)(6)

E. Revising paragraph (u).

The revisions and addition read as follow:

§ 412.63 Federal rates for inpatient operating costs for Federal fiscal years 1984 through 2004.

(a) *General rule.* (1) CMS determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in Federal fiscal years 1985 through 2004 involving inpatient hospital service of a hospital in the United States, subject to the PPS, and determines a regional adjusted PPS rate for operating costs for such discharges in each region for which payment may be made under Medicare Part A.

(2) Each such rate is determined for hospitals located in urban or rural areas within the United States and within each such region, respectively, as described under paragraphs (b) through (u) of this section.

* * * * *

(b) *Geographic classifications.* Effective for fiscal years 1985 through 2004, the following rules apply.

* * * * *

(c) *Updating previous standardized amounts.* (1) For discharges occurring in fiscal year 1985 through fiscal year 2003, CMS computes average standardized amounts for hospitals in urban areas and rural areas within the United States, and in urban areas and rural areas within each region. For discharges occurring in fiscal year 2004, CMS computes an average standardized amount for hospitals located in all areas.

* * * * *

(5) For fiscal years 1987 through 2004, CMS standardizes the average standardized amounts by excluding an estimate of indirect medical education payments.

(6) For fiscal years 1988 through 2003, CMS computes average standardized amounts for hospitals located in large urban areas, other urban areas, and rural areas. The term *large urban area* means an MSA with a population of more than 1,000,000 or an NECMA, with a population of more than 970,000 based on the most recent available population data published by the Census Bureau. For fiscal year 2004, CMS computes an average standardized amount for hospitals located in all areas.

* * * * *

(u) *Applicable percentage change for fiscal year 2004.* The applicable percentage change for fiscal year 2004 is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this subchapter) for hospitals in all areas.

* * * * *

7. A new § 412.64 is added to Subpart D to read as follows:

§ 412.64 Federal rates for inpatient operating costs for Federal fiscal year 2005 and subsequent fiscal years.

(a) *General rule.* CMS determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in Federal fiscal year 2005 and subsequent fiscal years involving inpatient hospital services of a hospital in the United States subject to the prospective payment system for which payment may be made under Medicare Part A.

(b) *Geographic classifications.* (1) For purposes of this section, the following definitions apply:

(i) The term *region* means one of the 9 metropolitan divisions comprising the 50 States and the District of Columbia, established by the Executive Office of Management and Budget for statistical and reporting purposes.

(ii) The term *urban area* means—

(A) A Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget; or

(B) The following New England counties, which are deemed to be parts of urban areas under section 601(g) of the Social Security Amendments of 1983 (Public Law 98–21, 42 U.S.S. 1395ww (note)): Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island.

(C) The term *rural area* means any area outside an urban area.

(D) The phrase *hospital reclassified as rural* means a hospital located in a county that, in FY 2004, was part of an MSA, but was redesignated as rural after September 30, 2004, as a result of the most recent census data and implementation of the new MSA definitions announced by OMB on June 6, 2003.

(2) For hospitals within an MSA that crosses census division boundaries, the MSA is deemed to belong to the census division in which most of the hospitals within the MSA are located.

(3) For discharges occurring on or after October 1, 2004, a hospital located in a rural county adjacent to one or more urban areas is deemed to be located in an urban area and receives the Federal payment amount for the urban area to which the greater number of workers in the county commute if the rural county would otherwise be considered part of an urban area, under the standards for designating MSAs if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or central counties of all adjacent MSAs. These EOMB standards are set forth in the notice of final revised standards for classification of MSAs published in the **Federal Register** on December 27, 2000 (65 FR 82228), announced by EOMB on June 6, 2003, and available from CMS, 7500 Security Boulevard, Baltimore, Maryland 21244.

(4) For purposes of this section, any change in an MSA designation is recognized on October 1 following the effective date of the change. Such a change in MSA designation may occur as a result of redesignation of an MSA by the Executive Office of Management and Budget.

(c) *Computing the standardized amount.* CMS computes an average standardized amount that is applicable to all hospitals located in all areas, updated by the applicable percentage increase specified in paragraph (d) of this section.

(d) *Applicable percentage change for fiscal year 2005 and for subsequent fiscal years.*

(1) Subject to the provisions of paragraph (d)(2) of this section, the applicable percentage change for fiscal year 2005 and for subsequent years for updating the standardized amount is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this subchapter) for hospitals in all areas.

(2) For fiscal years 2005, 2006, and 2007, the applicable percentage change specified in paragraph (d)(1) of this section is reduced by 0.4 percentage points in the case of a ''subsection (d) hospital,'' as defined under section 1886(d)(1)() of the Act, that does not submit quality data on a quarterly basis to CMS, as specified by CMS. Any reduction of the percentage change will apply only to the fiscal year involved and will not be taken into account in computing the applicable percentage increase for a subsequent fiscal year.

(e) *Maintaining budget neutrality.* (1) CMS makes an adjustment to the standardized amount to ensure that—

(i) Changes to the DRG classifications and recalibrations of the DRG relative weights are made in a manner so that aggregate payments to hospitals are not affected; and

(ii) The annual updates and adjustments to the wage index under paragraph (h) of this section are made in a manner that ensures that aggregate payments to hospitals are not affected.

(2) CMS also makes an adjustment to the rates to ensure that aggregate payments after implementation of reclassifications under subpart L of this part are equal to the aggregate prospective payments that would have

been made in the absence of these provisions.

(f) *Adjustment for outlier payments.* CMS reduces the adjusted average standardized amount determined under paragraph (c) through (e) of this section by a proportion equal to the proportion estimated by CMS) to the total amount of payments based on DRG prospective payment rates that are additional payments for outlier cases under subpart F of this part.

(g) *Computing Federal rates for inpatient operating costs for hospitals located in all areas.* For each discharge classified within a DRG, CMS establishes for the fiscal year a national prospective payment rate for inpatient operating costs based on the standardized amount for the fiscal year and the weighting factor determined under § 412.60(b) for that DRG.

(h) *Adjusting for different area wage levels.* CMS adjusts the proportion of the Federal rate for inpatient operating costs that are attributable to wages and labor-related costs for area differences in hospital wage levels by a factor (established by CMS based on survey data) reflecting the relative level of hospital wages and wage-related costs in the geographic area (that is, urban or rural area as determined under the provisions of paragraph (b) of this section) of the hospital compared to the national average level of hospital wages and wage-related costs. The adjustment described in this paragraph (h) also takes into account the earnings and paid hours of employment by occupational category.

(1) The wage index is updated annually.

(2) CMS determines the proportion of the Federal rate that is attributable to wages and labor-related costs from time to time, employing a methodology that is described in the annual regulation updating the system of payment for inpatient hospital operating costs.

(3) For discharges occurring on or after October 1, 2004, CMS employs 62 percent as the proportion of the rate that is adjusted for the relative level of hospital wages and wage-related costs, unless employing that percentage would result in lower payments for the hospital than employing the proportion determined under the methodology described in paragraph (h)(2) of this section.

(i) *Adjusting the wage index to account for commuting patterns of hospital workers.*

(1) *General criteria.* For discharges occurring on or after October 1, 2004, CMS adjusts the hospital wage index for hospitals located in qualifying counties to recognize the commuting patterns of hospital employees. A qualifying county is a county that meets all of the following criteria:

(i) Hospital employees in the county commute to work in an MSA (or MSAs) with a wage index (or wage indices) higher than the wage index of the MSA or rural statewide area in which the county is located.

(ii) At least 10 percent of the county's hospital employees commute to an MSA (or MSAs) with a higher wage index (or wage indices).

(iii) The 3-year average hourly wage of the hospital(s) in the county equals or exceeds the 3-year average hourly wage of all hospitals in the MSA or rural statewide area in which the county is located.

(2) *Amount of adjustment.* A hospital located in a county that meets the criteria under paragraphs (i)(l)(i) through (i)(1)(iii) of this section will receive an increase in its wage index that is equal to a weighted average of the difference between the prereclassified wage index of the MSA (or MSAs) with the higher wage index (or wage indices) and the prereclasssified wage index of the MSA or rural statewide area in which the qualifying county is located, weighted by the overall percentage of the hospital employees residing in the qualifying county who are employed in any MSA with a higher wage index.

(3) *Process for determining the adjustment.*

(i) CMS will use the most accurate data available, as determined by CMS, to determine the out-migration percentage for each county.

(ii) CMS will include, in its annual proposed and final notices of updates to the hospital inpatient prospective payment system, a listing of qualifying counties and the hospitals that are eligible to receive the adjustment to their wage indexes for commuting hospital employees, and the wage index increase applicable to each qualifying county.

(iii) Any wage index adjustment made under this paragraph (i) is effective for a period of 3 fiscal years, except that hospitals in a qualifying county may elect to waive the application of the wage index adjustment. A hospital may waive the application of the wage index adjustment by notifying CMS in writing within 45 days after the publication of the annual notice of proposed rulemaking for the hospital inpatient prospective payment system.

(iv) A hospital in a qualifying county that receives a wage index adjustment under this paragraph (g) is not eligible for reclassification under Subpart L of this part.

(j) *Wage index assignment for rural referral centers for FY 2005.*

(1) CMS makes an exception to the wage index assignment of a rural referral center for FY 2005 if the rural referral center meets the following conditions:

(i) The rural referral center was reclassified for FY 2004 by the MGCRB to another MSA, but, upon applying to the MGCRB for FY 2005, was found to be ineligible for reclassification because its average hourly wage was less than 84 percent (but greater than 82 percent) of the average hourly wage of the hospitals geographically located in the MSA to which the rural referral center applied for reclassification for FY 2005.

(ii) The hospital may not qualify for any geographic reclassification under subpart L of this part, effective for discharges occurring on or after October 1, 2004.

(2) CMS will assign a rural referral center that meets the conditions of paragraph (j)(1) of this section the wage index value of the MSA to which it was reclassified by the MGCRB in FY 2004.

(k) *Midyear corrections to the wage index.*

(1) CMS makes a midyear correction to the wage index for an area only if a hospital can show that—

(i) The intermediary or CMS made an error in tabulating its data; and

(ii) The hospital could not have known about the error, or did not have the opportunity to correct the error, before the beginning of the Federal fiscal year.

(2) A midyear correction to the wage index is effective prospectively from the date the change is made to the wage index.

(l) *Judicial decision.* If a judicial decision reverses a CMS denial of a hospital's wage data revision request, CMS pays the hospital by applying a revised wage index that reflects the revised wage data as if CMS's decision had been favorable rather than unfavorable.

8. Section 412.87 is amended by revising paragraph (b)(3) to read as follows:

§ 412.87 Additional payment for new medical services and technologies: General provisions.

* * * * *

(b) *Eligibility criteria.* * * *

(3) The DRG prospective payment rate otherwise applicable to discharges involving the medical service or technology is determined to be inadequate, based on application of a threshold amount to estimated charges incurred with respect to such discharges. To determine whether the

payment would be adequate, CMS will determine whether the charges of the cases involving a new medical service or technology will exceed a threshold amount that is the lesser of 75 percent of the standardized amount (increased to reflect the difference between cost and charges) or 75 percent of one standard deviation beyond the geometric mean standardized charge for all cases in the DRG to which the new medical service or technology is assigned (or the case-weighted average of all relevant DRGs if the new medical service or technology occurs in many different DRGs). Standardized charges reflect the actual charges of a case adjusted by the prospective payment system payment factors applicable to an individual hospital, such as the wage index, the indirect medical education adjustment factor, and the disproportionate share adjustment factor.

§ 412.88 [Amended]

9. Section 412.88 is amended by removing paragraph (c).

10. A new § 412.101 is added to read as follows:

§ 412.101 Special treatment: Inpatient hospital payment adjustment for low-volume hospitals.

(a) *General considerations.*

(1) CMS provides an additional payment to a qualifying hospital for the higher incremental costs associated with a low volume of discharges. The amount of any additional payment for a qualifying hospital is calculated in accordance with paragraph (b) of this section.

(2) In order to qualify for this adjustment, a hospital must have 500 or fewer discharges during the fiscal year, as reflected in its cost report specified in paragraph (a)(3) of this section, and be located more than 25 road miles from the nearest inpatient acute care prospective payment system hospital.

(3) The fiscal intermediary makes the determination of the discharge count for purposes of determining a hospital's qualification for the adjustment and the amount of the adjustment based on the hospital's most recent submitted cost report.

(4) In order to qualify for the adjustment, a hospital must provide its fiscal intermediary with sufficient evidence that it meets the distance requirement specified under paragraph (a)(2) of this section. The fiscal intermediary will base its determination of whether the distance requirement is satisfied upon the evidence presented by the hospital and other relevant evidence, such as maps, mapping software, and inquiries to State and local police, transportation officials, or other government officials.

(b) *Determination of the adjustment amount.* The maximum low-volume adjustment is 25 percent. Each qualifying hospital's low-volume adjustment is calculated as follows: 1.25–(.0005*D), where 0<D≤500 discharges, and 1.25 represents the maximum 25 percent add-on amount, .0005 is the payment adjustment per case (derived by dividing .25 by 500 discharges) and ''D'' is the number of discharges determined under paragraph (a)(3) of this section.

(c) *Eligibility of new hospitals for the adjustment.* A new hospital will be eligible for a low-volume adjustment under this section once it has submitted a cost report for a cost reporting period that indicates that it meets the number of discharge requirement during the fiscal year, as specified in paragraph (a) of this section.

11. Section 412.102 is amended by revising the introductory text to read as follows:

§ 412.102 Special treatment: Hospitals located in areas that are reclassified from urban to rural as a result of a geographic redesignation.

Effective on or after October 1, 1983, a hospital reclassified as rural, as defined in subpart D of this part, may receive an adjustment to its rural Federal payment amount for operating costs for two successive fiscal years.

* * * * *

12. Section 412.103 is amended by revising paragraph (a) introductory text to read as follows:

§ 412.103 Special treatment: Hospitals located in urban areas and that apply for reclassification as rural.

(a) *General criteria.* A prospective payment hospital that is located in an urban area (as defined in subpart D of this part) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:

* * * * *

13. Section 412.104 is amended by revising paragraph (a) to read as follows:

§ 412.104 Special treatment: Hospitals with high percentage of ESRD discharges.

(a) *Criteria for classification.* CMS provides an additional payment to a hospital for inpatient services provided to ESRD beneficiaries who receive a dialysis treatment during a hospital stay, if the hospital has established that ESRD beneficiary discharges, excluding discharges classified into DRG 302 (Kidney Transplant, DRG 316 (Renal Failure), or DRG 317 (Admit for Renal Dialysis), where the beneficiary received dialysis services during the inpatient stay, constitute 10 percent or more of its total Medicare discharges.

* * * * *

14. Section 412.105 is amended by—

A. Revising paragraph (d)(3)(vii).

B. Adding new paragraphs (d)(3)(viii) through (xii).

C. Adding a new paragraph (d)(4).

D. Redesignating the contents of paragraph (e) as paragraph (e)(1) and adding a new paragraph (e)(2).

E. Redesignating the contents of paragraph (f)(1)(iv) as paragraph (f)(1)(iv)(A) and adding new paragraphs (f)(1)(iv)(B) and (f)(1)(iv(C).

F. Adding a sentence at the end of paragraph (f)(1)(v).

Cross-Reference Changes

G. In paragraphs (a), (f), and (g) as indicated in the left column of the table below, remove the cross-reference indicated in the middle column from wherever it appears, and add the cross-reference in the right column:

Section	Remove cross-reference	Add cross-reference.
412.105(a)(1), introductory text	paragraph (f) and (h) of this section	paragraph (f) of this section..
412.105(f)(1)(i)(A)	§ 415.200(a)	§ 415.152..
412.105(f)(1)(ii)(C)	§ 413.86(f)(3) or § 413.86(f)(4)	§ 413.78(c) or § 413.78(d).
412.105(f)(1)(vi)	§ 413.86(b)	§ 413.75(b)..
412.105(f)(1)(vi)	§ 413.86(g)(7)	§ 413.79(f)..
412.105(f)(1)(vii)	§ 413.86(g)(13)	§ 413.79(l)..
412.105(f)(1)(vii)	§§ 413.86(g)(6)(i) through (iv)	§§ 413.79(e)(1) through (e)(4)..
412.105(f)(1)(viii)	§ 413.86(g)(8)	§ 413.79(g)..
412.105(f)(1)(ix)	§§ 413.86(g)(9)(i) and (g)(9)(ii)	§§ 413.79(h)(1) and (h)(2)..

Section	Remove cross-reference	Add cross-reference.
412.105(f)(1)(ix)	§§ 413.86(g)(9)(i) and (g)(9)(iii)(B)	§§ 413.79(h)(1) and (h)(3)(ii)..
412.105(f)(1)(ix)	§§ 413.86(g)(9)(i) and (g)(9)(iii)(A)	§§ 413.79(h)(1) and (h)(3)(i)..
412.105(f)(1)(x)	§ 413.86(g)(13)	§ 413.79(l)..
412.105(f)(1)(x)	§ 413.86(g)(12)	§ 413.79(k)..
412.105(f)(1)(xi)	§ 413.86(g)(10)	§ 413.79(i)..
412.105(f)(1)(xii)	§ 413.86(g)(11)	§ 413.79(j)..
412.105(g)	§§ 413.86(d)(3)(i) through (d)(3)(v)	§§ 413.76(c)(1) through (c)(5).

The revisions and additions read as follows:

§ 412.105 Special treatment: Hospitals that incur indirect costs for graduate medical education programs.

* * * * *

(d) *Determination of education adjustment factor.*

* * * * *

(3) *Step three.* * * *

(vii) For discharges occurring on or after October 1, 2002 and before April 1, 2004, 1.35.

(viii) For discharges occurring on or after April l, 2004 and before October l, 2004, 1.47.

(ix) For discharges occurring during fiscal year 2005, 1.42.

(x) For discharges occurring during fiscal year 2006, 1.37.

(xi) For discharges occurring during fiscal year 2007, 1.32.

(xii) For discharges occurring during fiscal year 2008 and thereafter, 1.35.

(4) For discharges occurring on or after July 1, 2005, with respect to FTE residents added as a result of increases in the FTE resident cap under paragraph (f)(1)(iv)(C) of this section, the factor derived from completing steps one and two is multiplied by 'c', where 'c' is equal to 0.66.

(e) *Determination of payment amount.*

(1) * * *

(2) For discharges occurring on or after July 1, 2005, a hospital that counts additional residents as a result of an increase in its FTE resident cap under paragraph (f)(1)(iv)(C) of this section will receive indirect medical education payments based on the sum of the following two indirect medical education adjustment factors:

(i) An adjustment factor that is calculated using the schedule of formula multipliers in paragraph (d)(3) of this section and the hospital's FTE resident count, not including residents attributable to an increase in its FTE cap under paragraph (f)(1)(iv)(C) under this section; and

(ii) An adjustment factor that is calculated using the applicable formula multiplier under paragraph (d)(4) of this section, and the additional number of FTE residents that are attributable to the increase in the hospital's FTE resident cap under paragraph (f)(1)(iv)(C) in this section.

(f) *Determining the total number of full-time equivalent residents for cost reporting periods beginning on or after July 1, 1991.*

(1) * * *

(iv)(A) * * *

(B) Effective for portions of cost reporting periods beginning on or after July l, 2005, a hospital's otherwise applicable FTE resident cap may be reduced if its reference resident level is less than its otherwise applicable FTE resident cap in a reference cost reporting period, in accordance with the provisions of § 413.79(c)(3) of this subchapter. The reduction is 75 percent of the difference between the otherwise applicable FTE resident cap and the reference resident level.

(C) Effective for portions of cost reporting periods beginning on or after July 1, 2005, a hospital may qualify to receive an increase in its otherwise applicable FTE resident cap (up to 25 additional FTE slots) if the criteria specified in § 413.79(c)(4) of this subchapter are met.

(v) * * * If a hospital increases its FTE count of residents as a result of paragraph (f)(1)(iv)(C) of this section, effective for cost reporting periods beginning on or after July 1, 2005, the FTE residents are included in the hospital's rolling average calculation described in this paragraph (f)(1)(v).

* * * * *

15. Section 412.106 is amended by—

A. In paragraph (a)(1)(iii), removing the cross-reference ''§ 412.62(f)'' and adding in its place ''§ 412.62(f) or § 412.64''.

B. Revising paragraphs (d)(2)(ii), (d)(2)(iii), and (d)(2)(iv) to read as follows:

§ 412.106 Special treatment: Hospitals that serve a disproportionate share of low-income patients.

* * * * *

(d) *Payment adjustment factor.*

* * * * *

(2) *Payment adjustment factors.*

* * * * *

(ii) If the hospital meets the criteria of paragraph (c)(1)(ii) of this section, the payment adjustment factor is equal to one of the following:

(A) If the hospital is classified as a rural referral center—

(*1*) For discharges occurring before April 1, 2001, the payment adjustment factor is 4 percent plus 60 percent of the difference between the hospital's disproportionate patient percentage and 30 percent.

(*2*) For discharges occurring on or after April 2, 2001, and before April 1, 2004, the following applies:

(*i*) If the hospital's disproportionate patient percentage is less than 19.3 percent, the applicable payment adjustment factor is 2.5 percent plus 65 percent of the difference between 15 percent and the hospital's disproportionate patient percentage.

(*ii*) If the hospital's disproportionate patient percentage is greater than 19.3 percent and less than 30 percent, the applicable payment adjustment factor is 5.25 percent.

(*iii*) If the hospital's disproportionate patient percentage is greater than or equal to 30 percent, the applicable payment adjustment factor is 5.25 percent plus 60 percent of the difference between 30 percent and the hospital's disproportionate patient percentage.

(*3*) For discharges occurring on or after April 1, 2004, the following applies:

(*i*) If the hospital's disproportionate patient percentage is less than 20.2 percent, the applicable payment adjustment factor is 2.5 percent plus 65 percent of the difference between 15 percent and the hospital's disproportionate patient percentage.

(*ii*) If the hospital's disproportionate patient percentage is greater than 20.2 percent, the applicable payment adjustment factor is 5.88 percent plus 82.5 percent of the difference between 20.2 percent and the hospital's disproportionate patient percentage.

(B) If the hospital is classified as a sole community hospital—

(*1*) For discharges occurring before April 1, 2001, the payment adjustment factor is 10 percent.

(*2*) For discharges occurring on or after April 1, 2001 and before April 1, 2004, the following applies:

(*i*) If the hospital's disproportionate patient percentage is less than 19.3 percent, the applicable payment adjustment factor is 2.5 percent plus 65 percent of the difference between 15 percent and the hospital's disproportionate patient percentage.

(*ii*) If the hospital's disproportionate patient percentage is equal to or greater than 19.3 percent and less than 30 percent, the applicable payment adjustment factor is 5.25 percent.

(*iii*) If the hospital's disproportionate patient percentage is equal to or greater than 30 percent, the applicable payment adjustment factor is 10 percent.

(*3*) For discharges occurring on or after April 1, 2004, the following applies:

(*i*) If the hospital's disproportionate patient percentage is less than 20.2 percent, the applicable payment adjustment factor is 2.5 percent plus 65 percent of the difference between 15 percent and the hospital's disproportionate patient percentage.

(*ii*) If the hospital's disproportionate patient percentage is greater than 20.2 percent, the applicable payment adjustment factor is 5.88 percent plus 82.5 percent of the difference between 20.2 percent and the hospital's disproportionate patient percentage.

(*iii*) The maximum payment adjustment factor is 12 percent.

(C) If the hospital is classified as both a rural referral center and a sole community hospital, the payment adjustment is—

(*1*) For discharges occurring before April 1, 2001, the greater of—

(*i*) 10 percent; or

(*ii*) 4 percent plus 60 percent of the difference between the hospital's disproportionate patient percentage and 30 percent.

(*2*) For discharges occurring on or after April 1, 2001 and before April 1, 2004, the greater of the adjustments determined under paragraphs (d)(2)(ii)(A) or (d)(2)(ii)(B) of this section.

(*3*) For discharges occurring on or after April 1, 2004, the following applies:

(*i*) If the hospital's disproportionate patient percentage is less than 20.2 percent, the applicable payment adjustment factor is 2.5 percent plus 65 percent of the difference between 15 percent and the hospital's disproportionate patient percentage.

(*ii*) If the hospital's disproportionate patient percentage is greater than 20.2 percent, the applicable payment adjustment factor is 5.88 percent plus 82.5 percent of the difference between 20.2 percent and the hospital's disproportionate patient percentage.

(D) If the hospital is classified as a rural hospital and is not classified as either a sole community hospital or a rural referral center, and has 100 or more beds—

(*1*) For discharges occurring before April 1, 2001, the payment adjustment factor is 4 percent.

(*2*) For discharges occurring on or after April 1, 2001 and before April 1, 2004, the following applies:

(*i*) If the hospital's disproportionate patient percentage is less than 19.3 percent, the applicable payment adjustment factor is 2.5 percent plus 65 percent of the difference between the hospital's disproportionate patient percentage and 15 percent.

(*ii*) If the hospital's disproportionate patient percentage is equal to or greater than 19.3 percent, the applicable payment adjustment factor is 5.25 percent.

(*3*) For discharges occurring on or after April 1, 2004, the following applies:

(*i*) If the hospital's disproportionate patient percentage is less than 20.2 percent, the applicable payment adjustment factor is 2.5 percent plus 65 percent of the difference between 15 percent and the hospital's disproportionate patient percentage.

(*ii*) If the hospital's disproportionate patient percentage is greater than 20.2 percent, the applicable payment adjustment factor is 5.88 percent plus 82.5 percent of the difference between 20.2 percent and the hospital's disproportionate patient percentage.

(*iii*) The maximum payment adjustment factor is 12 percent.

(iii) If the hospital meets the criteria of paragraph (c)(1)(iii) of this section—

(A) For discharges occurring before April 1, 2001, the payment adjustment factor is 5 percent.

(B) For discharges occurring on or after April 1, 2001 and before April 1, 2004, the following applies:

(*1*) If the hospital's disproportionate patient percentage is less than 19.3 percent, the applicable payment adjustment factor is 2.5 percent plus 65 percent of the difference between the hospital's disproportionate patient percentage and 15 percent.

(*2*) If the hospital's disproportionate patient percentage is equal to or greater than 19.3 percent, the applicable payment adjustment factor is 5.25 percent.

(C) For discharges occurring on or after April 1, 2004, the following applies:

(*1*) If the hospital's disproportionate patient percentage is less than 20.2 percent, the applicable payment adjustment factor is 2.5 percent plus 65 percent of the difference between 15 percent and the hospital's disproportionate patient percentage.

(*2*) If the hospital's disproportionate patient percentage is greater than 20.2 percent, the applicable payment adjustment factor is 5.88 percent plus 82.5 percent of the difference between 20.2 percent and the hospital's disproportionate patient percentage.

(*3*) The maximum payment adjustment factor is 12 percent.

(iv) If the hospital meets the criteria of paragraph (c)(1)(iv) of this section—

(A) For discharges occurring before April 1, 2001, the payment adjustment factor is 4 percent.

(B) For discharges occurring on or after April 1, 2001 and before April 1, 2004, the following applies:

(*1*) If the hospital's disproportionate patient percentage is less than 19.3 percent, the applicable payment adjustment factor is 2.5 percent plus 65 percent of the difference between the hospital's disproportionate patient percentage and 15 percent.

(*2*) If the hospital's disproportionate patient percentage is equal to or greater than 19.3 percent, the applicable payment adjustment factor is 5.25 percent.

(C) For discharges occurring on or after April 1, 2004, the following applies:

(*1*) If the hospital's disproportionate patient percentage is less than 20.2 percent, the applicable payment adjustment factor is 2.5 percent plus 65 percent of the difference between 15 percent and the hospital's disproportionate patient percentage.

(*2*) If the hospital's disproportionate patient percentage is greater than 20.2 percent, the applicable payment adjustment factor is 5.88 percent plus 82.5 percent of the difference between 20.2 percent and the hospital's disproportionate patient percentage.

(*3*) The maximum payment adjustment factor is 12 percent.

* * * * *

16. Section 412.108 is amended by revising paragraph (a)(1) introductory text to read as follows:

§ 412.108 Special treatment: Medicare-dependent, small rural hospitals.

(a) *Criteria for classification as a Medicare-dependent, small rural hospital.*

(1) *General considerations.* For cost reporting periods beginning on or after

April 1, 1990 and ending before October 1, 1994, or beginning on or after October 1, 1997 and ending before October 1, 2006, a hospital is classified as a Medicare-dependent, small rural hospital if it is located in a rural area (as defined in subpart D of this part) and meets all of the following conditions:

* * * * *

17. Section 412.204 is amended by—

A. Revising the introductory text of paragraph (a).

B. Revising the title and introductory text of paragraph (b).

C. Adding new paragraphs (c) and (d).

The revision and addition read as follows:

§ 412.204 Payment to hospitals in Puerto Rico.

(a) *FY 1988 through FY 1997.* For discharges occurring on or after October 1, 1987 and before October 1, 1997, payments for inpatient operating costs to hospitals located in Puerto Rico that are paid under the prospective payment system are equal to the sum of—

* * * * *

(b) *FY 1998 through March 31, 2004.* For discharges occurring on or after October 1, 1997 and before April 1, 2004, payments for inpatient operating costs to hospitals located in Puerto Rico that are paid under the prospective payment system are equal to the sum of—

* * * * *

(c) *Period of April 1, 2004 through September 31, 2004.* For discharges occurring on or after April 1, 2004 and before October 1, 2004, payment for inpatient operating costs to hospitals located in Puerto Rico that are paid under the prospective payment system are equal to the sum of—

(1) 37.5 percent of the Puerto Rico prospective payment rate for inpatient operating costs, as determined under § 412.208 or § 412.210; and

(2) 62.5 percent of the national prospective payment rate for inpatient operating costs, as determined under § 412.212.

(d) *FY 2005 and thereafter.* For discharges occurring on or after October 1, 2004, payments for inpatient operating costs to hospitals located in Puerto Rico that are paid under the prospective payment system are equal to the sum of—

(1) 25 percent of the Puerto Rico prospective payment rate for inpatient operating costs, as determined under § 412.208 or § 412.211; and

(2) 75 percent of a national prospective payment rate for inpatient operating costs, as determined under § 412.212.

18. Section 412.210 is amended by—

A. Revising the title of the section.

B. Revising paragraph (a)(1).

§ 412.210 Puerto Rico rates for Federal fiscal years 1989 through 2003.

(a) *General rule.* (1) CMS determines the Puerto Rico adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge occurring in Federal fiscal years 1989 through 2003 that involves inpatient hospital services of a hospital in Puerto Rico subject to the prospective payment system for which payment may be made under Medicare Part A.

* * * * *

19. New § 412.211 is added to read as follows:

§ 412.211 Puerto Rico rates for Federal fiscal year 2004 and subsequent fiscal years.

(a) *General rule.* CMS determines the Puerto Rico adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge occurring in Federal fiscal year 2004 and subsequent fiscal years that involves inpatient hospital services of a hospital in Puerto Rico subject to the prospective payment system for which payment may be made under Medicare Part A.

(b) *Geographic classifications.* (1) For purposes of this section, the following definitions apply

(i) The term *urban area* means a Metropolitan Statistical Area (MSA) as defined by the Executive Office of Management and Budget.

(ii) The term *rural* area means any area outside of an urban area.

(2) For discharges occurring on or after October 1, 2004, a hospital located in a rural county adjacent to one or more urban areas is deemed to be located in an urban area and receives the Federal payment amount for the urban area to which the greater number of workers in the county commute if the rural county would otherwise be considered part of an urban area, under the standards for designating MSAs if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or central counties of all adjacent MSAs. These EOMB standards are set forth in the notice of final revised standards for classification of MSAs published in the **Federal Register** on December 27, 2000 (65 FR 82228), announced by EOMB on June 6, 2003, and available from CMS, 7500 Security Boulevard, Baltimore, Maryland 21244.

(c) *Computing the standardized amount.* CMS computes a Puerto Rico standardized amount that is applicable to all hospitals located in all areas, increased by the applicable percentage change specified in § 412.64(d)(1).

(d) *Computing Puerto Rico Federal rates for inpatient operating costs for hospitals located in all areas.* For each discharge classified within a DRG, CMS establishes for the fiscal year a Puerto Rico prospective payment rate for inpatient operating costs equal to the product of—

(1) The average standardized amount for the fiscal year for hospitals located in all areas; and

(2) The weighting factor determined under § 412.60(b) for that DRG.

(e) *Adjusting for different area wage levels.* CMS adjusts the proportion of the Puerto Rico rate for inpatient operating costs that are attributable to wages and labor-related costs for area differences in hospital wage levels by a factor (established by CMS based on survey data) reflecting the relative level of hospital wages and wage-related costs in the geographic area (that is, urban or rural area as determined under the provisions of paragraph (b) of this section) of the hospital compared to the Puerto Rico average level of hospital wages and wage-related costs. The adjustment specified in this paragraph (e) also takes into account the earnings and paid hours of employment by occupational category.

(1) The wage index is updated annually.

(2) CMS determines the proportion of the Puerto Rico rate that is attributable to wages and labor-related costs from time to time, employing a methodology that is described in the annual update of the prospective payment system for payment of inpatient hospital operating costs published in the **Federal Register**.

(3) For discharges occurring on or after October 1, 2004, CMS employs 62 percent as the proportion of the rate that is adjusted for the relative level of hospital wages and wage-related costs, unless employing that percentage would result in lower payments for the hospital than employing the proportion determined under the methodology described in paragraph (e)(2) of this section.

(f) *Adjusting the wage index to account for commuting patterns of hospital workers.* (1) *General criteria.* For discharges occurring on or after October 1, 2004, CMS adjusts the hospital wage index for hospitals located in qualifying areas to recognize the commuting patterns of hospital employees. A qualifying area is an area that meets all of the following criteria:

(i) Hospital employees in the area commute to work in an MSA (or MSAs) with a wage index (or wage indices) higher than the wage index of the area.

(ii) At least 10 percent of the county's hospital employees commute to an MSA (or MSAs) with a higher wage index (or wage indices).

(iii) The 3-year average hourly wage of the hospital(s) in the area equals or exceeds the 3-year average hourly wage of all hospitals in the MSA or rural area in which the county is located.

(2) *Amount of adjustment.* A hospital located in an area that meets the criteria under paragraphs (f)(l)(i) through (f)(1)(iii) of this section will receive an increase in its wage index that is equal to a weighted average of the difference between the prereclassified wage index of the MSA (or MSAs) with the higher wage index (or wage indices) and the prereclassified wage index of the qualifying area, weighted by the overall percentage of the hospital employees residing in the qualifying area who are employed in any MSA with a higher wage index.

(3) *Process for determining the adjustment.*

(i) CMS will use the most accurate data available, as determined by CMS, to determine the out-migration percentage for each area.

(ii) CMS will include, in its annual proposed and final notices of updates to the hospital inpatient prospective payment system, a listing of qualifying areas and the hospitals that are eligible to receive the adjustment to their wage indexes for commuting hospital employees, and the wage index increase applicable to each qualifying area.

(iii) Any wage index adjustment made under this paragraph (f) is effective for a period of 3 fiscal years, except that hospitals in a qualifying county may elect to waive the application of the wage index adjustment. A hospital may waive the application of the wage index adjustment by notifying CMS in writing within 45 days after the publication in the **Federal Register** of the annual notice of proposed rulemaking for the hospital inpatient prospective payment system.

(iv) A hospital in a qualifying area that receives a wage index adjustment under this paragraph (f) is not eligible for reclassification under Subpart L of this part.

20. Section 412.212 is amended by revising paragraph (b) to read as follows:

§ 412.212 National rate.

* * * * *

(b) *Computing Puerto Rico standardized amounts.* (1) For Federal fiscal years before FY 2004, CMS computes a discharge-weighted average of the—

(i) National urban adjusted standardized amount determined under § 412.63(j)(1); and

(ii) National rural adjusted average standardized amount determined under § 412.63(j)(2)(i).

(2) For fiscal years 2004 and subsequent fiscal years, CMS computes a discharge-weighted average of the national adjusted standardized amount determined under § 412.64(e).

* * * * *

21. Section 412.230 is amended by—

A. Revising paragraph (a)(1).

B. Revising paragraph (a)(4).

C. Removing paragraph (a)(5)(ii) and redesignating paragraphs (a)(5)(iii), (a)(5)(iv), and (a)(5)(v) as paragraphs (a)(5)(ii), (a)(5)(iii), and (a)(5)(iv), respectively.

D. Removing paragraph (d).

E. Removing paragraph (e)(2)(i)(C).

F. Redesignating paragraph (e) as paragraph (d).

G. In redesignated paragraph (d)(1), removing the cross-reference ''paragraphs (e)(3) and (e)(4)'' and adding in its place ''paragraphs (d)(3) and (d)(4)''.

H. In redesignated paragraph (d)(2)(iii), removing the cross-reference ''paragraph (e)(2)'' and adding in its place ''paragraph (d)(2)''.

I. Revising redesignated paragraph (d)(3).

J. In redesignated paragraph (d)(4), removing the cross-reference ''paragraphs (e)(1)(i) and (e)(1)(iii)'' and adding in its place ''paragraph (d)(1)(i) and (d)(1)(iii)''.

K. In redesignated paragraph (d)(4)(iii), removing the cross-reference ''paragraph (e)'' and adding in its place ''paragraph (d)''.

§ 412.230 Criteria for an individual hospital seeking redesignation to another rural area or an urban area.

(a) *General.* (1) *Purposes.* Except as specified in paragraph (a)(5)—

(i) For fiscal years prior to fiscal year 2005, an individual hospital may be redesignated from a rural area to an urban area, from a rural area to another rural area, or from a rural area to another urban area for the purposes of using the other area's standardized amount for inpatient operating costs, the wage index value, or both.

(ii) Effective for fiscal year 2005 and subsequent fiscal years, an individual hospital may be redesignated from a rural area to an urban area, from a rural area to another rural area, or from a rural area to another urban area for the purposes of using the other area's wage index value.

(4) *Application of criteria.* In applying the numeric criteria contained in paragraphs (b)(1), (b)(2), (d)(1)(iii), (d)(1)(iv)(A), and (d)(1)(iv)(B) of this section, rounding of numbers to meet the mileage or qualifying percentage standards is not permitted.

* * * * *

(d) *Use of urban or other rural area's wage index.* * * *

* * * * *

(3) *Rural referral center exceptions.*

(i) If a hospital was ever a rural referral center, it does not have to demonstrate that it meets the criterion set forth in paragraph (d)(1)(iii) of this section concerning its average hourly wage.

(ii) If a hospital was ever a rural referral center, it is required to meet only the criterion that applies to rural hospitals under paragraph (d)(1)(iv) of this section, whether or not it is actually located in an urban or rural area.

* * * * *

22. Section 412.232 is amended by—

A. Revising paragraph (a)(1).

B. Revising paragraph (a)(4).

C. Revising paragraph (b).

§ 412.232 Criteria for all hospitals in a rural county seeking urban redesignation.

(a) *Criteria.* * * *

(1) The county in which the hospitals are located—

(i) For fiscal years prior to fiscal year 2005, must be adjacent to the MSA or NECMA to which they seek redesignation.

(ii) For fiscal years beginning with fiscal years 2005, must be adjacent to the MSA to which they seek redesignation.

* * * * *

(4) The hospital may be redesignated only if one of the following conditions is met:

(i) The prereclassified average hourly wage for the area to which they seek redesignation is higher than the prereclassified average hourly wage for the area in which they are currently located.

(ii) For fiscal years prior to fiscal year 2005, the standardized amount for the area to which they seek redesignation is higher than the standardized amount for the area in which they are located.

(b) *Metropolitan character.* (1) For fiscal years prior to FY 2005, the group of hospitals must demonstrate that the county in which the hospitals are located meets the standards for redesignation to an MSA or an NECMA as an outlying county that were published in the **Federal Register** on March 30, 1990 (55 FR 12154) using Bureau of the Census data or Bureau of Census estimates made after 1990.

(2) For fiscal years beginning with FY 2005, the group of hospitals must demonstrate that the county in which the hospitals are located meets the standards for redesignation to an MSA as an outlying county that were published in the **Federal Register** on December 27, 2000 (65 FR 82228) using Census Bureau data or Census Bureau estimates made after 2000.

* * * * *

23. Section 412.234 is amended by—

A. Revising paragraph (a)(3).

B. Revising paragraph (a)(4).

C. Removing paragraph (c).

D. Redesignating paragraph (d) as paragraph (c) and revising the redesignated paragraph (c).

The revisions read as follows.

§ 412.234 Criteria for all hospitals in an urban county seeking redesignation to another urban area.

(a) General criteria. * * *

(3) The county in which the hospital is located must be part of the CBSA that includes the urban area to which they seek redesignation.

(4) The hospital may be redesignated only if one of the following conditions is met:

(i) The prereclassified average hourly wage for the area to which they seek redesignation is higher than the prereclassified average hourly wage for the area in which they are currently located.

(ii) For fiscal years prior to fiscal year 2005, the standardized amount for the area to which they seek redesignation is higher than the standardized amount for the area in which they are located.

* * * * *

(c) *Appropriate wage data.* The hospitals must submit appropriate wage data as provided for in § 412.230(d)(2).

§ 412.236 [Removed]

24. Section 412.236 is removed.

§ 412.252 [Amended]

25. In § 412.252, paragraph (b), the phrase ''or in a NECMA'' is removed.

26. Section 412.274 is amended by revising paragraph (b)(1) to read as follows:

§ 412.274 Scope and effect of an MGCRB decision.

* * * * *

(b) *Effective date and term of the decision.*

(1) For reclassifications prior to fiscal year 2005, a standardized amount classification change is effective for 1 year beginning with discharges occurring on the first day (October 1) of the second Federal fiscal year following the Federal fiscal year in which the complete application is filed and ending effective at the end of that Federal fiscal year (the end of the next September 30).

* * * * *

27. Section 412.312 is amended by—

A. Revising paragraph (b)(2)(ii).

B. Revising paragraph (e).

The revisions read as follows.

§ 412.312 Payment based on the Federal rate.

(b) *Payment adjustment.* * * *

(2) *Geographic adjustment factor.*

* * *

(ii) *Large urban add-on.* An additional adjustment is made for hospitals located in a large urban area to reflect the higher costs incurred by hospitals located in those areas. For purposes of the payment adjustment under this paragraph, the definition of large urban area set forth at § 412.63(c)(6) continues to be in effect for discharges occurring on or after September 30, 2004.

* * * * *

(e) *Payment for extraordinary circumstances.* For cost reporting periods beginning on or after October 1, 2001—

(1) Payment for extraordinary circumstances is made as provided for in § 412.348(f).

(2) Although no longer independently in effect, the minimum payment levels established under § 412.348(c) continue to be used in the calculation of exception payments for extraordinary circumstances, according to the formula in § 412.348(f).

(3) Although no longer independently in effect, the offsetting amounts established under § 412.348(c) continue to be used in the calculation of exception payments for extraordinary circumstances. However, for cost reporting periods beginning during FY 2005 and subsequent fiscal years, the offsetting amounts in § 412.348(c) are determined based on the lesser of—

(i) The preceding 10-year period; or

(ii) The period of time under which the hospital is subject to the prospective payment system for capital-related costs.

26. Section 412.316 is amended by revising paragraph (b) to read as follows:

§ 412.316 Geographic adjustment factors.

* * * * *

(b) *Large urban location.* CMS provides an additional payment to a hospital located in a large urban area equal to 3.0 percent of what would otherwise be payable to the hospital based on the Federal rate.

(1) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital's location for the purpose of receiving payment under § 412.63(a). The term ''large urban area'' is defined under § 412.63(c)(6).

(2) For discharges occurring on or after October 1, 2004, the definition of large urban area under § 412.63(c)(6) continues to be in effect for purposes of the payment adjustment under this section, based on the geographic classification under § 412.64.

* * * * *

27. Section 412.320 is amended by revising paragraph (a)(1) to read as follows:

§ 412.320 Disproportionate share adjustment factor.

(a) *Criteria for classification.*

* * * * *

(1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).

(i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital's location, for the purpose of receiving payment, under § 412.63(a).

(ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64.

* * * * *

28. Section 412.374 is amended by—

A. Revising paragraph (a).

B. Redesignating paragraphs (b) and (c) as paragraphs (c) and (d), respectively.

C. Adding a new paragraph (b).

The revisions and addition read as follows:

§ 412.374 Payments to hospitals located in Puerto Rico.

(a) *FY 1998 through FY 2004.* Payments for capital-related costs to hospitals located in Puerto Rico that are paid under the prospective payment system are equal to the sum of the following:

(1) 50 percent of the Puerto Rico capital rate based on data from Puerto Rico hospitals only, which is determined in accordance with procedures for developing the Federal rate; and

(2) 50 percent of the Federal rate, as determined under § 412.308.

(b) *FY 2005 and FYs thereafter.* For discharges occurring on or after October 1, 2004, payments for capital-related costs to hospitals located in Puerto Rico that are paid under the prospective payment system are equal to the sum of the following:

(1) 25 percent of the Puerto Rico capital rate based on data from Puerto

Rico hospitals only, which is determined in accordance with procedures for developing the Federal rate; and

(2) 75 percent of the Federal rate, as determined under § 412.308.

* * * * *

29. Section 412.521 is amended by adding a new paragraph (e) to read as follows:

§ 412.521 Basis for payment.

* * * * *

(e) *Special payment provisions for patients in acute care hospitals that change classification status to LTCH status during a patient stay.* (1) If a patient is admitted to an acute care hospital and then the acute care hospital meets the criteria at § 412.23(e) to be paid as a LTCH during the course of the patient's hospitalization, Medicare considers all the days of the patient stay in the facility (days prior to and after the designation of LTCH status) to be a single episode of LTCH care. Payment for the entire patient stay (days prior to and after the designation of LTCH status) will include the day and cost data for that patient at both the acute care hospital and the LTCH in determining the payment to the LTCH under this subpart. The requirements of this paragraph (e)(1) apply only to a patient stay in which a patient is in an acute care hospital and that hospital is designated as a LTCH on or after October 1, 2004.

(2) The days of the patient's stay prior to and after the hospital's designation as a LTCH as specified in paragraph (e)(1) of this section are included for purposes of determining the beneficiary's length of stay.

C. Part 413 is amended as follows:

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; OPTIONAL PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

1. The authority citation for part 413 is revised to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395hh, 1395rr, 1395tt, and 1395ww).

2. Section 413.40 is amended by—

A. Republishing the introductory text of paragraphs (c)(4) and (c)(4)(iii) and revising paragraphs (c)(4)(iii)(A)(*1*) and (c)(4)(iii)(A)(*2*).

B. Republishing the introductory text of paragraph (c)(4)(iii)(B) and revising paragraph (c)(4)(iii)(B)(*4*)(*i*).

C. Revising the introductory text of paragraphs (d)(4)(i) and (d)(4)(ii).

The revisions read as follows:

§ 413.40 Ceiling on the rate of increase in hospital inpatient costs.

* * * * *

(c) *Costs subject to the ceiling.*

* * * * *

(4) *Target amounts.* The intermediary will establish a target amount for each hospital. The target amount for a cost reporting period is determined as follows:

* * * * *

(iii) In the case of a psychiatric hospital or unit, rehabilitation hospital or unit, or long-term care hospital, the target amount is the lower of the amounts specified in paragraph (c)(4)(iii)(A) or (c)(4)(iii)(B) of this section.

(A) The hospital-specific target amount.

(*1*) In the case of all hospitals and units, except long-term care hospitals for cost reporting periods beginning during FY 2001, the hospital-specific target amount is the net allowable costs in a base period increased by the applicable update factors.

(*2*) In the case of long-term care hospitals, for cost reporting periods beginning during FY 2001, the hospital-specific target amount is the net allowable costs in a base period increased by the applicable update factors multiplied by 1.25.

(B) One of the following for the applicable cost reporting period—

* * * * *

(*4*) For cost reporting periods beginning during fiscal years 2001 and 2002—

(*i*) The amounts determined under paragraph (c)(4)(iii)(B)(3)(*i*) of this section are: increased by the market basket percentage up through the subject period; or in the case of a long-term care hospital for cost reporting periods beginning during FY 2001, the amounts determined under paragraph (c)(4)(iii)(B)(*3*)(*i*) of this section, increased by the market basket percentage up through the subject period and further increased by 2 percent.

* * * * *

(d) *Application of the target amount in determining the amount of payment.*

* * * * *

(4) *Continuous improvement bonus payments.* (i) For cost reporting periods beginning on or after October 1, 1997, eligible hospitals (as defined in paragraph (d)(5) of this section) receive payments in addition to those in paragraph (d)(2) of this section, as applicable. These payments are equal to the lesser of—

* * * * *

(ii) For cost reporting periods beginning on or after October 1, 2000, and before September 30, 2001, eligible psychiatric hospitals and units and long-term care hospitals (as defined in paragraph (d)(5) of this section) receive payments in addition to those in paragraph (d)(2) of this section, as applicable. These payments are equal to the lesser of—

* * * * *

3. Section 413.64 is amended by—

A. Revising the introductory text of paragraph (h)(2) and adding a new paragraph (h)(2)(vi).

B. Removing paragraph (h)(3)(iv).

C. Removing and reserving paragraph (h)(4).

The additions and revisions read as follows:

§ 413.64 Payments to providers: Specific rules.

* * * * *

(h) *Periodic interim payment method of reimbursement.*

* * * * *

(2) *Covered services furnished on or after July 1, 1987.* Effective with claims received on or after July l, 1987, or as otherwise specified, the periodic interim payment (PIP) method is available for the following:

* * * * *

(vi) Effective for payments made on or after July l, 2004, inpatient CAH services furnished by a CAH as specified in § 413.70. Payment on a PIP basis is described in § 413.70(d).

* * * * *

(4) [Reserved]

* * * * *

4. Section 413.70 is amended by—

A. Revising the heading of paragraph (a) and paragraph (a)(1).

B. Adding a new paragraph (a)(4).

C. Revising paragraph (b)(2)(i) introductory text, paragraph (b)(2)(i)(A), and paragraph (b)(2)(i)(B).

D. Removing paragraphs (b)(2)(i)(C) and (b)(2)(i)(D).

E. In paragraph (b)(2)(iii), remove the phrase ''on a reasonable cost basis'' and add in its place ''at 101 percent of reasonable cost''.

F. Revising the heading of paragraph (b)(3) and the contents of paragraphs (b)(3)(i) and (b)(3)(ii).

G. Revising paragraph (b)(4).

H. Adding a new paragraph (d).

I. Adding a new paragraph (e).

The revisions and additions read as follows:

§ 413.70 Payment for services of a CAH.

(a) *Payment for inpatient services furnished by a CAH (other than services of distinct part units).* (1) Effective for cost reporting periods beginning on or after January 1, 2004, payment for inpatient services of a CAH, other than services of a distinct part unit of the CAH, is 101 percent of the reasonable costs of the CAH in providing CAH services to its inpatients, as determined in accordance with section 1861(v)(1)(A) of the Act and the applicable principles of cost reimbursement in this part and in Part 415 of this chapter, except that the following payment principles are excluded when determining payment for CAH inpatient services:

(i) Lesser of cost or charges;

(ii) Ceilings on hospital operating costs;

(iii) Reasonable compensation equivalent (RCE) limits for physician services to providers; and

(iv) The payment window provisions for preadmission services, specified in § 412.2(c)(5) of this subchapter and § 413.40(c)(2).

* * * * *

(4) Payment for inpatient services of distinct part psychiatric or rehabilitation units is described in paragraph (e) of this section.

(b) *Payment for outpatient services furnished by a CAH.*

* * * * *

(2) *Reasonable costs for facility services.* (i) Effective for cost reporting periods beginning on or after January 1, 2004, payment for outpatient services of a CAH is 101 percent of the reasonable costs of the CAH in providing CAH services to its outpatients, as determined in accordance with section 1861(v)(1)(A) of the Act and the applicable principles of cost reimbursement in this part and in Part 415 of this chapter, except that the following payment principles are excluded when determining payment for CAH outpatient services:

(A) Lesser of cost or charges; and

(B) RCE limits.

* * * * *

(3) *Election to be paid 101 percent of reasonable costs for facility services plus fee schedule for professional services.*

(i) A CAH may elect to be paid for outpatient services in any cost reporting period beginning on or after July 1, 2004 under the method described in paragraphs (b)(3)(ii) and (b)(3)(iii) of this section.

(A) The election must be made in writing, made on an annual basis, and delivered to the fiscal intermediary servicing the CAH at least 30 days before the start of the cost reporting period for which the election is made.

(B) An election of this payment method, once made for a cost reporting period, remains in effect for all of that period and, effective for cost reporting periods beginning on or after July 1, 2004, applies to all services furnished to outpatients during that period by a physician or other practitioner who has reassigned his or her rights to bill for those services to the CAH in accordance with 42 CFR Part 424, Subpart F of this chapter. If a physician or other practitioner does not reassign his or her billing rights to the CAH in accordance with 42 CFR Part 424, payment for the physician's or practitioner's services to CAH outpatients will be made on a fee schedule or other applicable basis as specified in Subpart B of part 414 of this subchapter.

(C) In the case of a CAH that made an election under this section before November 1, 2003, for a cost reporting period beginning before December 1, 2003, the rules in paragraph (b)(3)(i)(B) of this section are effective for cost reporting periods beginning on or after July 1, 2001.

(D) An election made under paragraph (b)(3)(i)(B) or paragraph (b)(3)(i)(C) of this section is effective only for a period for which it was made and does not apply to an election that was withdrawn or revoked prior to the start of the cost reporting period for which it was made.

(ii) If the CAH elects payment under this method, payment to the CAH for each outpatient visit will be the sum of the following:

(A) For facility services not including any services for which payment may be made under paragraph (b)(3)(ii)(B) of this section, 101 percent of the reasonable costs of the services as determined under paragraph (b)(2)(i) of this section; and

(B) For professional services that are furnished by a physician or other practitioner who has reassigned his or her rights to bill for those services to the CAH in accordance with Part 424, Subpart F of this chapter, and that would otherwise be payable to the physician or other practitioner if the rights to bill for them had not been reassigned, 115 percent of the amounts that otherwise would be paid for the service if the CAH had not elected payment under this method.

* * * * *

(4) *Costs of certain emergency room on-call providers.* (i) Effective for cost reporting periods beginning on or after October 1, 2001, the reasonable costs of outpatient CAH services under paragraph (b) of this section may include amounts for reasonable compensation and related costs for an emergency room physician who is on call but who is not present on the premise of the CAH involved, is not otherwise furnishing physicians' services, and is not on call at any other provider or facility. Effective for costs incurred for services furnished on or after January 1, 2005, the payment amount of 101 percent of the reasonable costs of outpatient CAH services may also include amounts for reasonable compensation and related costs for the following emergency room providers who are on call but who are not present on the premise of the CAH involved, are not otherwise furnishing physicians' services, and are not on call at any other provider or facility: physician assistants, nurse practitioners, and clinical nurse specialists.

(ii) For purposes of this paragraph (b)(4)—

(A) ''Amounts for reasonable compensation and related costs'' means all allowable costs of compensating emergency room physicians, physician assistants, nurse practitioners, and clinical nurse specialists who are on call to the extent that the costs are found to be reasonable under the rules specified in paragraph (b)(2) of this section and the applicable sections of Part 413. Costs of compensating these specified medical emergency room staff are allowable only if the costs are incurred under written contracts that require the physician, physician assistant, nurse practitioner, or clinical nurse specialist to come to the CAH when the physician's or other practitioner's presence is medically required.

(B) Effective for costs incurred on or after January 1, 2005, an ''emergency room physician, physician assistant, nurse practitioner, or clinical nurse specialist who is on call'' means a doctor of medicine or osteopathy, a physician assistant, a nurse practitioner, or a clinical nurse specialist with training or experience in emergency care who is immediately available by telephone or radio contact, and is available onsite within the timeframes specified in § 485.618(d) of this chapter.

* * * * *

(d) *Periodic interim payments.* Subject to the provisions of § 413.64(h), a CAH receiving payments under this section may elect to receive periodic interim payments (PIP) for Part A inpatient CAH services, effective for payments made on or after July l, 2004. Payment is made biweekly under the PIP method unless the CAH requests a longer fixed interval (not to exceed one month) between

payments. The biweekly interim payment amount is based on the total estimated Medicare payment (after estimated beneficiary deductibles and coinsurance) for the cost reporting period. Each payment is made 2 weeks after the end of a biweekly period of service, as described in § 413.64(h)(6). These PIP provisions are further described in § 413.64(h)(6). Under certain circumstances that are described in § 413.64(g), a CAH that is not receiving PIP may request an accelerated payment.

(e) *Payment for services of distinct part psychiatric and rehabilitation units of CAHs.* Payment for inpatient services of distinct part psychiatric units of CAHs is made in accordance with regulations governing IPPS-excluded psychiatric units of hospitals at § 413.40. Payment for inpatient services of distinct part rehabilitation units of CAHs is made in accordance with regulations governing the IRF PPS at Subpart F (§§ 412.600 through 412.632) of Part 412 of this subchapter.

§ 413.80 [Redesignated as § 413.89]

5. Section 413.80 is redesignated as § 413.89.

§ 413.85 [Amended]

6. In § 413.85—

A. In paragraph (b)(2), the cross-reference ''§ 413.86'' is removed and the cross-reference ''§§ 413.75 through 413.83'' is added in its place.

B. In paragraph (c)(3), in the definition ''Redistribution of costs,'' the cross-reference ''§ 413.86'' is removed and ''§ 413.75 through 413.83'' is added in its place.

7. Section 413.86 is removed and §§ 413.75 through 413.83 are added to Subpart F to read as follows:

Subpart F—Specific Categories of Costs

§ 413.75 Direct GME payments: General requirements.

(a) *Statutory basis and scope*— (1) *Basis.* This section and §§ 413.76 through 413.83 implement section 1886(h) of the Act by establishing the methodology for Medicare payment of the cost of direct graduate medical educational activities.

(2) *Scope.* This section and §§ 413.76 through 413.83 apply to Medicare payments to hospitals and hospital-based providers for the costs of approved residency programs in medicine, osteopathy, dentistry, and podiatry for cost reporting periods beginning on or after July 1, 1985.

(b) *Definitions.* For purposes of this section and §§ 413.76 through 413.83, the following definitions apply:

''*All or substantially all of the costs for the training program in the nonhospital setting*'' means the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries and fringe benefits attributable to direct graduate medical education (GME).

Approved geriatric program means a fellowship program of one or more years in length that is approved by one of the national organizations listed in § 415.152 of this chapter under that respective organization's criteria for geriatric fellowship programs.

Approved medical residency program means a program that meets one of the following criteria:

(1) Is approved by one of the national organizations listed in § 415.152 of this chapter.

(2) May count towards certification of the participant in a specialty or subspecialty listed in the current edition of either of the following publications:

(i) The Directory of Graduate Medical Education Programs published by the American Medical Association, and available from American Medical Association, Department of Directories and Publications, 515 North State Street, Chicago, Illinois 60610; or

(ii) The Annual Report and Reference Handbook published by the American Board of Medical Specialties, and available from American Board of Medical Specialties, One Rotary Center, Suite 805, Evanston, Illinois 60201.

(3) Is approved by the Accreditation Council for Graduate Medical Education (ACGME) as a fellowship program in geriatric medicine.

(4) Is a program that would be accredited except for the accrediting agency's reliance upon an accreditation standard that requires an entity to perform an induced abortion or require, provide, or refer for training in the performance of induced abortions, or make arrangements for such training, regardless of whether the standard provides exceptions or exemptions.

Base period means a cost reporting period that began on or after October 1, 1983 but before October 1, 1984.

Community support means funding that is provided by the community and generally includes all non-Medicare sources of funding (other than payments made for furnishing services to individual patients), including State and local government appropriations. Community support does not include grants, gifts, and endowments of the kind that are not to be offset in accordance with section 1134 of the Act.

CPI–U stands for the Consumer Price Index for All Urban Consumers as compiled by the Bureau of Labor Statistics.

Foreign medical graduate means a resident who is not a graduate of a medical, osteopathy, dental, or podiatry school, respectively, accredited or approved as meeting the standards necessary for accreditation by one of the following organizations:

(1) The Liaison Committee on Medical Education of the American Medical Association.

(2) The American Osteopathic Association.

(3) The Commission on Dental Accreditation.

(4) The Council on Podiatric Medical Education.

FMGEMS stands for the Foreign Medical Graduate Examination in the Medical Sciences (Part I and Part II).

FTE stands for full-time equivalent.

GME stands for graduate medical education.

Medicare GME affiliated group means—

(1) Two or more hospitals that are located in the same urban or rural area (as those terms are defined in § 412.62(f) of this subchapter) or in a contiguous area and meet the rotation requirements in § 413.79(g)(2).

(2) Two or more hospitals that are not located in the same or in a contiguous urban or rural area, but meet the rotation requirement in § 413.79(g)(2), and are jointly listed—

(i) As the sponsor, primary clinical site, or major participating institution for one or more programs as these terms are used in the most current publication of the *Graduate Medical Education Directory*; or

(ii) As the sponsor or is listed under ''affiliations and outside rotations'' for

one or more programs in operation in *Opportunities, Directory of Osteopathic Postdoctoral Education Programs*.

(3) Two or more hospitals that are under common ownership and, effective for all Medicare GME affiliation agreements beginning July 1, 2003, meet the rotation requirement in § 413.79(g)(2).

Medicare GME affiliation agreement means a written, signed, and dated agreement by responsible representatives of each respective hospital in a Medicare GME affiliated group, as defined in this section, that specifies—

(1) The term of the Medicare GME affiliation agreement (which, at a minimum is 1 year), beginning on July 1 of a year;

(2) Each participating hospital's direct and indirect GME FTE caps in effect prior to the Medicare GME affiliation;

(3) The total adjustment to each hospital's FTE caps in each year that the Medicare GME affiliation agreement is in effect, for both direct GME and IME, that reflects a positive adjustment to one hospital's direct and indirect FTE caps that is offset by a negative adjustment to the other hospital's (or hospitals') direct and indirect FTE caps of at least the same amount;

(4) The adjustment to each participating hospital's FTE counts resulting from the FTE resident's (or residents') participation in a shared rotational arrangement at each hospital participating in the Medicare GME affiliated group for each year the Medicare GME affiliation agreement is in effect. This adjustment to each participating hospital's FTE count is also reflected in the total adjustment to each hospital's FTE caps (in accordance with paragraph (3) of this definition); and

(5) The names of the participating hospitals and their Medicare provider numbers.

Medicare patient load means, with respect to a hospital's cost reporting period, the total number of hospital inpatient days during the cost reporting period that are attributable to patients for whom payment is made under Medicare Part A divided by total hospital inpatient days. In calculating inpatient days, inpatient days in any distinct part of the hospital furnishing a hospital level of care are included and nursery days are excluded.

Primary care resident is a resident enrolled in an approved medical residency training program in family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine or osteopathic general practice.

Redistribution of costs occurs when a hospital counts FTE residents in medical residency programs and the costs of the program had previously been incurred by an educational institution.

Resident means an intern, resident, or fellow who participates in an approved medical residency program, including programs in osteopathy, dentistry, and podiatry, as required in order to become certified by the appropriate specialty board.

Rural track FTE limitation means the maximum number of residents (as specified in § 413.79(l)) training in a rural track residency program that an urban hospital may include in its FTE count and that is in addition to the number of FTE residents already included in the hospital's FTE cap.

Rural track or integrated rural track means an approved medical residency training program established by an urban hospital in which residents train for a portion of the program at the urban hospital and then rotate for a portion of the program to a rural hospital(s) or a rural nonhospital site(s).

Shared rotational arrangement means a residency training program under which a resident(s) participates in training at two or more hospitals in that program.

(c) *Payment for GME costs—General rule*. Beginning with cost reporting periods starting on or after July 1, 1985, hospitals, including hospital-based providers, are paid for the costs of approved GME programs as described in §§ 413.76 through 413.83.

§ 413.76 Direct GME payments: Calculation of payments for GME costs.

A hospital's Medicare payment for the costs of an approved residency program is calculated as follows:

(a) *Step one*. The hospital's updated per resident amount (as determined under § 413.77) is multiplied by the actual number of FTE residents (as determined under § 413.79). This result is the aggregate approved amount for the cost reporting period.

(b) *Step two*. The product derived in step one is multiplied by the hospital's Medicare patient load.

(c) *Step three*. For portions of cost reporting periods occurring on or after January 1, 1998, the product derived in step one is multiplied by the proportion of the hospital's inpatient days attributable to individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1876 of the Act and who are entitled to Medicare Part A or with a Medicare+Choice organization under Title XVIII, Part C of the Act. This amount is multiplied by an applicable payment percentage equal to—

(1) 20 percent for 1998;

(2) 40 percent for 1999;

(3) 60 percent in 2000;

(4) 80 percent in 2001; and

(5) 100 percent in 2002 and subsequent years.

(d) *Step four*. Effective for portions of cost reporting periods occurring on or after January 1, 2000, the product derived from step three is reduced by a percentage equal to the ratio of the Medicare+Choice nursing and allied health payment ''pool'' for the current calendar year as described at § 413.87(f), to the projected total Medicare+Choice direct GME payments made to all hospitals for the current calendar year.

(e) *Step five*. (1) For portions of cost reporting periods beginning on or after January 1, 1998 and before January 1, 2000, add the results of steps two and three.

(2) Effective for portions of cost reporting periods beginning on or after January 1, 2000, add the results of steps two and four.

(f) *Step six*. The product derived in step two is apportioned between Part A and Part B of Medicare based on the ratio of Medicare's share of reasonable costs excluding GME costs attributable to each part as determined through the Medicare cost report.

§ 413.77 Direct GME payments: Determination of per resident amounts.

(a) *Per resident amount for the base period*—(1) Except as provided in paragraph (d) of this section, the intermediary determines a base-period per resident amount for each hospital as follows:

(i) Determine the allowable GME costs for the cost reporting period beginning on or after October 1, 1983 but before October 1, 1984. In determining these costs, GME costs allocated to the nursery cost center, research and other nonreimbursable cost centers, and hospital-based providers that are not participating in Medicare are excluded and GME costs allocated to distinct-part hospital units and hospital-based providers that participate in Medicare are included.

(ii) Divide the costs calculated in paragraph (a)(1)(i) of this section by the average number of FTE residents working in all areas of the hospital complex (including those areas whose costs were excluded under paragraph (a)(1)(i) of this section) for its cost reporting period beginning on or after October 1, 1983 but before October 1, 1984.

(2) In determining the base-period per resident amount under paragraph (a)(1) of this section, the intermediary—

(i) Verifies the hospital's base-period GME costs and the hospital's average number of FTE residents;

(ii) Excludes from the base-period GME costs any nonallowable or misclassified costs, including those previously allowed under § 412.113(b)(3) of this chapter; and

(iii) Upon a hospital's request, includes GME costs that were misclassified as operating costs during the hospital's prospective payment base year and were not allowable under § 412.113(b)(3) of this chapter during the GME base period. These costs may be included only if the hospital requests an adjustment of its prospective payment hospital-specific rate or target amount as described in § 413.82(a) of this chapter.

(3) If the hospital's cost report for its GME base period is no longer subject to reopening under § 405.1885 of this chapter, the intermediary may modify the hospital's base-period costs solely for purposes of computing the per resident amount.

(4) If the intermediary modifies a hospital's base-period GME costs as described in paragraph (a)(2)(ii) of this section, the hospital may request an adjustment of its prospective payment hospital-specific rate or target amount as described in § 413.82(a) of this chapter.

(5) The intermediary notifies each hospital that either had direct GME costs or received indirect education payment in its cost reporting period beginning on or after October 1, 1984, and before October 1, 1985, of its base-period average per resident amount. A hospital may appeal this amount within 180 days of the date of that notice.

(b) *Per resident amount for cost reporting periods beginning on or after July 1, 1985, and before July 1, 1986.* For cost reporting periods beginning on or after July 1, 1985, and before July 1, 1986, a hospital's base-period per resident amount is adjusted as follows:

(1) If a hospital's base period began on or after October 1, 1983, and before July 1, 1984, the amount is adjusted by the percentage change in the CPI–U that occurred between the hospital's base period and the first cost reporting period to which the provisions of this section apply. The adjusted amount is then increased by one percent.

(2) If a hospital's base period began on or after July 1, 1984 and before October 1, 1984, the amount is increased by one percent.

(c) *Per resident amount for cost reporting periods beginning on or after July 1, 1986.* Subject to the provisions of paragraph (d) of this section, for cost reporting periods beginning on or after July 1, 1986, a hospital's base-period per resident amount is adjusted as follows:

(1) Except as provided in paragraph (c)(2) of this section, each hospital's per resident amount for the previous cost reporting is adjusted by the projected change in the CPI–U for the 12-month cost reporting period. This adjustment is subject to revision during the settlement of the cost report to reflect actual changes in the CPI–U that occurred during the cost reporting period.

(2) For cost reporting periods beginning on or after October 1, 1993 through September 30, 1995, each hospital's per resident amount for the previous cost reporting period will not be adjusted for any resident FTEs who are not either a primary care resident or an obstetrics and gynecology resident.

(d) *Per resident amount for cost reporting periods beginning on or after October 1, 2000 and ending on or before September 30, 2013.* For cost reporting periods beginning on or after October 1, 2000 and ending on or before September 30, 2013, a hospital's per resident amount for each fiscal year is adjusted in accordance with the following provisions:

(1) *General provisions.* For purposes of this § 413.77—

(i) *Weighted average per resident amount.* The weighted average per resident amount is established as follows:

(A) Using data from hospitals' cost reporting periods ending during FY 1997, CMS calculates each hospital's single per resident amount by adding each hospital's primary care and nonprimary care per resident amounts, weighted by its respective FTEs, and dividing by the sum of the FTEs for primary care and nonprimary care residents.

(B) Each hospital's single per resident amount calculated under paragraph (d)(1)(i)(A) of this section is standardized by the 1999 geographic adjustment factor for the physician fee schedule area (as determined under § 414.26 of this chapter) in which the hospital is located.

(C) CMS calculates an average of all hospitals' standardized per resident amounts that are determined under paragraph (d)(1)(i)(B) of this section. The resulting amount is the weighted average per resident amount.

(ii) *Primary care/obstetrics and gynecology and nonprimary care per resident amounts.* A hospital's per resident amount is an amount inclusive of any CPI–U adjustments that the hospital may have received since the hospital's base year, including any CPI–U adjustments the hospital may have received because the hospital trains primary care/obstetrics and gynecology residents and nonprimary care residents as specified under paragraph (c)(2) of this section.

(2) *Adjustment beginning in FY 2001 and ending in FY 2013.* For cost reporting periods beginning on or after October 1, 2000, and ending on or before September 30, 2013, a hospital's per resident amount is adjusted in accordance with paragraphs (d)(2)(i) through (d)(2)(iv) of this section, in that order:

(i) *Updating the weighted average per resident amount for inflation.* The weighted average per resident amount (as determined under paragraph (d)(1)(i) of this section) is updated by the estimated percentage increase in the CPI–U during the period beginning with the month that represents the midpoint of the cost reporting periods ending during FY 1997 (that is, October 1, 1996) and ending with the midpoint of the hospital's cost reporting period that begins in FY 2001.

(ii) *Adjusting for locality.* The updated weighted average per resident amount determined under paragraph (d)(2)(i) of this section (the national average per resident amount) is adjusted for the locality of each hospital by multiplying the national average per resident amount by the 1999 geographic adjustment factor for the physician fee schedule area in which each hospital is located, established in accordance with § 414.26 of this chapter.

(iii) *Determining necessary revisions to the per resident amount.* The locality-adjusted national average per resident amount, as calculated in accordance with paragraph (d)(2)(ii) of this section, is compared to the hospital's per resident amount and is revised, if appropriate, according to the following three categories:

(A) *Floor.* (*1*) For cost reporting periods beginning on or after October 1, 2000, and before October 1, 2001, if the hospital's per resident amount would otherwise be less than 70 percent of the locality-adjusted national average per resident amount for FY 2001 (as determined under paragraph (d)(2)(ii) of this section), the per resident amount is equal to 70 percent of the locality-adjusted national average per resident amount for FY 2001.

(*2*) For cost reporting periods beginning on or after October 1, 2001, and before October 1, 2002, if the hospital's per resident amount would otherwise be less than 85 percent of the locality-adjusted national average per resident amount for FY 2002 (as determined under paragraph (d)(2)(ii) of this section), the per resident amount is equal to 85 percent of the locality-

adjusted national average per resident amount for FY 2002.

(*3*) For subsequent cost reporting periods beginning on or after October 1, 2002, the hospital's per resident amount is updated using the methodology specified under paragraph (c)(1) of this section.

(B) *Ceiling.* If the hospital's per resident amount is greater than 140 percent of the locality-adjusted national average per resident amount, the per resident amount is adjusted as follows for FY 2001 through FY 2013:

(*1*) *FY 2001.* For cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2001, if the hospital's FY 2000 per resident amount exceeds 140 percent of the FY 2001 locality-adjusted national average per resident amount (as calculated under paragraph (d)(2)(ii) of this section), subject to the provision stated in paragraph (d)(2)(iii)(B)(*5*) of this section, the hospital's per resident amount is frozen at the FY 2000 per resident amount and is not updated for FY 2001 by the CPI–U factor.

(*2*) *FY 2002.* For cost reporting periods beginning on or after October 1, 2001, and on or before September 30, 2002, if the hospital's FY 2001 per resident amount exceeds 140 percent of the FY 2002 locality-adjusted national average per resident amount, subject to the provision stated in paragraph (d)(2)(iii)(B)(*5*) of this section, the hospital's per resident amount is frozen at the FY 2001 per resident amount and is not updated for FY 2002 by the CPI–U factor.

(*3*) *FY 2003.* For cost reporting periods beginning on or after October 1, 2002, and on or before September 30, 2003, if the hospital's per resident amount for the previous cost reporting period is greater than 140 percent of the locality-adjusted national average per resident amount for that same previous cost reporting period (for example, for cost reporting periods beginning in FY 2003, compare the hospital's per resident amount from the FY 2002 cost report to the hospital's locality-adjusted national average per resident amount from FY 2002), subject to the provision stated in paragraph (d)(2)(iii)(B)(*5*) of this section, the hospital's per resident amount is adjusted using the methodology specified in paragraph (c)(1) of this section, except that the CPI–U applied for a 12-month period is reduced (but not below zero) by 2 percentage points.

(*4*) *FY 2004 through FY 2013.* For cost reporting periods beginning on or after October 1, 2003, and on or before September 30, 2013, if the hospital's preceding year per resident amount exceeds 140 percent of the current year's locality-adjusted national average per resident amount (as calculated under paragraph (d)(2)(ii) of this section), subject to the provision stated in paragraph (d)(2)(iii)(B)(*5*) of this section, the hospital-specific per resident amount is frozen for the current year at the preceding year's hospital-specific per resident amount and is not updated by the CPI–U factor.

(*5*) *General rule for hospitals that exceed the ceiling.* For cost reporting periods beginning on or after October 1, 2000, and on or before September 30, 2013, if a hospital's per resident amount exceeds 140 percent of the hospital's locality-adjusted national average per resident amount and it is adjusted under any of the criteria under paragraphs (d)(2)(iii)(B)(*1*) through (d)(2)(iii)(B)(*3*) of this section, the current year per resident amount cannot be reduced below 140 percent of the locality-adjusted national average per resident amount.

(C) *Per resident amounts greater than or equal to the floor and less than or equal to the ceiling.* For cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2013, if a hospital's per resident amount is greater than or equal to 70 percent and less than or equal to 140 percent of the hospital's locality-adjusted national average per resident amount for each respective fiscal year, the hospital's per resident amount is updated using the methodology specified in paragraph (c)(1) of this section.

(e) *Exceptions*—(1) *Base period for certain hospitals.* If a hospital did not have any approved medical residency training programs or did not participate in Medicare during the base period, but either condition changes in a cost reporting period beginning on or after July 1, 1985, the intermediary establishes a per resident amount for the hospital using the information from the first cost reporting period during which the hospital participates in Medicare and the residents are on duty during the first month of that period. Any GME program costs incurred by the hospital before that cost reporting period are reimbursed on a reasonable cost basis. The per resident amount is based on the lower of the amount specified in paragraph (e)(1)(i) or in paragraph (e)(1)(ii) of this section, subject to the provisions of paragraph (e)(1)(iii) of this section.

(i) The hospital's actual costs, incurred in connection with the GME program for the hospital's first cost reporting period in which residents were on duty during the first month of the cost reporting period.

(ii) Except as specified in paragraph (e)(1)(iii)of this section—

(A) For base periods that begin before October 1, 2002, the updated weighted mean value of per resident amounts of all hospitals located in the same geographic wage area, as that term is used in the prospective payment system under Part 412 of this chapter.

(B) For base periods beginning on or after October 1, 2002, the updated weighted mean value of per resident amounts of all hospitals located in the same geographic wage area is calculated using all per resident amounts (including primary care and obstetrics and gynecology and nonprimary care) and FTE resident counts from the most recently settled cost reports of those teaching hospitals.

(iii) If, under paragraph (e)(1)(ii)(A) or paragraph (e)(1)(ii)(B) of this section, there are fewer than three existing teaching hospitals with per resident amounts that can be used to calculate the weighted mean value per resident amount, for base periods beginning on or after October 1, 1997, the per resident amount equals the updated weighted mean value of per resident amounts of all hospitals located in the same census region as that term is used in § 412.62(f)(1)(i) of this chapter.

(2) *Short or long base-period cost reporting periods.* If a hospital's base-period cost reporting period reflects GME costs for a period that is shorter than 50 weeks or longer than 54 weeks, the intermediary converts the allowable costs for the base period into a daily figure. The daily figure is then multiplied by 365 or 366, as appropriate, to derive the approved per resident amount for a 12-month base-period cost reporting period. If a hospital has two cost reporting periods beginning in the base period, the later period serves as the base-period cost reporting period.

(3) *Short or long cost reporting periods beginning on or after July 1, 1985.* If a hospital's cost reporting period is shorter than 50 weeks or longer than 54 weeks, the hospital's intermediary should contact CMS Central Office to receive a special CPI–U adjustment factor.

(f) *Special use of locality-adjusted national average per resident amount.* Effective for portions of cost reporting periods beginning on or after July 1, 2005, a hospital that counts additional residents as a result of an increase in its FTE resident cap under § 413.79(c)(4) will receive direct GME payments based on those additional FTE residents using the locality-adjusted national average per resident amount, as determined under paragraph (d)(2)(ii) of this

section. The hospital will receive direct GME payments based on the sum of the following two direct GME calculations:

(1) A calculation using the hospital's per resident amount(s) as determined under paragraph (d) of this section and the hospital's number of FTE residents that are not attributable to an FTE resident cap increase under § 413.79(c)(4); and

(2) A calculation using the locality-adjusted national average per resident amount, as determined under paragraph (d)(2)(ii) of this section, inflated to the hospital's current cost reporting period, and the hospital's number of FTE residents that is attributable to the increase in the hospital's FTE resident cap under § 413.79(c)(4).

§ 413.78 Direct GME payments: Determination of the total number of FTE residents.

Subject to the weighting factors in §§ 413.79 and 413.80, and subject to the provisions of § 413.81, the count of FTE residents is determined as follows:

(a) Residents in an approved program working in all areas of the hospital complex may be counted.

(b) No individual may be counted as more than one FTE. A hospital cannot claim the time spent by residents training at another hospital. Except as provided in paragraphs (c), (d), and (e) of this section, if a resident spends time in more than one hospital or in a nonprovider setting, the resident counts as partial FTE based on the proportion of time worked at the hospital to the total time worked. A part-time resident counts as a partial FTE based on the proportion of allowable time worked compared to the total time necessary to fill a full-time internship or residency slot.

(c) On or after July 1, 1987, and for portions of cost reporting periods occurring before January 1, 1999, the time residents spend in nonprovider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs is not excluded in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met—

(1) The resident spends his or her time in patient care activities.

(2) There is a written agreement between the hospital and the outside entity that states that the resident's compensation for training time spent outside of the hospital setting is to be paid by the hospital.

(d) For portions of cost reporting periods occurring on or after January 1, 1999, and before October 1, 2004, the time residents spend in nonprovider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs may be included in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met—

(1) The resident spends his or her time in patient care activities.

(2) The written agreement between the hospital and the nonhospital site must indicate that the hospital will incur the cost of the resident's salary and fringe benefits while the resident is training in the nonhospital site and the hospital is providing reasonable compensation to the nonhospital site for supervisory teaching activities. The agreement must indicate the compensation the hospital is providing to the nonhospital site for supervisory teaching activities.

(3) The hospital must incur all or substantially all of the costs for the training program in the nonhospital setting in accordance with the definition in § 413.75(b).

(4) The hospital is subject to the principles of community support and redistribution of costs as specified in § 413.81.

(e) For portions of cost reporting periods occurring on or after October 1, 2004, the time residents spend in nonprovider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs may be included in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met—

(1) The resident spends his or her time in patient care activities.

(2) The hospital must incur all or substantially all of the costs of the training program in a nonhospital setting(s) (in accordance with the definition under § 413.75(b)) attributable to training that occurs during a month by the end of the month following the month in which the training in the nonhospital site occurred.

(3) The hospital is subject to the principles of community support and redistribution of costs as specified in § 413.81.

§ 413.79 Direct GME payments: Determination of the weighted number of FTE residents.

Subject to the provisions in § 413.80, CMS determines a hospital's number of FTE residents by applying a weighting factor to each resident and then summing the resulting numbers that represent each resident. The weighting factor is determined as follows:

(a) *Initial residency period.* Generally, for purposes of this section, effective July 1, 1995, an initial residency period is defined as the minimum number of years required for board eligibility.

(1) Prior to July 1, 1995, the initial residency period equals the minimum number of years required for board eligibility in a specialty or subspecialty plus 1 year. An initial residency period may not exceed 5 years in order to be counted toward determining FTE status except in the case of a resident in an approved geriatric program whose initial residency period may last up to 2 additional years.

(2) Effective October 1, 2003, for a resident who trains in an approved geriatric program that requires the residents to complete 2 years of training to initially become board eligible in the geriatric specialty, the 2 years spent in the geriatrics program are treated as part of the resident's initial residency period.

(3) Effective July 1, 2000, for residency programs that began before, on, or after November 29, 1999, the period of board eligibility and the initial residency period for a resident in an approved child neurology program is the period of board eligibility for pediatrics plus 2 years.

(4) Effective August 10, 1993, residents or fellows in an approved preventive medicine residency or fellowship program also may be counted as a full FTE resident for up to 2 additional years beyond the initial residency period limitations.

(5) For combined residency programs, an initial residency period is defined as the time required for individual certification in the longer of the programs. If the resident is enrolled in a combined medical residency training program in which all of the individual programs (that are combined) are for training primary care residents (as defined in § 413.75(b)) or obstetrics and gynecology residents, the initial residency period is the time required for individual certification in the longer of the programs plus 1 year.

(6) For residency programs other than those specified in paragraphs (a)(2) through (a)(4) of this section, the initial residency period is the minimum number of years of formal training necessary to satisfy the requirements for initial board eligibility in the particular specialty for which the resident is training, as specified in the most recently published edition of the Graduate Medical Education Directory.

(7) For residency programs in osteopathy, dentistry, and podiatry, the minimum requirement for certification in a specialty or subspecialty is the minimum number of years of formal

training necessary to satisfy the requirements of the appropriate approving body listed in § 415.152 of this chapter.

(8) For residency programs in geriatric medicine, accredited by the appropriate approving body listed in § 415.152 of this chapter, these programs are considered approved programs on the later of—

(i) The starting date of the program within a hospital; or

(ii) The hospital's cost reporting periods beginning on or after July 1, 1985.

(9) The time spent in residency programs that do not lead to certification in a specialty or subspecialty, but that otherwise meet the definition of approved programs, as described in § 413.75(b), is counted toward the initial residency period limitation.

(b) *Weighting factor*—(1) If the resident is in an initial residency period, the weighting factor is one.

(2) If the resident is not in an initial residency period, the weighting factor is 1.00 during the period beginning on or after July 1, 1985 and before July 1, 1986, .75 during the period beginning on or after July 1, 1986 and before July 1, 1987, and .50 thereafter without regard to the hospital's cost reporting period.

(c) *Unweighted FTE counts.*

(1) *Definitions.* As used in this paragraph (c):

(i) *Otherwise applicable resident cap* refers to a hospital's FTE resident cap that is determined for a particular cost reporting period under paragraph (c)(2) of this section.

(ii) *Reference resident level* refers to a hospital's resident level in the applicable reference period specified under paragraph (c)(3)(ii) of this section.

(iii) *Resident level* refers to the number of unweighted allopathic and osteopathic FTE residents who are training in a hospital in a particular cost reporting period.

(2) *Determination of the FTE resident cap.* Subject to the provisions of paragraphs (c)(3) and (c)(4) of this section and § 413.81, for purposes of determining direct GME payment—

(i) For cost reporting periods beginning on or after October 1, 1997, a hospital's resident level may not exceed the hospital's unweighted FTE count (or, effective for cost reporting periods beginning on or after April 1, 2000, 130 percent of the unweighted FTE count for a hospital located in a rural area) for these residents for the most recent cost reporting period ending on or before December 31, 1996.

(ii) If a hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 1997, and before October 1, 2001, exceeds the limit described in this section, the hospital's total weighted FTE count (before application of the limit) will be reduced in the same proportion that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996.

(iii) If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section, the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced in the same proportion that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996.

(iv) Hospitals that are part of the same Medicare GME affiliated group (as described under § 413.75(b)) may elect to apply the limit on an aggregate basis as described under paragraph (f) of this section.

(v) The fiscal intermediary may make appropriate modifications to apply the provisions of this paragraph (c) of this section based on the equivalent of a 12-month cost reporting period.

(3) *Determination of the reduction to the FTE resident cap due to unused FTE resident slots.* If a hospital's reference resident level is less than its otherwise applicable FTE resident cap as determined under paragraph (c)(2) of this section or paragraph (e) of this section in the reference cost reporting period (as described under paragraph (c)(3)(ii) of this section), for portions of cost reporting periods beginning on or after July 1, 2005, the hospital's otherwise applicable FTE resident cap is reduced by 75 percent of the difference between the otherwise applicable FTE resident cap and the reference resident level. Under this provision—

(i) *Exemption for certain rural hospitals.* Rural hospitals, as defined at § 412.62(f)(iii), with less than 250 beds (as determined at § 412.105(b)) in its most recent cost reporting period ending on or before September 30, 2002, are exempt from the reduction to the otherwise applicable FTE resident cap limit under paragraph (c)(3) of this section.

(ii) *Reference cost reporting periods.*

(A) To determine a hospital's reference resident level, CMS uses one of the following periods:

(*1*) A hospital's most recent cost reporting period ending on or before September 30, 2002, for which a cost report has been settled or if the cost report has not been settled, the as-submitted cost report (subject to audit); or

(*2*) A hospital's cost reporting period that includes July 1, 2003 if the hospital increased its resident level due to an expansion of an existing program and that expansion is not reflected on the hospital's most recent settled cost report; and if the hospital makes a request to use that cost reporting period within a timeframe designated by CMS. An expansion of an existing program means that, except for expansions due to newly approved programs under paragraph (c)(3)(ii)(A)(*3*) of this section, the number of unweighted allopathic and osteopathic FTE residents, regardless of specialty, in any cost reporting period after the hospital's most recent settled cost report, up to and including the hospital's cost report that includes July 1, 2003, is greater than the number of unweighted allopathic and osteopathic FTE residents in the hospital's most recent settled cost report.

(*3*) A hospital may submit a request, within the timeframe designated by CMS, that CMS adjust the resident level for purposes of determining any reduction under paragraph (c)(3) of this section.

(*i*) In the hospital's reference cost reporting period under paragraph (c)(3)(ii)(A)(*1*) of this section, to include the number of FTE residents for which a new program was accredited by the appropriate allopathic or osteopathic accrediting body (listed under § 415.152 of this chapter) before January 1, 2002, if the program was not in operation during the reference cost reporting period under paragraph (c)(3)(ii)(A)(*1*) or (c)(3)(ii)(A)(*2*) of this section; or

(*ii*) In the hospital's reference cost reporting period under paragraph (c)(3)(ii)(A)(*2*) of this section, to include the number of FTE residents for which a new program was accredited by the appropriate allopathic or osteopathic accrediting body (listed under § 415.152 of this chapter) before January 1, 2002, if the program was not in operation during the cost reporting period that includes July 1, 2003, and if the hospital also qualifies to use its cost report under paragraph (c)(3)(ii)(A)(*2*) of this section due to an expansion of an existing program.

(B) If the cost report that is used to determine a hospital's otherwise

applicable FTE resident cap in the reference period is not equal to 12 months, the fiscal intermediary may make appropriate modifications to apply the provisions of paragraph (c)(3)(i)(A) of this section based on the equivalent of a 12-month cost reporting period.

(iii) If the new program described in paragraph (c)(3)(ii)(A)(3)(i) or paragraph (c)(3)(ii)(A)(ii) was accredited for a range of residents, the hospital may request that its reference resident level in its applicable reference cost reporting period under paragraph (c)(3)(ii)(A)(*1*) or (c)(3)(ii)(A)(*2*) of this section be adjusted to reflect the maximum number of accredited slots.

(iv) *Consideration of Medicare GME affiliated group agreements.* For hospitals that are members of the same affiliated group for the program year July 1, 2003 through June 30, 2004, in determining whether a hospital's otherwise applicable resident FTE resident cap is reduced under paragraph (c)(3) of this section, CMS utilizes a hospital's otherwise applicable FTE resident cap as revised by a Medicare GME affiliation agreement for hospitals that are members of the same affiliated group (as described under § 413.75(b)) for the program year July 1, 2003 through June 30, 2004. Possible reductions to a hospital's otherwise applicable FTE resident cap are made on a hospital-specific basis. If the hospital's reference resident level is below its otherwise applicable FTE resident cap as adjusted by the July 1, 2003 Medicare GME affiliation agreement, the hospital's otherwise applicable FTE resident cap is reduced by 75 percent of the difference between the hospital's reference resident level and the otherwise applicable FTE resident cap as adjusted by the July 1, 2003 Medicare GME affiliation agreement.

(4) *Determination of an increase in otherwise applicable resident cap.* For portions of cost reporting periods beginning on or after July 1, 2005, a hospital may receive an increase in its otherwise applicable FTE resident cap up to an additional 25 FTEs (as determined by CMS) if the hospital meets the requirements and qualifying criteria of section 1886(h)(7) of the Act and implementing instructions issued by CMS and if the hospital submits an application to CMS within the timeframe specified by CMS.

(5) *Special rules for hospitals that participate in demonstration projects or voluntary resident reduction plans.*

(i) If a hospital was participating in a demonstration project under section 402 of Public Law 90–248 or the voluntary reduction plan under § 413.88 at any time during the hospital's most recent cost reporting period ending on or before September 30, 2002, for purposes of determining a possible reduction to the FTE resident caps under paragraph (c)(3) of this section, CMS compares the higher of the hospital's base number of residents or the hospital's reference resident level to the hospital's otherwise applicable resident cap determined under paragraph (c)(2) of this section.

(ii) If a hospital withdrew its participation in the demonstration project or the voluntary resident reduction plan prior to its most recent cost reporting period ending on or before September 30, 2002, the special rules in paragraph(c)(5)(i) do not apply, and the hospital is subject to the procedures applicable to all other hospitals for determining possible reductions to the FTE resident caps under paragraph (c)(3) of this section.

(iii) CMS will not redistribute residency positions that are attributable to a hospital's participation in a demonstration project or a voluntary resident reduction plan to other hospitals that seek to increase their FTE resident caps under paragraph (c)(4) of this section.

(d) *Weighted FTE counts.* Subject to the provisions of § 413.81, for purposes of determining direct GME payment—

(1) For the hospital's first cost reporting period beginning on or after October 1, 1997, the hospital's weighted FTE count is equal to the average of the weighted FTE count for the payment year cost reporting period and the preceding cost reporting period.

(2) For cost reporting periods beginning on or after October 1, 1998, and before October 1, 2001, the hospital's weighted FTE count is equal to the average of the weighted FTE count for the payment year cost reporting period and the preceding two cost reporting periods.

(3) For cost reporting periods beginning on or after October 1, 2001, the hospital's weighted FTE count for primary care and obstetrics and gynecology residents is equal to the average of the weighted primary care and obstetrics and gynecology counts for the payment year cost reporting period and the preceding two cost reporting periods, and the hospital's weighted FTE count for nonprimary care residents is equal to the average of the weighted nonprimary care FTE counts for the payment year cost reporting period and the preceding two cost reporting periods.

(4) The fiscal intermediary may make appropriate modifications to apply the provisions of this paragraph (d) based on the equivalent of 12-month cost reporting periods.

(5) If a hospital qualifies for an adjustment to the limit established under paragraph (c)(2) of this section for new medical residency programs created under paragraph (e) of this section, the count of the residents participating in new medical residency training programs above the number included in the hospital's FTE count for the cost reporting period ending during calendar year 1996 is added after applying the averaging rules in this paragraph (d), for a period of years. Residents participating in new medical residency training programs are included in the hospital's FTE count before applying the averaging rules after the period of years has expired. For purposes of this paragraph (d), for each new program started, the period of years equals the minimum accredited length for each new program. The period of years begins when the first resident begins training in each new program.

(6) Subject to the provisions of paragraph (h) of this section, FTE residents that are displaced by the closure of either another hospital or another hospital's program are added to the FTE count after applying the averaging rules in this paragraph (d), for the receiving hospital for the duration of the time that the displaced residents are training at the receiving hospital.

(7) Subject to the provisions under paragraph (k) of this section, effective for cost reporting periods beginning on or after April 1, 2000, FTE residents in a rural track program at an urban hospital are included in the urban hospital's rolling average calculation described in this paragraph (d).

(8) Subject to the provisions under paragraph(c)(4) of this section, effective for portions of cost reporting periods beginning on or after July 1, 2005, FTE residents added by a hospital as a result of an increase in a hospital's FTE resident cap under paragraph (c)(4) of this section are included in the hospital's rolling average calculation described in this paragraph (d).

(e) *New medical residency training programs.* If a hospital establishes a new medical residency training program as defined in paragraph (l) of this section on or after January 1, 1995, the hospital's FTE cap described under paragraph (c) of this section may be adjusted as follows:

(1) If a hospital had no allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, and it establishes a new medical residency training program on or after January 1, 1995, the hospital's unweighted FTE

resident cap under paragraph (c) of this section may be adjusted based on the product of the highest number of residents in any program year during the third year of the first program's existence for all new residency training programs and the number of years in which residents are expected to complete the program based on the minimum accredited length for the type of program. The adjustment to the cap may not exceed the number of accredited slots available to the hospital for the new program.

(i) If the residents are spending an entire program year (or years) at one hospital and the remainder of the program at another hospital, the adjustment to each respective hospital's cap is equal to the product of the highest number of residents in any program year during the third year of the first program's existence and the number of years the residents are training at each respective hospital.

(ii) Prior to the implementation of the hospital's adjustment to its FTE cap beginning with the fourth year of the hospital's residency program(s), the hospital's cap may be adjusted during each of the first 3 years of the hospital's new residency program using the actual number of residents participating in the new program. The adjustment may not exceed the number of accredited slots available to the hospital for each program year.

(iii) Except for rural hospitals, the cap will not be adjusted for new programs established more than 3 years after the first program begins training residents.

(iv) An urban hospital that qualifies for an adjustment to its FTE cap under paragraph (e)(1) of this section is not permitted to be part of a Medicare GME affiliated group for purposes of establishing an aggregate FTE cap.

(v) A rural hospital that qualifies for an adjustment to its FTE cap under paragraph (e)(1) of this section is permitted to be part of a Medicare GME affiliated group for purposes of establishing an aggregate FTE cap.

(2) If a hospital had allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, the hospital's unweighted FTE cap may be adjusted for new medical residency training programs established on or after January 1, 1995 and on or before August 5, 1997. The adjustment to the hospital's FTE resident limit for the new program is based on the product of the highest number of residents in any program year during the third year of the newly established program and the number of years in which residents are expected to complete each program based on the minimum accredited length for the type of program.

(i) If the residents are spending an entire program year (or years) at one hospital and the remainder of the program at another hospital, the adjustment to each respective hospital's cap is equal to the product of the highest number of residents in any program year during the third year of the first program's existence and the number of years the residents are training at each respective hospital.

(ii) Prior to the implementation of the hospital's adjustment to its FTE cap beginning with the fourth year of the hospital's residency program, the hospital's cap may be adjusted during each of the first 3 years of the hospital's new residency program, using the actual number of residents in the new programs. The adjustment may not exceed the number of accredited slots available to the hospital for each program year.

(3) If a hospital with allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, is located in a rural area (or other hospitals located in rural areas that added residents under paragraph (e)(1) of this section), the hospital's unweighted FTE limit may be adjusted in the same manner described in paragraph (e)(2) of this section to reflect the increase for residents in the new medical residency training programs established after August 5, 1997. For these hospitals, the limit will be adjusted for additional new programs but not for expansions of existing or previously existing programs.

(4) A hospital seeking an adjustment to the limit on its unweighted resident count policy must provide documentation to its fiscal intermediary justifying the adjustment.

(f) *Medicare GME affiliated group.* A hospital may receive a temporary adjustment to its FTE cap, which is subject to the averaging rules under paragraph (e)(3) of this section, to reflect residents added or subtracted because the hospital is participating in a Medicare GME affiliated group (as defined under § 413.75(b)). Under this provision—

(1) Each hospital in the Medicare GME affiliated group must submit the Medicare GME affiliation agreement, as defined under § 413.75(b) of this section, to the CMS fiscal intermediary servicing the hospital and send a copy to CMS's Central Office no later than July 1 of the residency program year during which the Medicare GME affiliation agreement will be in effect.

(2) Each hospital in the Medicare GME affiliated group must have a shared rotational arrangement, as defined in § 413.75(b), with at least one other hospital within the Medicare GME affiliated group, and all of the hospitals within the Medicare GME affiliated group must be connected by a series of such shared rotational arrangements.

(3) During the shared rotational arrangements under a Medicare GME affiliation agreement, as defined in § 413.75(b), more than one of the hospitals in the Medicare GME affiliated group must count the proportionate amount of the time spent by the resident(s) in its FTE resident counts. No resident may be counted in the aggregate as more than one FTE.

(4) The net effect of the adjustments (positive or negative) on the Medicare GME affiliated hospitals' aggregate FTE cap for each Medicare GME affiliation agreement must not exceed zero.

(5) If the Medicare GME affiliation agreement terminates for any reason, the FTE cap of each hospital in the Medicare GME affiliated group will revert to the individual hospital's pre-affiliation FTE cap that is determined under the provisions of paragraph (c) of this section.

(g) *Newly constructed hospitals.* A hospital that began construction of its facility prior to August 5, 1997, and sponsored new medical residency training programs on or after January 1, 1995, and on or before August 5, 1997, that either received initial accreditation by the appropriate accrediting body or temporarily trained residents at another hospital(s) until the facility was completed, may receive an adjustment to its FTE cap.

(1) The newly constructed hospital's FTE cap is equal to the lesser of—

(i) The product of the highest number of residents in any program year during the third year of the newly established program and the number of years in which residents are expected to complete the programs based on the minimum accredited length for each type of program; or

(ii) The number of accredited slots available to the hospital for each year of the programs.

(2) If the new medical residency training programs sponsored by the newly constructed hospital have been in existence for 3 years or more by the time the residents begin training at the newly constructed hospital, the newly constructed hospital's cap will be based on the number of residents training in the third year of the programs begun at the temporary training site.

(3) If the new medical residency training programs sponsored by the newly constructed hospital have been in existence for less than 3 years by the

time the residents begin training at the newly constructed hospital, the newly constructed hospital's cap will be based on the number of residents training at the newly constructed hospital in the third year of the programs (including the years at the temporary training site).

(4) A hospital that qualifies for an adjustment to its FTE cap under this paragraph (g) may be part of an affiliated group for purposes of establishing an aggregate FTE cap.

(5) The provisions of this paragraph (g) are applicable during portions of cost reporting periods occurring on or after October 1, 1999.

(h) *Closure of hospital or hospital residency program.*

(1) *Definitions.* For purposes of this section—

(i) *Closure of a hospital* means the hospital terminates its Medicare agreement under the provisions of § 489.52 of this chapter.

(ii) *Closure of a hospital residency training program* means the hospital ceases to offer training for residents in a particular approved medical residency training program.

(2) *Closure of a hospital.* A hospital may receive a temporary adjustment to its FTE cap to reflect residents added because of another hospital's closure if the hospital meets the following criteria:

(i) The hospital is training additional residents from a hospital that closed on or after July 1, 1996.

(ii) No later than 60 days after the hospital begins to train the residents, the hospital submits a request to its fiscal intermediary for a temporary adjustment to its FTE cap, documents that the hospital is eligible for this temporary adjustment by identifying the residents who have come from the closed hospital and have caused the hospital to exceed its cap, and specifies the length of time the adjustment is needed.

(3) *Closure of a hospital's residency training program.* If a hospital that closes its residency training program voluntarily agrees to temporarily reduce its FTE cap according to the criteria specified in paragraph (h)(3)(ii) of this section, another hospital(s) may receive a temporary adjustment to its FTE cap to reflect residents added because of the closure of the residency training program if the criteria specified in paragraph (h)(3)(i) of this section are met.

(i) *Receiving hospital(s).* A hospital may receive a temporary adjustment to its FTE cap to reflect residents added because of the closure of another hospital's residency training program if—

(A) The hospital is training additional residents from the residency training program of a hospital that closed a program; and

(B) No later than 60 days after the hospital begins to train the residents, the hospital submits to its fiscal intermediary a request for a temporary adjustment to its FTE cap, documents that it is eligible for this temporary adjustment by identifying the residents who have come from another hospital's closed program and have caused the hospital to exceed its cap, specifies the length of time the adjustment is needed, and submits to its fiscal intermediary a copy of the FTE reduction statement by the hospital that closed its program, as specified in paragraph (h)(3)(ii)(B) of this section.

(ii) *Hospital that closed its program(s).* A hospital that agrees to train residents who have been displaced by the closure of another hospital's program may receive a temporary FTE cap adjustment only if the hospital with the closed program—

(A) Temporarily reduces its FTE cap based on the FTE residents in each program year training in the program at the time of the program's closure. This yearly reduction in the FTE cap will be determined based on the number of those residents who would have been training in the program during that year had the program not closed; and

(B) No later than 60 days after the residents who were in the closed program begin training at another hospital, submit to its fiscal intermediary a statement signed and dated by its representative that specifies that it agrees to the temporary reduction in its FTE cap to allow the hospital training the displaced residents to obtain a temporary adjustment to its cap; identifies the residents who were in training at the time of the program's closure; identifies the hospitals to which the residents are transferring once the program closes; and specifies the reduction for the applicable program years.

(i) *Additional FTEs for residents on maternity or disability leave or other approved leave of absence.* Effective for cost reporting periods beginning on or after November 29, 1999, a hospital may receive an adjustment to its FTE cap of up to three additional resident FTEs, if the hospital meets the following criteria:

(1) The additional residents are residents of a primary care program that would have been counted by the hospital as residents for purposes of the hospital's FTE cap but for the fact that the additional residents were on maternity or disability leave or a similar approved leave of absence during the hospital's most recent cost reporting period ending on or before December 31, 1996;

(2) The leave of absence was approved by the residency program director to allow the residents to be absent from the program and return to the program after the leave of absence; and

(3) No later than 6 months after August 1, 2000, the hospital submits to the fiscal intermediary a request for an adjustment to its FTE cap, and provides contemporaneous documentation of the approval of the leave of absence by the residency director, specific to each additional resident that is to be counted for purposes of the adjustment.

(j) *Residents previously trained at VA hospitals.* For cost reporting periods beginning on or after October 1, 1997, a non-Veterans Affairs (VA) hospital may receive a temporary adjustment to its FTE cap to reflect residents who had previously trained at a VA hospital and were subsequently transferred to the non-VA hospital, if that hospital meets the following criteria:

(1) The transferred residents had been training previously at a VA hospital in a program that would have lost its accreditation by the ACGME if the residents continued to train at the VA hospital;

(2) The residents were transferred to the hospital from the VA hospital on or after January 1, 1997, and before July 31, 1998; and

(3) The hospital submits a request to its fiscal intermediary for a temporary adjustment to its FTE cap, documents that it is eligible for this temporary adjustment by identifying the residents who have come from the VA hospital, and specifies the length of time those residents will be trained at the hospital.

(k) *Residents training in rural track programs.* Subject to the provisions of § 413.81, an urban hospital that establishes a new residency program, or has an existing residency program, with a rural track (or an integrated rural track) may include in its FTE count residents in those rural tracks, in addition to the residents subject to its FTE cap specified under paragraph (c) of this section. An urban hospital with a rural track residency program may count residents in those rural tracks up to a rural track FTE limitation if the hospital complies with the conditions specified in paragraphs (k)(2) through (k)(6) of this section.

(1) If an urban hospital rotates residents to a separately accredited rural track program at a rural hospital(s) for two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2000, and before October 1, 2003, or for more than

one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003, the urban hospital may include those residents in its FTE count for the time the rural track residents spend at the urban hospital. The urban hospital may include in its FTE count those residents in the rural track training at the urban hospital, not to exceed its rural track FTE limitation, determined as follows:

(i) For the first 3 years of the rural track's existence, the rural track FTE limitation for each urban hospital will be the actual number of FTE residents, subject to the rolling average at paragraph (d)(7) of this section, training in the rural track at the urban hospital.

(ii) Beginning with the fourth year of the rural track's existence, the rural track FTE limitation is equal to the product of the highest number of residents, in any program year, who during the third year of the rural track's existence are training in the rural track at the urban hospital or the rural hospital(s) and are designated at the beginning of their training to be rotated to the rural hospital(s) for at least two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2000, and before October 1, 2002, or for more than one-half of the duration of the program effective for cost reporting periods beginning on or after October 1, 2003, and the number of years those residents are training at the urban hospital.

(2) If an urban hospital rotates residents to a separately accredited rural track program at a rural nonhospital site(s) for two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2000, and before October 1, 2003, or for more than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003, the urban hospital may include those residents in its FTE count, subject to the requirements under § 413.78(d). The urban hospital may include in its FTE count those residents in the rural track, not to exceed its rural track FTE limitation, determined as follows:

(i) For the first 3 years of the rural track's existence, the rural track FTE limitation for each urban hospital will be the actual number of FTE residents, subject to the rolling average specified in paragraph (d)(7) of this section, training in the rural track at the urban hospital and the rural nonhospital site(s).

(ii) Beginning with the fourth year of the rural track's existence, the rural track FTE limitation is equal to the product of—

(A) The highest number of residents in any program year who, during the third year of the rural track's existence, are training in the rural track at—

(*1*) The urban hospital and are designated at the beginning of their training to be rotated to a rural nonhospital site(s) for at least two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2000 and before October 1, 2003, or for more than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003; and

(*2*) The rural nonhospital site(s); and

(B) The number of years in which the residents are expected to complete each program based on the minimum accredited length for the type of program.

(3) If an urban hospital rotates residents in the rural track program to a rural hospital(s) for less than two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2000, and before October 1, 2003, or for one-half or less than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003, the rural hospital may not include those residents in its FTE count (if the rural track is not a new program under paragraph (e)(3) of this section, or if the rural hospital's FTE count exceeds that hospital's FTE cap), nor may the urban hospital include those residents when calculating its rural track FTE limitation.

(4) If an urban hospital rotates residents in the rural track program to a rural nonhospital site(s) for period of time is less than two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2000 and before October 1, 2003, or for one-half or less than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003, the urban hospital may include those residents in its FTE count, subject to the requirements under § 413.78(d). The urban hospital may include in its FTE count those residents in the rural track, not to exceed its rural track limitation, determined as follows:

(i) For the first 3 years of the rural track's existence, the rural track FTE limitation for the urban hospital will be the actual number of FTE residents, subject to the rolling average specified in paragraph (d)(7) of this section, training in the rural track at the rural nonhospital site(s).

(ii) Beginning with the fourth year of the rural track's existence, the rural track FTE limitation is equal to the product of—

(A) The highest number of residents in any program year who, during the third year of the rural track's existence, are training in the rural track at the rural nonhospital site(s) or are designated at the beginning of their training to be rotated to the rural nonhospital site(s) for a period that is less than two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2002, and before October 1, 2003, or for one-half or less than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003; and

(B) The length of time in which the residents are being training at the rural nonhospital site(s) only.

(5) All urban hospitals that wish to count FTE residents in rural tracks, not to exceed their respective rural track FTE limitation, must also comply with all of the following conditions:

(i) An urban hospital may not include in its rural track FTE limitation or (assuming the urban hospital's FTE count exceeds its FTE cap) FTE count residents who are training in a rural track residency program that were already included as part of the hospital's FTE cap.

(ii) The hospital must base its count of residents in a rural track on written contemporaneous documentation that each resident enrolled in a rural track program at the hospital intends to rotate for a portion of the residency program to a rural area.

(iii) All residents that are included by the hospital as part of its rural track FTE count (not to exceed its rural track FTE limitation) must train in the rural area. However, where a resident begins to train in the rural track program at the urban hospital but leaves the program before completing the total required portion of training in the rural area, the urban hospital may count the time the resident trained in the urban hospital if another resident fills the vacated FTE slot and completes the training in the rural portion of the rural track program. An urban hospital may not receive GME payment for the time the resident trained at the urban hospital if another resident fills the vacated FTE slot and first begins to train at the urban hospital.

(6) If CMS finds that residents who are included by the urban hospital as part of its FTE count did not actually complete the training in the rural area, CMS will reopen the urban hospital's cost report within the 3-year reopening period as specified in § 405.1885 of this chapter and adjust the hospital's Medicare GME payments (and, where applicable, the hospital's rural track FTE limitation).

(l) For purposes of this section, a new medical residency training program means a medical residency that receives initial accreditation by the appropriate accrediting body or begins training residents on or after January 1, 1995.

§ 413.80 Direct GME payments: Determination of weighting factors for foreign medical graduates.

(a) The weighting factor for a foreign medical graduate is determined under the provisions of § 413.79 if the foreign medical graduate—

(1) Has passed FMGEMS; or

(2) Before July 1, 1986, received certification from, or passed an examination of, the Educational Committee for Foreign Medical Graduates.

(b) Before July 1, 1986, the weighting factor for a foreign medical graduate is 1.0 times the weight determined under the provisions of § 413.79. On or after July 1, 1986, and before July 1, 1987, the weighting factor for a graduate of a foreign medical school who was in a residency program both before and after July 1, 1986 but who does not meet the requirements set forth in paragraph (a) of this section is .50 times the weight determined under the provisions of § 413.79.

(c) On or after July 1, 1987, these foreign medical graduates are not counted in determining the number of FTE residents.

(d) During the cost reporting period in which a foreign medical graduate passes FMGEMS, the weighting factor for that resident is determined under the provisions of § 413.79 for the part of the cost reporting period beginning with the month the resident passes the test.

(e) On or after September 1, 1989, the National Board of Medical Examiners Examination, Parts I and II, may be substituted for FMGEMS for purposes of the determination made under paragraphs (a) and (d) of this section.

(f) On or after June 1, 1992, the United States Medical Licensing Examination may be substituted for the FMGEMS for purposes of the determination made under paragraphs (a) and (d) of this section. On or after July 1, 1993, only the results of steps I and II of the United States Medical Licensing Examination will be accepted for purposes of making this determination.

(g) To include a resident in the FTE count for a particular cost reporting period, the hospital must furnish the following information. The information must be certified by an official of the hospital and, if different, an official responsible for administering the residency program.

(1) The name and social security number of the resident.

(2) The type of residency program in which the individual participates and the number of years the resident has completed in all types of residency programs.

(3) The dates the resident is assigned to the hospital and any hospital-based providers.

(4) The dates the resident is assigned to other hospitals, or other freestanding providers, and any nonprovider setting during the cost reporting period, if any.

(5) The name of the medical, osteopathic, dental, or podiatric school from which the resident graduated and the date of graduation.

(6) If the resident is an FMG, documentation concerning whether the resident has satisfied the requirements of this section.

(7) The name of the employer paying the resident's salary.

§ 413.81 Direct GME payments: Application of community support and redistribution of costs in determining FTE resident counts.

(a) For purposes of determining direct GME payments, the following principles apply:

(1) *Community support.* If the community has undertaken to bear the costs of medical education through community support, the costs are not considered GME costs to the hospital for purposes of Medicare payment.

(2) *Redistribution of costs.* The costs of training residents that constitute a redistribution of costs from an educational institution to the hospital are not considered GME costs to the hospital for purposes of Medicare payment.

(b) *Application.* A hospital must continuously incur costs of direct GME of residents training in a particular program at a training site since the date the residents first began training in that program in order for the hospital to count the FTE residents in accordance with the provisions of §§ 413.78, 413.79 (c) through (e), and 413.79(k). This rule also applies to providers that are paid for direct GME in accordance with § 405.2468 of this chapter, § 422.270 of this subchapter, and § 413.70.

(c)(1) *Effective date.* Subject to the provisions of paragraph (c)(2) of this section, payments made in accordance with determinations made under the provisions of paragraphs (a) and (b) of this section will be effective for portions of cost reporting periods occurring on or after October 1, 2003.

(2) *Applicability for certain hospitals.* With respect to an FTE resident who begins training in a residency program on or before October 1, 2003, and with respect to whom there has been a redistribution of costs or community support determined under the provisions of paragraphs (a) and (b) of this section, the hospital may continue to count the FTE resident until the resident has completed training in that program, or until 3 years after the date the resident began training in that program, whichever comes first.

§ 413.82 Direct GME payments: Special rules for States that formerly had a waiver from Medicare reimbursement principles.

(a) Effective for cost reporting periods beginning on or after January 1, 1986, hospitals in States that, prior to becoming subject to the prospective payment system, had a waiver for the operation of a State reimbursement control system under section 1886(c) of the Act, section 402 of the Social Security Amendments of 1967 (42 U.S.C. 1395b–1 or section 222(a) of the Social Security Amendment of 1972 (42 U.S.C. 1395b–1 (note)) are permitted to change the order in which they allocate administrative and general costs to the order specified in the instructions for the Medicare cost report.

(b) For hospitals making this election, the base-period costs for the purpose of determining the per resident amount are adjusted to take into account the change in the order by which they allocate administrative and general costs to interns and residents in approved program cost centers.

(c) Per resident amounts are determined for the base period and updated as described in § 413.77. For cost reporting periods beginning on or after January 1, 1986, payment is made based on the methodology described in § 413.76.

§ 413.83 Direct GME payments: Adjustment of a hospital's target amount or prospective payment hospital-specific rate.

(a) *Misclassified operating costs*—(1) *General rule.* If a hospital has its base-period GME costs reduced under § 413.77(a) of this section because those costs included misclassified operating costs, the hospital may request that the intermediary review the classification of the affected costs in its rate-of-increase ceiling or prospective payment base year for purposes of adjusting the hospital's target amount or hospital-specific rate. For those cost reports that are not subject to reopening under § 405.1885 of this chapter, the hospital's reopening request must explicitly state that the review is limited to this one issue.

(2) *Request for review.* The hospital must request review of the classification

of its rate-of-increase ceiling or prospective payment base year costs no later than 180 days after the date of the notice by the intermediary of the hospital's base-period average per resident amount. A hospital's request for review must include sufficient documentation to demonstrate to the intermediary that adjustment of the hospital's hospital-specific rate or target amount is warranted.

(3) *Effect of intermediary's review.* If the intermediary, upon review of the hospital's costs, determines that the hospital's hospital-specific rate or target amount should be adjusted, the adjustment of the hospital-specific rate or the target amount is effective for the hospital's cost reporting periods subject to the prospective payment system or the rate-of-increase ceiling that are still subject to reopening under § 405.1885 of this chapter.

(b) *Misclassification of GME costs*—(1) *General rule.* If costs that should have been classified as GME costs were treated as operating costs during both the GME base period and the rate-of-increase ceiling base year or prospective payment base year and the hospital wishes to receive benefit for the appropriate classification of these costs as GME costs in the GME base period, the hospital must request that the intermediary review the classification of the affected costs in the rate-of-increase ceiling or prospective payment base year for purposes of adjusting the hospital's target amount or hospital-specific rate. For those cost reports that are not subject to reopening under § 405.1885 of this chapter, the hospital's reopening request must explicitly state that the review is limited to this one issue.

(2) *Request for review.* The hospital must request review of the classification of its costs no later than 180 days after the date of the intermediary's notice of the hospital's base-period average per resident amount. A hospital's request for review must include sufficient documentation to demonstrate to the intermediary that modification of the adjustment of the hospital's hospital-specific rate or target amount is warranted.

(3) *Effect of intermediary's review.* If the intermediary, upon review of the hospital's costs, determines that the hospital's hospital-specific rate or target amount should be adjusted, the adjustment of the hospital-specific rate and the adjustment of the target amount is effective for the hospital's cost reporting periods subject to the prospective payment system or the rate-of-increase ceiling that are still subject to reopening under § 405.1885 of this chapter.

§ 413.87 [Amended]

8. In § 413.87—

A. In paragraph (e), the cross-reference ''§ 413.86(d)(4)'' is removed and the cross-reference ''413.76(d)'' is added in its place.

B. In paragraph (f)(1)(i), the cross-reference ''413.86(d)(3)'' is removed and the cross-reference ''413.76(c)'' is added in its place.

§ 413.88 [Amended]

9. In § 413.88—

A. In paragraph (b)(1), the cross-reference ''413.86(b)'' is removed and the cross-reference ''§ 413.75(b)'' is added in its place.

B. In paragraph (b)(2), the cross-reference ''§ 413.86(b)'' is removed and the cross-reference ''§ 413.75(b)'' is added in its place.

C. In paragraph (d)(7), the reference ''413.86(b)'' is removed and the cross-reference ''§ 413.75(b)'' is added in its place.

D. In paragraphs (g)(1)(i)(A) and (B), the cross-reference ''§ 413.86(g)'' is removed and the cross-reference ''§ 413.79'' is added in its place, wherever it appears.

E. In paragraph (h)(1)(i), the cross-reference ''§ 413.86(d)'' (2 times) is removed and the cross-reference ''§ 413.76'' (2 times) is added in its place.

10. Section 413.114 is amended by revising the last sentence of paragraph (a)(2) to read as follows:

§ 413.114 Payment for posthospital SNF care furnished by a swing-bed hospital.

(a) * * *

(2) *Services furnished in cost reporting periods beginning on and after July 1, 2002.* * * * Posthospital SNF care furnished in general routine inpatient beds in CAHs is paid based on reasonable cost for cost reporting periods beginning on and after July l, 2002 and before January 1, 2004, and is paid based on 101 percent of reasonable cost for cost reporting periods beginning on and after January 1, 2004, in accordance with the provisions of subparts A through G of this part (other than paragraphs (c) and (d) of this section).

* * * * *

11. Section 413.302 is amended by revising the definition of ''Urban area'' to read as follows:

§ 413.302 Definitions.

For purposes of this subpart I—

* * * * *

Urban area means—

(1) Prior to October 1, 2004, a Metropolitan Statistical Area (MSA), or New England County Metropolitan Area (NECMA), as defined by the Office of Management and Budget, or a New England county deemed to be an urban area as listed in § 412.62(f)(1)(ii)(B) of this chapter.

(2) Effective October 1, 2004, a Metropolitan Statistical Area (MSA), as defined by the Office of Management and Budget, or a New England county deemed to be an urban area as specified under § 412.64.

D. Part 418 is amended as follows:

PART 418—HOSPICE CARE

1. The authority citation for part 418 continues to read as follows:

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

Section 418.100 is amended as follows:

A. Revising paragraph (d)(1).

B. Revising paragraph (d)(4).

C. Adding a new paragraph (d)(5).

The revision and addition read as follows:

§ 418.100 Condition of Participation: Hospices that provide inpatient care directly.

* * * * *

(d) *Standard: Fire protection.* (1) Except as otherwise provided in this section—

(i) The hospice must meet the provisions applicable to nursing homes of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101® 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD and at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: *http://www.archives.gov./federal_register/code_of_federal_regulations/ibr_locations.html.* Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the **Federal Register** to announce the changes.

(ii) Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the LSC does not apply to a hospice.

* * * * *

(4) Beginning March 13, 2006, a hospice must be in compliance with Chapter 9.2.9, Emergency Lighting.

(5) Beginning March 13, 2006, Chapter 19.3.6.3.2, exception number 2 does not apply to hospices.

* * * * *

E. Part 460 is amended as follows:

PART 460—PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

1. The authority citation for part 460 continues to read as follows:

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

Subpart E—PACE Administrative Requirements

2. Section 460.72 is amended by—

A. Revising paragraph (b)(1).

B. Revising paragraph (b)(3).

C. Adding paragraph (b)(4).

The revision and addition read as follows:

§ 460.72 Physical environment.

* * * * *

(b) *Fire safety.* (1) *General rule.* Except as otherwise provided in this section—

(i) A PACE center must meet the applicable provisions of the 2000 edition of the Life Safety Code (LSC) of the National Fire Protection Association that apply to the type of setting in which the center is located. The Director of the Office of the Federal Register has approved the NFPA 101® 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD and at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: *http://www.archives.gov./federal_register/code_of_federal_regulations/ibr_locations.html.* Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the **Federal Register** to announce the changes.

(ii) Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the LSC does not apply to PACE centers.

* * * * *

(3) Beginning March 13, 2006, a PACE center must be in compliance with Chapter 9.2.9, Emergency Lighting.

(4) Beginning March 13, 2006, Chapter 19.3.6.3.2, exception number 2 does not apply to PACE centers.

* * * * *

F. The title of Part 480 under Subchapter F is revised to read as follows:

PART 480—ACQUISITION, PROTECTION, AND DISCLOSURE OF QUALITY IMPROVEMENT ORGANIZATION INFORMATION

G. Part 480 is amended as follows:

1. The authority citation for Part 480 continues to read:

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

2. Section 480.106 is amended by adding a new paragraph (c) to read as follows:

§ 480.106 Exceptions to QIO notice requirements.

* * * * *

(c) *Other.* The notification requirements in § 480.105(a) and (b)(2) do not apply if:

(1) The institution or practitioner has requested, in writing, that the QIO make the disclosure;

(2) The institution or practitioner has provided, in writing, consent for the disclosure; or

(3) The information is public information as defined in § 480.101(b) and specified under § 480.120.

3. Section 480.133 is amended by revising paragraph (a)(2)(iii) to read as follows:

§ 480.133 Disclosure of information about practitioners, reviewers and institutions.

(a) * * *

(2) *Disclosure to others.* * * *

(iii) A QIO may disclose to any person, agency, or organization information on a particular practitioner or reviewer at the written request of or with the written consent of that practitioner or reviewer. The recipient of the information has the same redisclosure rights and responsibilities as the requesting or consenting practitioner or reviewer as provided under this Subpart B.

* * * * *

4. Section 480.140 is amended by redesignating paragraphs (d) and (e) as paragraphs (e) and (f), respectively, and adding a new paragraph (d) to read as follows:

§ 480.140 Disclosure of quality review study information.

* * * * *

(d) A QIO may disclose quality review study information with identifiers of particular practitioners or institutions, or both, at the written request of, or with the written consent of, the identified practitioner(s) or institution(s).

(1) The consent or request must specify the information that is to be disclosed and the intended recipient of the information.

(2) The recipient of the information has the same redisclosure rights and responsibilities as the requesting or consenting practitioner or reviewer as provided under this Subpart B.

* * * * *

5. Cross-Reference Changes

§§ 480.101, 480.104, 480.105, 480.106, 480.120, 480.121, 480.130, 480.132, 480.133, 480.136, 480.137, 480.138, 480.141, 480.142 [Amended]

In the table below, for each section indicated in the left column, remove the cross-reference indicated in the middle column from wherever it appears in the section, and add the cross-reference in the right column:

Section	Remove	Add.
480.101(b), under the definition ''Patient representative''	§ 476.132(c)(3)	§ 480.132(c)(3).
§ 480.104(a)(1)	§ 476.105	§ 480.105.
§ 480.104(a)(2)	§ 476.106	§ 480.106.
§ 480.104(a)(2)	§ 476.107	§ 480.107.
§ 480.104(d)	§ 476.120(a)(6)	§ 480.120(a)(6).
§ 480.105(a)	§ 476.106	§ 480.106.
§ 480.105(b)(1)	§ 476.132	§ 480.132.
§ 480.105(b)(2)	§§ 476.137 and 476.138	§§ 480.137 and 480.138.
§ 480.105(b)(2)	§ 476.106	§ 480.106.
§ 480.106(a)	§ 476.105	§ 480.105.

Section	Remove	Add.
§ 480.106(b)	§ 476.105	§ 480.105.
§ 480.120, introductory text	§§ 476.104 and 476.105	§§ 480.104 and 480.105.
§ 480.120(a)(5)	§ 476.139	§ 480.139.
§ 480.121	§ 476.105	§ 480.105.
§ 480.121	§ 476.120	§ 480.120.
§ 480.130	§§ 476.139(a) and 476.140	§§ 480.139(a) and 480.140.
§ 480.132(b)(2)	§ 476.139(a)	§ 480.139(a).
§ 480.132(b)(3)	§ 476.140	§ 480.140.
§ 480.133(a)(2)(ii)	§§ 476.137 and 476.138	§§ 480.137 and 480.138.
§ 480.133(b)(2)	§ 476.139(a)	§ 480.139(a).
§ 480.133(b)(3)	§ 476.140	§ 480.140.
§ 480.136(a), introductory text	§§ 476.139(a) and 476.140	§§ 480.139(a) and 480.140.
§ 480.137(a), introductory text	§§ 476.139(a) and 476.140	§§ 480.139(a) and 480.140.
§ 480.138(b)(2)	§§ 476.139(a) and 476.140	§§ 480.139(a) and 480.140.
§ 480.141	§§ 476.104 and 476.105	§§ 480.104 and 480.105.
§ 480.142(b)	§ 476.137	§ 480.137

H. Part 482 is amended as follows:

PART 482—CONDITIONS OF PARTICIPATION FOR HOSPITALS

1. The authority citation for part 482 continues to read as follows:

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

2. Section 482.41 is amended by-revising paragraph (b).

§ § 482.41 Conditions of participation: Physical environment.

* * * * *

(b) *Standard: Life safety from fire.* (1) Except as otherwise provided in this section—

(i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101® 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD and at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: *http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.* Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the **Federal Register** to announce the changes.

(ii) Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the LSC does not apply to hospitals.

(2) After consideration of State survey agency findings, CMS may waive specific provisions of the Life Safety Code which, if rigidly applied, would result in unreasonable hardship upon the facility, but only if the waiver does not adversely affect the health and safety of the patients.

(3) The provisions of the Life Safety Code do not apply in a State where CMS finds that a fire and safety code imposed by State law adequately protects patients in hospitals.

(4) Beginning March 13, 2006, a hospital must be in compliance with Chapter 19.2.9, Emergency Lighting.

(5) Beginning March 13, 2006, Chapter 19.3.6.3.2, exception number 2 does not apply to hospitals.

(6) The hospital must have procedures for the proper routine storage and prompt disposal of trash.

(7) The hospital must have written fire control plans that contain provisions for prompt reporting of fires; extinguishing fires; protection of patients, personnel and guests; evacuation; and cooperation with fire fighting authorities.

(8) The hospital must maintain written evidence of regular inspection and approval by State or local fire control agencies.

* * * * *

3. Section 482.43 is amended by adding new paragraphs (c)(6), (c)(7), and (c)(8) to read as follows:

§ 482.43 Conditions of participation: Discharge planning.

* * * * *

(c) * * *

(6) The hospital must include in the discharge plan a list of HHAs or SNFs that are available to the patient, that are participating in the Medicare program, and that serve the geographic area (as defined by the HHA) in which the patient resides, or in the case of a SNF, in the geographic area requested by the patient. HHAs must request to be listed by the hospital as available.

(i) This list must only be presented to patients for whom home health care or post-hospital extended care services are indicated and appropriate as determined by the discharge planning evaluation.

(ii) The hospital must document in the patient's medical record that the list was presented to the patient or to the individual acting on the patient's behalf.

(7) The hospital, as part of the discharge planning process, must inform the patient or the patient's family of their freedom to choose among participating Medicare providers of home health services and posthospital extended care services and must, when possible, respect patient and family preferences when they are expressed. The hospital must not exclude qualified providers that are available to the patient.

(8) The discharge plan must identify any HHA or SNF to which the patient is referred in which the hospital has a disclosable financial interest, as specified by the Secretary, and any HHA or SNF that has a disclosable financial interest in a hospital under Medicare. Financial interests that are disclosable under Medicare are determined in accordance with the provisions of Part 420, Subpart C, of this chapter.

I. Part 483 is amended as follows:

PART 483—REQUIREMENTS FOR STATES AND LONG TERM CARE FACILITIES

The authority citation for part 483 continues to read as follows:

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

2. Section 483.70 is amended by revising paragraph (a) to read as follows.

§ 483.70 Physical environment.

* * * * *

(a) *Life safety from fire.*

(1) Except as otherwise provided in this section—

(i) The facility must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101® 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD and at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: *http://www.archives.gov./federal_register/code_of_federal_regulations/ibr_locations.html.* Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the **Federal Register** to announce the changes.

(ii) Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the LSC does not apply to long-term care facilities.

(2) After consideration of State survey agency findings, CMS may waive specific provisions of the Life Safety Code which, if rigidly applied, would result in unreasonable hardship upon the facility, but only if the waiver does not adversely affect the health and safety of the patients.

(3) The provisions of the Life Safety Code do not apply in a State where CMS finds, in accordance with applicable provisions of sections 1819(d)(2)(B)(ii) and 1919(d)(2)(B)(ii) of the Act, that a fire and safety code imposed by State law adequately protects patients, residents and personnel in long term care facilities.

(4) Beginning March 13, 2006, a long-term care facility must be in compliance with Chapter 19.2.9, Emergency Lighting.

(5) Beginning March 13, 2006, Chapter 19.3.6.3.2, exception number 2 does not apply to long-term care facilities.

* * * * *

3. Section 483.470 is amended by revising paragraph (j) to read as follows:

§ 483.470 Condition of participation: Physical environment.

* * * * *

(j) *Standard: Fire protection.*

(1) *General.* Except as otherwise provided in this section—

(i) The facility must meet the applicable provisions of either the Health Care Occupancies Chapters or the Residential Board and Care Occupancies Chapter of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101® 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD and at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: *http://www.archives.gov./federal_register/code_of_federal_regulations/ibr_locations.html.* Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the **Federal Register** to announce the changes.

(ii) Chapter 19.3.6.3.2, exception number 2 of the adopted LSC does not apply to a facility.

(2) The State survey agency may apply a single chapter of the LSC to the entire facility or may apply different chapters to different buildings or parts of buildings as permitted by the LSC.

(3) A facility that meets the LSC definition of a residential board and care occupancy must have its evacuation capability evaluated in accordance with the Evacuation Difficulty Index of the Fire Safety Evaluation System for Board and Care facilities (FSES/BC).

(4) If CMS finds that the State has a fire and safety code imposed by State law that adequately protects a facility's clients, CMS may allow the State survey agency to apply the State's fire and safety code instead of the LSC.

(5) Beginning March 13, 2006, a facility must be in compliance with Chapter 19.2.9, Emergency Lighting.

(6) Beginning March 13, 2006, Chapter 19.3.6.3.2, exception number 2 does not apply to a facility.

(7) *Facilities that meet the LSC definition of a health care occupancy.* After consideration of State survey agency recommendations, CMS may waive, for appropriate periods, specific provisions of the Life Safety Code if the following requirements are met:

(i) The waiver would not adversely affect the health and safety of the clients.

(ii) Rigid application of specific provisions would result in an unreasonable hardship for the facility.

* * * * *

J. Part 485 is amended as follows:

PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

1. The authority citation for Part 485 continues to read as follows:

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

2. Section 485.610 is amended by revising paragraph (c) to read as follows:

§ 485.610 Condition of participation: Status and location.

* * * * *

(c) *Standard: Location relative to other facilities or necessary provider certification.* The CAH is located more than a 35-mile drive (or, in the case of mountainous terrain or in areas with only secondary roads available, a 15-mile drive) from a hospital or another CAH, or before January 1, 2006, the CAH is certified by the State as being a necessary provider of health care services to residents in the area. A CAH that is designated as a necessary provider as of January 1, 2006, will maintain its necessary provider designation after January 1, 2006.

3. Section 485.618 is amended by—

A. Revising paragraph (d)(1) introductory text.

B. In paragraph (d)(2)(iv), removing the cross-reference ''paragraph (d)(2)(ii)'' and adding in its place the cross-reference ''paragraph (d)(2)(iii)''.

C. In paragraph (d)(3), removing the cross-reference ''paragraph (d)(2)(ii)'' and adding in its place the cross-reference ''paragraph (d)(2)(iii)''.

The revision reads as follows:

§ 485.618 Condition of participation: Emergency services.

* * * * *

(d) *Standard: Personnel.* (1) Except as specified in paragraph (d)(2) of this section, there must be a doctor of medicine or osteopathy, a physician assistant, a nurse practitioner, or a clinical nurse specialist with training or experience in emergency care on call and immediately available by telephone

or radio contact, and available onsite within the following timeframes:

* * * * *

4. Section 485.620 is amended by revising paragraph (a) to read as follows:

§ 485.620 Condition of participation: Number of beds and average length of stay.

(a) *Standard: Number of beds.* Except as permitted for CAHs having distinct part units under § 485.646, the CAH maintains no more than 25 inpatient beds after January 1, 2004, that can be used for either inpatient or swing-bed services.

* * * * *

5. Section 485.623 is amended by—

A. Revising paragraph (d)(1)

B. Revising paragraph (d)(5).

C. Adding a new paragraph (d)(6).

The revisions and addition read as follows.

§ 485.623 Condition of participation: Physical plant and environment.

* * * * *

(d) *Standard: Life safety from fire.*

(1) Except as otherwise provided in this section—

(i) The CAH must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101® 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD and at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: *http://www.archives.gov./federal_register/code_of_federal_regulations/ibr_locations.html.* Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the **Federal Register** to announce the changes.

(ii) Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the Life Safety Code does not apply to a CAH.

* * * * *

(5) Beginning March 13, 2006, a critical access hospital must be in compliance with Chapter 9.2.9, Emergency Lighting.

(6) Beginning March 13, 2006, Chapter 19.3.6.3.2, exception number 2 does not apply to critical access hospitals.

6. Section 485.645 is amended by republishing the introductory text of paragraph (a) and revising paragraph (a)(2) to read as follows:

§ 485.645 Special requirements for CAH providers of long-term care services (''swing-beds'').

* * * * *

(a) *Eligibility.* A CAH must meet the following eligibility requirements:

* * * * *

(2) The facility provides not more than 25 inpatient beds. Any bed of a unit of the facility that is licensed as a distinct-part SNF at the time the facility applies to the State for designation as a CAH is not counted under paragraph (a) of this section.

* * * * *

7. A new § 485.647 is added in subpart F to read as follows:

§ 485.647 Condition of participation: psychiatric and rehabilitation distinct part units.

(a) *Conditions.*

(1) If a CAH provides inpatient psychiatric services in a distinct part unit, the services furnished by the distinct part unit must comply with the hospital requirements specified in Subparts A, B, C, and D of Part 482 of this subchapter, the common requirements of § 412.25(a)(2) through (f) of Part 412 of this chapter for hospital units excluded from the prospective payment systems, and the additional requirements of § 412.27 of Part 412 of this chapter for excluded psychiatric units.

(2) If a CAH provides inpatient rehabilitation services in a distinct part unit, the services furnished by the distinct part unit must comply with the hospital requirements specified in Subparts A, B, C, and D of Part 482 of this subchapter, the common requirements of § 412.25(a)(2) through (f) of Part 412 of this chapter for hospital units excluded from the prospective payments systems, and the additional requirements of §§ 412.29 and § 412.30 of Part 412 of this chapter related specifically to rehabilitation units.

(b) *Eligibility requirements.*

(1) To be eligible to receive Medicare payments for psychiatric or rehabilitation services as a distinct part unit, the facility provides no more than 10 beds in the distinct part unit.

(2) The beds in the distinct part are excluded from the 25 inpatient-bed count limit specified in § 485.620(a).

(3) The average annual 96-hour length of stay requirement specified under § 485.620(b) does not apply to the 10 beds in the distinct part units specified in paragraph (b)(1) of this section, and admissions and days of inpatient care in the distinct part units are not taken into account in determining the CAH's compliance with the limits on the number of beds and length of stay in § 485.620.

K. Part 489 is amended as follows:

PART 489—PROVIDER AGREEMENT AND SUPPLIER APPROVAL

1. The authority citation for part 489 continues to read as follows:

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

2. Section 489.20 is amended as follows:

A. In paragraph (m), the cross-reference ''§ 489.24(d)'' is removed and the cross-reference ''§ 489.24(e)'' is added in its place.

B. A new paragraph (t) is added.

§ 489.20 Basic commitments.

* * * * *

(t) Hospitals that are not otherwise subject to the Occupational Safety and Health Act of 1970 (or a State occupational safety and health plan that is approved under section 18(b) of the Occupational Safety and Health Act) must comply with the bloodborne pathogens (BBP) standards under 29 CFR 1910.1030. A hospital that fails to comply with the BBP standards may be subject to a civil money penalty in accordance with section 17 of the Occupational Safety and Health Act of 1970, including any adjustments of the civil money penalty amounts under the Federal Civil Penalties Inflation Adjustment Act, for a violation of the BBP standards. A civil money penalty will be imposed and collected in the same manner as civil money penalties under section 1128A(a) of the Social Security Act.

§ 489.53 [Amended]

3. In § 489.53 (b)(2), the cross-reference ''489.24 (d)'' is removed and the cross-reference ''489.24 (e)'' is added in its place.

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: May 4, 2004.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services

Dated: May 7, 2004.

Tommy G. Thompson,

Secretary.

[**Editorial Note:** The following Addendum and appendixes will not appear in the Code of Federal Regulations.]

Addendum—Proposed Schedule of Standardized Amount Effective With Discharges Occurring on or After October 1, 2004 and Update Factors and Rate-of-Increase Percentages Effective With Cost Reporting Periods Beginning On or After October 1, 2004

[If you choose to comment on issues in this section, please include the caption ''Operating Payment Rates'' at the beginning of your comment.]

I. Summary and Background

In this Addendum, we are setting forth the proposed amounts and factors for determining prospective payment rates for Medicare hospital inpatient operating costs and Medicare hospital inpatient capital-related costs. We are also setting forth proposed rate-of-increase percentages for updating the target amounts for hospitals and hospital units excluded from the IPPS.

For discharges occurring on or after October 1, 2004, except for SCHs, MDHs, and hospitals located in Puerto Rico, each hospital's payment per discharge under the IPPS will be based on 100 percent of the Federal national rate, which will be based on the national adjusted standardized amount. This amount reflects the national average hospital costs per case from a base year, updated for inflation.

SCHs are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal national rate; the updated hospital-specific rate based on FY 1982 costs per discharge; the updated hospital-specific rate based on FY 1987 costs per discharge; or the updated hospital-specific rate based on FY 1996 costs per discharge.

Under section 1886(d)(5)(G) of the Act, MDHs are paid based on the Federal national rate or, if higher, the Federal national rate plus 50 percent of the difference between the Federal national rate and the updated hospital-specific rate based on FY 1982 or FY 1987 costs per discharge, whichever is higher. MDHs do not have the option to use their FY 1996 hospital-specific rate.

For hospitals in Puerto Rico, the payment per discharge is based on the sum of 25 percent of a Puerto Rico rate that reflects base year average costs per case of Puerto Rico hospitals and 75 percent of the Federal national rate. (See section II.D.3. of this Addendum for a complete description.)

As discussed below in section II. of this Addendum, we are proposing to make changes in the determination of the prospective payment rates for Medicare inpatient operating costs for FY 2005. The proposed changes, to be applied prospectively effective with discharges occurring on or after October 1, 2004, affect the calculation of the Federal rates. In section III. of this Addendum, we discuss our proposed changes for determining the prospective payment rates for Medicare inpatient capital-related costs for FY 2005. Section IV. of this Addendum sets forth our proposed changes for determining the rate-of-increase limits for hospitals excluded from the IPPS for FY 2004. Section V. of this Addendum sets forth policies on payment for blood clotting factor administered to hemophilia patients. The tables to which we refer in the preamble of this proposed rule are presented in section VI. of this Addendum.

II. Proposed Changes to Prospective Payment Rates for Hospital Inpatient Operating Costs for FY 2005

The basic methodology for determining prospective payment rates for hospital inpatient operating costs is set forth at existing § 412.63 and proposed new § 412.64. The basic methodology for determining the prospective payment rates for hospital inpatient operating costs for hospitals located in Puerto Rico is set forth at existing §§ 412.210 and 412.212 and proposed new § 412.211. Below, we discuss the factors used for determining the prospective payment rates.

In summary, the proposed standardized amounts set forth in Tables 1A, 1B, 1C, and 1D of section VI. of this Addendum reflect—

- The requirements of section 401 of Public Law 108–173, equalizing the standardized amounts for urban and other areas at the level computed for urban hospitals during FY 2004, updated by the applicable percentage increase required under section 501(a) of Public Law 108–173;
- The requirements of section 403 of Public Law 108–173, establishing two labor-related shares that are applicable to the standardized amounts depending on whether the hospital's payments would be higher with a lower (in the case of a wage index below 1.0000) or higher (in the case of a wage index above 1.0000) labor share;
- Updates of 3.3 percent for all areas (that is, the full market basket percentage increase of 3.3 percent, as required by section 501(a) of Public Law 108–173), and reflecting the requirements of section 501(b) of Public Law 108–173, to reduce the applicable percentage increase by 0.4 percentage points for hospitals that fail to submit data in a form and manner specified by the Secretary, relating to the quality of inpatient care furnished by the hospital;
- An adjustment to ensure the proposed DRG recalibration and wage index update and changes are budget neutral, as provided for under sections 1886(d)(4)(C)(iii) and (d)(3)(E) of the Act, by applying new budget neutrality adjustment factors to the standardized amount;
- An adjustment to ensure the effects of geographic reclassification are budget neutral, as provided for in section 1886(d)(8)(D) of the Act, by removing the FY 2004 budget neutrality factor and applying a revised factor;
- An adjustment to apply the new outlier offset by removing the FY 2004 outlier offsets and applying a new offset;
- An adjustment to ensure the effects of the rural community hospital demonstration required under section 410A of Public Law 108–173 are budget neutral, as required under section 410A(c)(2) of Public Law 108–173.

A. Calculation of the Adjusted Standardized Amount

1. Standardization of Base-Year Costs or Target Amounts

The national standardized amount is based on per discharge averages of adjusted hospital costs from a base period (section 1886(d)(2)(A) of the Act) or, for Puerto Rico, adjusted target amounts from a base period (section 1886(d)(9)(B)(i) of the Act), updated and otherwise adjusted in accordance with the provisions of section 1886(d) of the Act. The preamble to the September 1, 1983 interim final rule (48 FR 39763) contained a detailed explanation of how base-year cost data (from cost reporting periods ending during FY 1981) were established in the initial development of standardized amounts for the IPPS. The September 1, 1987 final rule (52 FR 33043, 33066) contains a detailed explanation of how the target amounts were determined, and how they are used in computing the Puerto Rico rates.

Sections 1886(d)(2)(B) and (d)(2)(C) of the Act require us to update base-year per discharge costs for FY 1984 and then standardize the cost data in order to remove the effects of certain sources of cost variations among hospitals. These effects include case-mix, differences in area wage levels, cost-of-living adjustments for Alaska and Hawaii, indirect medical education

costs, and costs to hospitals serving a disproportionate share of low-income patients.

Under sections 1886(d)(2)(H) and (d)(3)(E) of the Act, the Secretary estimates from time-to-time the proportion of costs that are wages and wage-related costs. The standardized amount is divided into labor-related and nonlabor-related amounts; only the proportion considered the labor-related amount is adjusted by the wage index. The current labor-related share is 71.1 percent. The current labor-related share in Puerto Rico is 71.3 percent.

Section 403 of Public Law 108–173 revises the proportion of the standardized amount that is considered labor-related. Specifically, section 403 requires that 62 percent of the standardized amount be adjusted by the wage index, unless doing so would result in lower payments to a hospital than would otherwise be made (section 403(b) extends this provision to the Puerto Rico standardized amounts). As a consequence, we are adjusting 62 percent of the national and Puerto Rico standardized amount by the wage index for all hospitals whose wage indexes are less than or equal to 1.0000; otherwise, the wage index is applied to 71.1 percent of the standardized amount.

2. Computing the Average Standardized Amount

Sections 1886(d)(2)(D) and (d)(3) of the Act previously required the Secretary to compute two average standardized amounts for discharges occurring in a fiscal year: one for hospitals located in large urban areas and one for hospitals located in other areas. In addition, under sections 1886(d)(9)(B)(iii) and (d)(9)(C)(i) of the Act, the average standardized amount per discharge was determined for hospitals located in large urban and other areas in Puerto Rico. In accordance with section 1886(b)(3)(B)(i) of the Act, the large urban average standardized amount was 1.6 percent higher than the other area average standardized amount.

Section 402(b) of Public Law 108–7 required that, effective for discharges occurring on or after April 1, 2003, and before October 1, 2003, the Federal rate for all IPPS hospitals would be based on the large urban standardized amount. Subsequently, Public Law 108–89, extended section 402(b) of Public Law 108–7 beginning with discharges on or after October 1, 2003 and before March 31, 2004. Finally, section 401(a) of Public Law 108–173 requires that, beginning with fiscal year 2004 and thereafter, an equal standardized amount is to be computed for all hospitals at the level computed for large urban hospitals during FY 2003, updated by the applicable percentage update. This provision in effect makes permanent the equalization of the standardized amounts at the level of the previous standardized amount for large urban hospitals. Section 401(c) also equalizes the Puerto Rico-specific urban and other area rates. Accordingly, we are providing in this proposed rule for a single national standardized amount, and a single Puerto Rico standardized amount, for FY 2005 and thereafter.

3. Updating the Average Standardized Amount

In accordance with section 1886(d)(3)(A)(iv) of the Act, we are proposing to update the equalized standardized amount for FY 2005 by the full estimated market basket percentage increase for hospitals in all areas, as specified in section 1886(b)(3)(B)(i)(XIX) of the Act, as amended by section 501 of Public Law 108–173. The percentage change in the market basket reflects the average change in the price of goods and services purchased by hospitals to furnish inpatient care. The most recent forecast of the hospital market basket increase for FY 2005 is 3.3 percent. Thus, for FY 2005, the proposed update to the average standardized amount equals 3.3 percent for hospitals in all areas.

As discussed above in section IV.E. of this proposed rule, section 501(b) of Public Law 108–173 amended section 1886(b)(3)(B) of the Act to add a new subclause (vii) to revise the mechanism used to update the standardized amount for payment for inpatient hospital operating costs. Specifically, the amendment provides for a reduction of 0.4 percentage points to the update percentage increase (also known as the market basket update) for each of FYs 2005 through 2007 for any ''subsection (d) hospital'' that does not submit data on a set of 10 quality indicators established by the Secretary as of November 1, 2003. The statute also provides that any reduction will apply only to the fiscal year involved, and will not be taken into account in computing the applicable percentage increase for a subsequent fiscal year. This measure establishes an incentive for hospitals to submit data on quality measures established by the Secretary. The standardized amount in Tables 1A through 1D of section VI. of this addendum reflect these differential amounts.

Although the update factors for FY 2005 are set by law, we are required by section 1886(e)(3) of the Act to report to the Congress our initial recommendation of update factors for FY 2005 for both IPPS hospitals and hospitals excluded from the IPPS. Our recommendation on the update factors (which is required by sections 1886(e)(4)(A) and (e)(5)(A) of the Act) is set forth as Appendix B of this proposed rule.

4. Other Adjustments to the Average Standardized Amount

As in the past, we are proposing to adjust the FY 2005 standardized amount to remove the effects of the FY 2004 geographic reclassifications and outlier payments before applying the FY 2005 updates. We then apply the new offsets for outliers and geographic reclassifications to the standardized amount for FY 2005.

We do not remove the prior year's budget neutrality adjustments for reclassification and recalibration of the DRG weights and for updated wage data because, in accordance with section 1886(d)(4)(C)(iii) of the Act, estimated aggregate payments after the changes in the DRG relative weights and wage index should equal estimated aggregate payments prior to the changes. If we removed the prior year adjustment, we would not satisfy this condition.

Budget neutrality is determined by comparing aggregate IPPS payments before and after making the changes that are required to be budget neutral (for example, reclassifying and recalibrating the DRGs, updating the wage data, and geographic reclassifications). We include outlier payments in the payment simulations because outliers may be affected by changes in these payment parameters.

We are also proposing to adjust the standardized amount this year by an amount estimated to ensure that aggregate IPPS payments do not exceed the amount of payments that would have been made in the absence of the rural community hospital demonstration required under section 410A of Public Law 108–173. This demonstration is required to be budget neutral under section 410A(c)(2) of Public Law 108–173.

a. Recalibration of DRG Weights and Updated Wage Index—Budget Neutrality Adjustment

Section 1886(d)(4)(C)(iii) of the Act specifies that, beginning in FY 1991, the annual DRG reclassification and recalibration of the relative weights must be made in a manner that ensures that aggregate payments to hospitals are not affected. As discussed in section II. of the preamble, we normalized the recalibrated DRG weights by an adjustment factor, so that the average

case weight after recalibration is equal to the average case weight prior to recalibration. However, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payments to hospitals are affected by factors other than average case weight. Therefore, as we have done in past years, we are proposing to make a budget neutrality adjustment to ensure that the requirement of section 1886(d)(4)(C)(iii) of the Act is met.

Section 1886(d)(3)(E) of the Act requires us to update the hospital wage index on an annual basis beginning October 1, 1993. This provision also requires us to make any updates or adjustments to the wage index in a manner that ensures that aggregate payments to hospitals are not affected by the change in the wage index. For FY 2005, we are proposing to apply an occupational mix adjustment to the wage index. We describe our proposed occupational mix adjustment in section III.C. of this proposed rule. Since section 1886(d)(3)(E) of the Act requires us to update the wage index on a budget neutral basis, we are including the effects of this proposed occupational mix adjustment on the wage index in our budget neutrality calculations.

Section 4410 of Public Law 105–33 provides that, for discharges on or after October 1, 1997, the area wage index applicable to any hospital that is not located in a rural area may not be less than the area wage index applicable to hospitals located in rural areas in that State. This provision is required by section 4410(b) of Public Law 105–33 to be budget neutral. Therefore, we include the effects of this provision in our calculation of the wage update budget neutrality factor.

Section 1886(d)(5)(K)(ii)(III) of the Act previously required that we adjust the rates to ensure that any add-on payments for new technology under section 1886(d)(5)(K) of the Act be budget neutral. However, section 503(d)(2) of Public Law 108–173 has repealed this requirement. We discuss this provision in section II.E. of this proposed rule. In accordance with this provision, we are proposing no budget neutrality adjustment to account for approval of new technologies for add-on payments in FY 2005.

To comply with the requirement that DRG reclassification and recalibration of the relative weights be budget neutral, and the requirement that the updated wage index be budget neutral, we used FY 2003 discharge data to simulate payments and compared aggregate payments using the FY 2004 relative weights and wage index to aggregate payments using the proposed FY 2005 relative weights and wage index. The same methodology was used for the FY 2004 budget neutrality adjustment (although the FY 2004 adjustment included the effects of new technology add-on payments).

Based on this comparison, we computed a proposed budget neutrality adjustment factor equal to 0.998969. We also are proposing to adjust the Puerto Rico-specific standardized amount for the effect of DRG reclassification and recalibration. We computed a proposed budget neutrality adjustment factor for Puerto Rico-specific standardized amount equal to 0.999326. These budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the FY 2004 budget neutrality adjustments.

In addition, we are proposing to apply these same adjustment factors to the hospital-specific rates that are effective for cost reporting periods beginning on or after October 1, 2004. (See the discussion in the September 4, 1990 final rule (55 FR 36073)).

b. Reclassified Hospitals—Budget Neutrality Adjustment

Section 1886(d)(8)(B) of the Act provides that, effective with discharges occurring on or after October 1, 1988, certain rural hospitals are deemed urban. In addition, section 1886(d)(10) of the Act provides for the reclassification of hospitals based on determinations by the MGCRB. Under section 1886(d)(10) of the Act, a hospital may be reclassified for purposes of the wage index.

Under section 1886(d)(8)(D) of the Act, the Secretary is required to adjust the standardized amount to ensure that aggregate payments under the IPPS after implementation of the provisions of sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act are equal to the aggregate prospective payments that would have been made absent these provisions. (Neither the wage index reclassifications provided under section 508 of Public Law 108–173, nor the wage index adjustments provided under section 505 of Public Law 108–173, are budget neutral. Section 508(b) provides that the wage index reclassifications approved under section 508(a) ''shall not be effected in a budget neutral manner.'' Section 505(a) similarly provides that any increase in a wage index under that section shall not be taken into account ''in computing any budget neutrality adjustment with respect to such index under'' section 1886(d)(8)(D) of the Act.) To calculate this budget neutrality factor, we used FY 2003 discharge data to simulate payments, and compared total IPPS payments prior to any reclassifications under sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act to total IPPS payments after such reclassifications. Based on these simulations, we are proposing to apply an adjustment factor of 0.994295 to ensure that the effects of this reclassification are budget neutral.

The proposed adjustment factor is applied to the standardized amount after removing the effects of the FY 2004 budget neutrality adjustment factor. We note that the proposed FY 2005 adjustment reflects proposed FY 2005 wage index reclassifications approved by the MGCRB or the Administrator, and the effects of MGCRB reclassifications approved in FY 2003 and FY 2004 (section 1886(d)(10)(D)(v) of the Act makes wage index reclassifications effective for 3 years).

c. Outliers

Section 1886(d)(5)(A) of the Act provides for payments in addition to the basic prospective payments, for ''outlier'' cases involving extraordinarily high costs. To qualify for outlier payments, a case must have costs above a fixed-loss cost threshold amount (a dollar amount by which the costs of a case must exceed payments in order to qualify for outlier payment). To determine whether the costs of a case exceed the fixed-loss threshold, a hospital's cost-to-charge ratio is applied to the total covered charges for the case to convert the charges to costs. Payments for eligible cases are then made based on a marginal cost factor, which is a percentage of the costs above the threshold.

Under section 1886(d)(5)(A)(iv) of the Act, outlier payments for any year must be projected to be not less than 5 percent nor more than 6 percent of total operating DRG payments plus outlier payments. Section 1886(d)(3)(B) of the Act requires the Secretary to reduce the average standardized amount by a factor to account for the estimated proportion of total DRG payments made to outlier cases. Similarly, section 1886(d)(9)(B)(iv) of the Act requires the Secretary to reduce the average standardized amounts applicable to hospitals in Puerto Rico to account for the estimated proportion of total DRG payments made to outlier cases.

i. Proposed FY 2005 outlier fixed-loss cost threshold. In the August 1, 2003 IPPS final rule (68 FR 45476–45478), we established a threshold for FY 2004 that was equal to the prospective payment rate for the DRG, plus any IME and DSH payments and any additional payments

for new technology, plus $31,000. The marginal cost factor (the percent of costs paid after costs for the case exceed the threshold) was 80 percent.

To calculate the proposed FY 2005 outlier thresholds, we simulated payments by applying proposed FY 2005 rates and policies using cases from the FY 2003 MedPAR file. Therefore, in order to determine the appropriate proposed FY 2005 threshold, it was necessary to inflate the charges on the MedPAR claims by 2 years, from FY 2003 to FY 2005. We are proposing to use a 2-year average annual rate of change in charges per case to inflate FY 2003 charges to approximate FY 2005 charges. The 2-year average annual rate of change in charges per case from FY 2000 to FY 2001, and from FY 2001 to FY 2002, was 12.5978 percent annually or 26.8 percent over 2 years.

We are proposing to continue to use the 2-year average annual rate of change in charges per case to establish the proposed FY 2005 threshold. The 2-year average annual rate of change in charges per case from FY 2001 to FY 2002, and from FY 2002 to FY 2003, was 14.5083 percent annually, or 31.1 percent over 2 years. As we have done in the past, we are using hospital cost-to-charge ratio from the most recently Provider Specific File, in this case the December 2003 update. This file includes cost-to-charge ratios reflecting implementation of changes we made last year to the policy affecting the applicable cost-to-charge ratios (68 FR 34494). As of October 1, 2003, fiscal intermediaries use either the most recent settled or the most recent tentative settled cost report, whichever is from the latest reporting period. Because in the past cost-to-charge ratios were taken from the latest settled cost reports and for some hospitals there were delays in settling their cost reports, the cost-to-charge ratios on the Provider Specific File may have been from cost reporting periods that were several years prior. This change results in more up-to-date and, generally, lower cost-to-charge ratios.

Using this methodology, we are proposing to establish a fixed-loss cost outlier threshold equal to the prospective payment rate for the DRG, plus any IME and DSH payments, and any add-on payments for new technology, plus $35,085. This single threshold would be applicable to qualify for both operating and capital outlier payments. We also are proposing to maintain the marginal cost factor for cost outliers at 80 percent.

This proposed outlier threshold for FY 2005 may be higher than might have been anticipated on the basis of the more up-to-date and, generally, lower cost-to-charge ratios that we are now employing. We believe that a significant factor in this result may be the 2-year average annual rates of change that we are employing to update charges in the MedPAR data from FY 20003 to FY 2005. As we discussed above, we are employing the 2-year average annual rate of change in charges per case from FY 2001 to FY 2002, and from FY 2002 to FY 2003, which is 14.5083 percent annually, or 31.1 percent over 2 years. These rates of increase derive from the period before the changes we made last year to the policy affecting the applicable cost-to-charge ratios (68 FR 34494). In fact, they derive from the years just prior to the adoption of the policy changes, when some hospitals were increasing charges at a rapid rate in order to increase their outlier payments. Therefore, they represent rates of increase that may be higher than the rates of increase under our new policy. We have always used actual data from prior years, rather than projections, to update charges for purposes of determining the outlier threshold. In light of the increase in the proposed outlier threshold for FY 2005, compared to the threshold previously in effect, we welcome comments on the data we are using to update charges for purposes of computing the threshold. We especially encourage commenters to provide any recommendations for data that might better reflect current trends in charge increases.

ii. Other changes concerning outliers. As stated in the September 1, 1993 final rule (58 FR 46348), we establish outlier thresholds that are applicable to both hospital inpatient operating costs and hospital inpatient capital-related costs. When we modeled the combined operating and capital outlier payments, we found that using a common set of thresholds resulted in a lower percentage of outlier payments for capital-related costs than for operating costs. We project that the proposed thresholds for FY 2005 would result in outlier payments equal to 5.10 percent of operating DRG payments and 5.03 percent of capital payments based on the Federal rate.

In accordance with section 1886(d)(3)(B) of the Act, we reduced the proposed FY 2005 standardized amount by the same percentage to account for the projected proportion of payments paid to outliers.

The proposed outlier adjustment factors to be applied to the standardized amount for FY 2005 are as follows:

	Operating standardized amounts	Capital Federal rate
National	0.948994	0.949706
Puerto Rico	0.974692	0.9747329

We apply the outlier adjustment factors after removing the effects of the FY 2004 outlier adjustment factors on the standardized amount.

To determine whether a case qualifies for outlier payments, we apply hospital-specific cost-to-charge ratios to the total covered charges for the case. Operating and capital costs for the case are calculated separately by applying separate operating and capital cost-to-charge ratios. These costs are then combined and compared with the fixed-loss outlier threshold.

The June 9, 2003 outlier final rule (68 FR 34494) eliminated the application of the statewide average for hospitals whose cost-to-charge ratios fall below 3 standard deviations from the national mean cost-to-charge ratio. However, for those hospitals for which the fiscal intermediary computes operating cost-to-charge ratios greater than 1.460 or capital cost-to-charge ratios greater than 0.173, or hospitals for whom the fiscal intermediary is unable to calculate a cost-to-charge ratio (as described at § 412.84(i)(3)), we are still using statewide average ratios to calculate costs to determine whether a hospital qualifies for outlier payments.[7] Table 8A in section VI. of this Addendum contains the statewide average operating cost-to-charge ratios for urban hospitals and for rural hospitals for which the fiscal intermediary is unable to compute a hospital-specific cost-to-charge ratio within the above range. These statewide average ratios would replace the ratios published in the August 1, 2003 IPPS final rule (68 FR 45637). Table 8B in section VI. of this Addendum contains the proposed comparable statewide average capital cost-to-charge ratios. Again, the proposed cost-to-charge ratios in Tables 8A and 8B would be used during FY 2005 when hospital-specific cost-to-charge ratios based on the latest settled cost report are either not available or are outside the range noted above.

iii. FY 2003 and FY 2004 outlier payments. In the August 1, 2003 IPPS final rule (68 FR 45478), we stated that, based on available data, we estimated that actual FY 2003 outlier payments would be approximately 6.5 percent of actual total DRG payments. This estimate was computed based on

[7] These figues represent 3.0 standard deviations from the mean of the log distribution of cost-to-charge ratios for all hospitals.

simulations using the FY 2002 MedPAR file (discharge data for FY 2002 bills). That is, the estimate of actual outlier payments did not reflect actual FY 2003 bills, but instead reflected the application of FY 2003 rates and policies to available FY 2002 bills.

Our current estimate, using available FY 2003 bills, is that actual outlier payments for FY 2003 were approximately 5.7 percent of actual total DRG payments. Thus, the data indicate that, for FY 2003, the percentage of actual outlier payments relative to actual total payments is higher than we projected before FY 2003 (and, thus, exceeds the percentage by which we reduced the standardized amounts for FY 2003). Nevertheless, consistent with the policy and statutory interpretation we have maintained since the inception of the IPPS, we do not plan to make retroactive adjustments to outlier payments to ensure that total outlier payments for FY 2003 are equal to 5.1 percent of total DRG payments.

We currently estimate that actual outlier payments for FY 2004 will be approximately 4.4 percent of actual total DRG payments, 0.7 percentage points lower than the 5.1 percent we projected in setting outlier policies for FY 2004. This estimate is based on simulations using the FY 2003 MedPAR file (discharge data for FY 2003 bills). We used these data to calculate an estimate of the actual outlier percentage for FY 2004 by applying FY 2004 rates and policies, including an outlier threshold of $31,000 to available FY 2003 bills.

d. Section 410A Rural Community Hospital Demonstration Program Adjustment

Section 410A of Public Law 108–173 requires the Secretary to establish a demonstration that will modify reimbursement for inpatient services for up to fifteen small rural hospitals. Section 410A(c)(2) requires that ''in conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.'' As discussed in section IV.P. of this proposed rule, we are proposing to satisfy this requirement by adjusting national IPPS rates by a factor that is sufficient to account for the added costs of this demonstration. We estimate that the average additional annual payment that will be made to each participating hospital under the demonstration will be approximately $1,120,000. We based this estimate on the recent historical experience of the difference between inpatient cost and payment for hospitals that would be eligible for the demonstration. For 15 participating hospitals, the total annual impact of the demonstration program is estimated to be $16,820,148. We estimate that there will be an average decrease in payment per discharge of approximately $0.83. The required adjustment as a result of the demonstration to the Federal rate in calculating Medicare inpatient prospective payments is 0.999818.

In order to achieve budget neutrality, we are proposing to adjust national IPPS rates by an amount sufficient to account for the added costs of this demonstration. We are proposing, in other words, to apply budget neutrality across the payment system as a whole rather than merely across the participants of this demonstration. We believe that the language of the statutory budget neutrality requirement permits the agency to implement the budget neutrality provision in this manner. This is because the statutory language requires ''aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration * * * was not implemented,'' but does not identify the range across which aggregate payments must be held equal. We invite public comment on this proposal.

5. Proposed FY 2005 Standardized Amount

The adjusted standardized amount is divided into labor and nonlabor portions. Tables 1A and 1B in section VI. of this Addendum contain the national standardized amount that we are proposing to apply to all hospitals, except hospitals in Puerto Rico. The amounts shown in the two tables differ only in that the labor-related share applied to the standardized amounts in Table 1A is 71.1 percent, and the labor-related share applied to the standardized amounts in Table 1B is 62 percent. As described in section II.A.1. of this Addendum, we are proposing to implement section 403 of Public Law 108–173, which provides that the labor-related share is 62 percent, unless the application of that percentage would result in lower payments to a hospital than would otherwise be made. The effect of this provision is that the labor-related share of the standardized amount is 62 percent for all hospitals whose wage indexes are less than or equal to 1.0000. However, the labor-related share of the standardized amount remains 71.1 percent (reflecting the Secretary's current estimate of the proportion of costs that are wages and wage-related costs) for hospitals whose wage indexes are greater than 1.0000. In addition, both tables include standardized amounts reflecting the full 3.3 percent update for FY 2005, and standardized amounts reflecting the 0.4 percentage point reduction to the update applicable for hospitals that fail to submit quality data consistent with section 501(b) of Public Law 108–173. (Tables 1C and 1D show the new standardized amounts for Puerto Rico, reflecting the different labor shares that apply, that is, 71.3 percent or 62 percent.)

The following tables illustrate the proposed changes from the FY 2004 national average standardized amount. The first column shows the proposed changes from the 2004 standardized amounts for hospitals that satisfy the quality data submission requirement for receiving the full update (3.3 percent). The second column shows the proposed changes for hospitals receiving the reduced update (2.9 percent). The first row in the table shows the updated (through FY 2003) average standardized amount after restoring the FY 2004 offsets for outlier payments and geographic reclassification budget neutrality. The DRG reclassification and recalibration and wage index budget neutrality factor is cumulative. Therefore, the FY 2004 factor is not removed from the amount in the table. We have added separate rows to this table to reflect the different labor-related shares that apply to hospitals.

COMPARISON OF FY 2004 STANDARDIZED AMOUNTS TO PROPOSED FY 2005 SINGLE STANDARDIZED AMOUNT WITH FULL UPDATE AND REDUCED UPDATE

	Full update (3.3 percent)	Reduced update (2.9 percent).
FY 2004 Base Rate (after removing reclassification budget neutrality and outlier offset).	Labor: $3,331.33 Nonlabor: $1,354.09	Labor: $3,331.33 Nonlabor: $1,354.09.
Proposed FY 2005 Update Factor	1.033	1.029.

COMPARISON OF FY 2004 STANDARDIZED AMOUNTS TO PROPOSED FY 2005 SINGLE STANDARDIZED AMOUNT WITH FULL UPDATE AND REDUCED UPDATE—Continued

	Full update (3.3 percent)	Reduced update (2.9 percent).
Proposed FY 2005 DRG Recalibrations and Wage Index Budget Neutrality Factor.	0.998969	0.998969.
Proposed FY 2005 Reclassification Budget Neutrality Factor	0.994295	0.994295.
Adjusted for Blend of FY 2004 DRG Recalibration and Wage Index Budget Neutrality Factors*.	Labor: $3,418.04 Nonlabor: $1,389.33	Labor: $3,404.81 Nonlabor: $1,383.95.
Proposed FY 2005 Outlier Factor	0.948994	0.948994.
Proposed Rural Demo Budget Neutrality Factor	0.999818	0.999818.
Proposed Rate for FY 2005 (after multiplying FY 2004 base rate by above factors) where the wage index is less than or equal to 1.0000.	Labor: $2,828.03 Nonlabor: $1,733.30	Labor: $2,817.08 Nonlabor: $1,726.59.
Proposed Rate for FY 2005 (after multiplying FY 2004 base rate by above factors) where the wage index is greater than 1.0000.	Labor: $3,243.10 Nonlabor: $1,318.22	Labor: $3,230.55 Nonlabor: $1,313.12

*In order to calculate this adjustment correctly, it is necessary to multiply on the DRG recalibration and wage index budget neutrality factor of 1.002608 (1.002588 from October 1, 2003 through March 31, 2004; 1.002628 from April 1, 2004 through September 30, 2004) and divide off the factor of 1.002628 from the second half of FY 2004. This is to account for the fact that it was necessary to employ different budget neutrality adjustments for the first and second halves of FY 2004 due to the extension of the extension of the standardized amount equalization, effective April 1, 2004.

Under section 1886(d)(9)(A)(ii) of the Act, the Federal portion of the Puerto Rico payment rate is based on the discharge-weighted average of the national large urban standardized amount (as set forth in Table 1A). The labor and nonlabor portions of the national average standardized amounts for Puerto Rico hospitals are set forth in Table 1C of section VI. of this Addendum. This table also includes the Puerto Rico standardized amounts. The labor share applied to the Puerto Rico standardized amount is 71.3 percent, or 62 percent, depending on which is more advantageous to the hospital. (Section 403(b) of Public Law 108–173 provides that the labor-related share for hospitals in Puerto Rico will be 62 percent, unless the application of that percentage would result in lower payments to the hospital.)

B. Adjustments for Area Wage Levels and Cost-of-Living

Tables 1A through 1D, as set forth in section VI. of this Addendum, contain the labor-related and nonlabor-related shares that we are proposing to use to calculate the prospective payment rates for hospitals located in the 50 States, the District of Columbia, and Puerto Rico. This section addresses two types of adjustments to the standardized amounts that are made in determining the proposed prospective payment rates as described in this Addendum.

1. Adjustment for Area Wage Levels

Sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act require that we make an adjustment to the labor-related portion of the national and Puerto Rico prospective payment rates, respectively, to account for area differences in hospital wage levels. This adjustment is made by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. In section III. of the preamble to this proposed rule, we discuss the data and methodology for the proposed FY 2005 wage index. The proposed FY 2005 wage index is set forth in Tables 4A, 4B, 4C, and 4F of section VI. of this Addendum.

2. Adjustment for Cost-of-Living in Alaska and Hawaii

Section 1886(d)(5)(H) of the Act authorizes an adjustment to take into account the unique circumstances of hospitals in Alaska and Hawaii. Higher labor-related costs for these two States are taken into account in the adjustment for area wages described above. For FY 2005, we are proposing to adjust the payments for hospitals in Alaska and Hawaii by multiplying the nonlabor portion of the standardized amount by the appropriate adjustment factor contained in the table below. If the Office of Personnel Management releases revised cost-of-living adjustment factors before July 1, 2004, we will publish them in the final rule and use them in determining FY 2005 payments.

TABLE OF COST-OF-LIVING ADJUSTMENT FACTORS, ALASKA AND HAWAII HOSPITALS

Area	Cost of living adjustment factor.
Alaska-All areas	1.25.
Hawaii:	.
County of Honolulu	1.25.

TABLE OF COST-OF-LIVING ADJUSTMENT FACTORS, ALASKA AND HAWAII HOSPITALS—Continued

Area	Cost of living adjustment factor.
County of Hawaii	1.165.
County of Kauai	1.2325.
County of Maui	1.2375.
County of Kalawao	1.2375

(The above factors are based on data obtained from the U.S. Office of Personnel Management.)

C. DRG Relative Weights

As discussed in section II. of the preamble, we have developed a classification system for all hospital discharges, assigning them into DRGs, and have developed relative weights for each DRG that reflect the resource utilization of cases in each DRG relative to Medicare cases in other DRGs. Table 5 of section VI. of this Addendum contains the relative weights that we are proposing to use for discharges occurring in FY 2005. These factors have been recalibrated as explained in section II. of the preamble of this proposed rule.

D. Calculation of Proposed Prospective Payment Rates for FY 2005

General Formula for Calculation of Proposed Prospective Payment Rates for FY 2005

The proposed operating prospective payment rate for all hospitals paid under the IPPS located outside of Puerto Rico, except SCHs and MDHs, equals the Federal rate based on the corresponding amounts in Table 1A or Table 1B in section VI. of this Addendum.

The proposed prospective payment rate for SCHs equals the higher of the applicable Federal rate (from Table 1A or Table 1B) or the hospital-specific rate as described below. The proposed prospective payment rate for MDHs equals the higher of the Federal rate, or the Federal rate plus 50 percent of the difference between the Federal rate and the hospital-specific rate as described below. The proposed prospective payment rate for Puerto Rico equals 25 percent of the Puerto Rico rate plus 75 percent of the applicable national rate from Table 1C or Table 1D in section VI. of this Addendum.

1. Federal Rate

For discharges occurring on or after October 1, 2004 and before October 1, 2005, except for SCHs, MDHs, and hospitals in Puerto Rico, payment under the IPPS is based exclusively on the Federal rate.

The Federal rate is determined as follows:

Step 1—Select the appropriate average standardized amount considering the applicable wage index (Table 1A for wage indexes greater than 1.0000 and Table 1B for wage indexes less than or equal to 1.0000) and whether the hospital has submitted qualifying quality data (full update for qualifying hospitals, update minus 0.4 percent for nonqualifying hospitals).

Step 2—Multiply the labor-related portion of the standardized amount by the applicable wage index for the geographic area in which the hospital is located or the area to which the hospital is reclassified (see Tables 4A, 4B, and 4C of section VI. of this Addendum).

Step 3—For hospitals in Alaska and Hawaii, multiply the nonlabor-related portion of the standardized amount by the appropriate cost-of-living adjustment factor.

Step 4—Add the amount from Step 2 and the nonlabor-related portion of the standardized amount (adjusted, if appropriate, under Step 3).

Step 5—Multiply the final amount from Step 4 by the relative weight corresponding to the appropriate DRG (see Table 5 of section VI. of this Addendum).

The Federal rate as determined in Step 5 may then be further adjusted if the hospital qualifies for either the IME or DSH adjustment.

2. Hospital-Specific Rate (Applicable Only to SCHs and MDHs)

a. Calculation of Hospital-Specific Rate

Section 1886(b)(3)(C) of the Act provides that SCHs are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal rate; the updated hospital-specific rate based on FY 1982 costs per discharge; the updated hospital-specific rate based on FY 1987 costs per discharge; or the updated hospital-specific rate based on FY 1996 costs per discharge.

Section 1886(d)(5)(G) of the Act provides that MDHs are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal rate or the Federal rate plus 50 percent of the difference between the Federal rate and the greater of the updated hospital-specific rates based on either FY 1982 or FY 1987 costs per discharge. MDHs do not have the option to use their FY 1996 hospital-specific rate.

Hospital-specific rates have been determined for each of these hospitals based on either the FY 1982 costs per discharge, the FY 1987 costs per discharge or, for SCHs, the FY 1996 costs per discharge. For a more detailed discussion of the calculation of the hospital-specific rates, we refer the reader to the September 1, 1983 interim final rule (48 FR 39772); the April 20, 1990 final rule with comment (55 FR 15150); the September 4, 1990 final rule (55 FR 35994); and the August 1, 2000 final rule (65 FR 47082). In addition, for both SCHs and MDHs, the hospital-specific rate is adjusted by the proposed budget neutrality adjustment factor (that is, by 0.998969) as discussed in section II.A.4.a. of this Addendum. The resulting rate would be used in determining the payment rate an SCH or MDH would receive for its discharges beginning on or after October 1, 2004.

b. Updating the FY 1982, FY 1987, and FY 1996 Hospital-Specific Rates for FY 2005

We are proposing to increase the hospital-specific rates by 3.3 percent (the hospital market basket percentage increase) for SCHs and MDHs for FY 2005. Section 1886(b)(3)(C)(iv) of the Act provides that the update factor applicable to the hospital-specific rates for SCHs is equal to the update factor provided under section 1886(b)(3)(B)(iv) of the Act, which, for SCHs in FY 2005, is the market basket rate of increase. Section 1886(b)(3)(D) of the Act provides that the update factor applicable to the hospital-specific rates for MDHs also equals the update factor provided under section 1886(b)(3)(B)(iv) of the Act, which, for FY 2005, is the market basket rate of increase.

3. General Formula for Calculation of Proposed Prospective Payment Rates for Hospitals Located in Puerto Rico Beginning On or After October 1, 2004 and Before October 1, 2005

Section 504 of Public Law 108–173 changes the current blend of 50 percent the Puerto Rico national prospective payment rate and 50 percent of the Puerto Rico-specific prospective payment rate to 62.5 percent Puerto Rico national and 37.5 percent Puerto Rico-specific effective for discharges occurring on or after April 1, 2004 and before October 1, 2004. Effective for discharges occurring on or after October 1, 2004, the effective blend is 75 percent of the Puerto Rico national prospective payment rate and 25 percent of the Puerto Rico-specific rate.

a. Puerto Rico Rate

The Puerto Rico prospective payment rate is determined as follows:

Step 1—Select the appropriate average standardized amount considering the applicable wage index (Table 1C for wage indexes greater than 1.0000 and Table 1D for wage indexes less than or equal to 1.0000).

Step 2—Multiply the labor-related portion of the standardized amount by the appropriate Puerto Rico-specific wage index (see Table 4F of section VI. of the Addendum).

Step 3—Add the amount from Step 2 and the nonlabor-related portion of the standardized amount.

Step 4—Multiply the result in Step 3 by 25 percent.

Step 5—Multiply the amount from Step 4 by the appropriate DRG relative weight (see Table 5 of section VI. of the Addendum).

b. National Rate

The national prospective payment rate is determined as follows:

Step 1—Select the appropriate average standardized amount considering the applicable wage index (Table 1C for wage indexes greater than 1.0000 and Table 1D for wage indexes less than or equal to 1.0000).

Step 2—Add the amount from Step 1 and the nonlabor-related portion of the national average standardized amount.

Step 3—Multiply the result in Step 2 by 75 percent.

Step 4—Multiply the amount from Step 3 by the appropriate DRG relative weight (see Table 5 of section VI. of the Addendum).

The sum of the Puerto Rico rate and the national rate computed above equals the prospective payment for a given discharge for a hospital located in Puerto Rico. This rate may then be

further adjusted if the hospital qualifies for either the IME or DSH adjustment.

III. Proposed Changes to Payment Rates for Acute Care Hospital Inpatient Capital-Related Costs for FY 2005

The PPS for acute care hospital inpatient capital-related costs was implemented for cost reporting periods beginning on or after October 1, 1991. Effective with that cost reporting period, hospitals were paid during a 10-year transition period (which extended through FY 2001) to change the payment methodology for Medicare acute care hospital inpatient capital-related costs from a reasonable cost-based methodology to a prospective methodology (based fully on the Federal rate).

The basic methodology for determining Federal capital prospective rates is set forth in regulations at §§ 412.308 through 412.352. Below we discuss the factors that we are proposing to use to determine the capital Federal rate for FY 2005, which would be effective for discharges occurring on or after October 1, 2004. The 10-year transition period ended with hospital cost reporting periods beginning on or after October 1, 2001 (FY 2002). Therefore, for cost reporting periods beginning in FY 2002, all hospitals (except ''new'' hospitals under §§ 412.304(c)(2) and 412.324(b)) are paid based on 100 percent of the capital Federal rate.

For FY 1992, we computed the standard Federal payment rate for capital-related costs under the IPPS by updating the FY 1989 Medicare inpatient capital cost per case by an actuarial estimate of the increase in Medicare inpatient capital costs per case. Each year after FY 1992, we update the capital standard Federal rate, as provided at § 412.308(c)(1), to account for capital input price increases and other factors. The regulations at § 412.308(c)(2) provides that the capital Federal rate is adjusted annually by a factor equal to the estimated proportion of outlier payments under the capital Federal rate to total capital payments under the capital Federal rate. In addition, § 412.308(c)(3) requires that the capital Federal rate be reduced by an adjustment factor equal to the estimated proportion of payments for (regular and special) exception under § 412.348. Section 412.308(c)(4)(ii) requires that the capital standard Federal rate be adjusted so that the effects of the annual DRG reclassification and the recalibration of DRG weights and changes in the geographic adjustment factor are budget neutral.

For FYs 1992 through 1995, § 412.352 required that the capital Federal rate also be adjusted by a budget neutrality factor so that aggregate payments for inpatient hospital capital costs were projected to equal 90 percent of the payments that would have been made for capital-related costs on a reasonable cost basis during the fiscal year. That provision expired in FY 1996. Section 412.308(b)(2) describes the 7.4 percent reduction to the capital rate that was made in FY 1994, and § 412.308(b)(3) describes the 0.28 percent reduction to the capital rate made in FY 1996 as a result of the revised policy of paying for transfers. In FY 1998, we implemented section 4402 of Public Law 105–33, which requires that, for discharges occurring on or after October 1, 1997, and before October 1, 2002, the unadjusted capital standard Federal rate is reduced by 17.78 percent. As we discussed in the August 1, 2002 IPPS final rule (67 FR 50102) and implemented in § 412.308(b)(6)), a small part of that reduction was restored effective October 1, 2002.

To determine the appropriate budget neutrality adjustment factor and the regular exceptions payment adjustment during the 10-year transition period, we developed a dynamic model of Medicare inpatient capital-related costs; that is, a model that projected changes in Medicare inpatient capital-related costs over time. With the expiration of the budget neutrality provision, the capital cost model was only used to estimate the regular exceptions payment adjustment and other factors during the transition period. As we explained in the August 1, 2001 IPPS final rule (66 FR 39911), beginning in FY 2003, an adjustment for regular exception payments is no longer necessary because regular exception payments were only made for cost reporting periods beginning on or after October 1, 1991, and before October 1, 2001 (see § 412.348(b)). Because, effective with cost reporting periods beginning in FY 2002, payments are no longer being made under the regular exception policy, we no longer use the capital cost model. The capital cost model and its application during the transition period are described in Appendix B of the August 1, 2001 IPPS final rule (66 FR 40099).

In accordance with section 1886(d)(9)(A) of the Act, under the IPPS for acute care hospital operating costs, hospitals located in Puerto Rico are paid for operating costs under a special payment formula. Prior to FY 1998, hospitals in Puerto Rico were paid a blended capital rate that consisted of 75 percent of the applicable standardized amount specific to Puerto Rico hospitals and 25 percent of the applicable national average standardized amount. However, effective October 1, 1997, in accordance with section 4406 of Public Law 105–33, operating payments to hospitals in Puerto Rico are based on a blend of 50 percent of the applicable standardized amount specific to Puerto Rico hospitals and 50 percent of the applicable national average standardized amount. In conjunction with this change to the operating blend percentage, effective with discharges on or after October 1, 1997, we also revised the methodology for computing capital payments to hospitals in Puerto Rico and computing capital payments based on a blend of 50 percent of the Puerto Rico capital rate and 50 percent of the capital Federal rate.

As we discuss in section VI. of this Addendum to the proposed rule, section 504 of Public Law 108–173 increases the national portion of the operating IPPS payment for Puerto Rico hospitals from 50 percent to 62.5 percent and decreases the Puerto Rico portion of the operating IPPS payments from 50 percent to 37.5 percent for discharges occurring on or after April 1, 2004 through September 30, 2004 (see the March 26, 2004 One-Time Notification (Change Request 3158)). In addition, section 504 of Public Law 108–173 provides that the national portion of operating IPPS payments for Puerto Rico hospitals is equal to 75 percent and the Puerto Rico portion of operating IPPS payments is equal to 35 percent for discharges occurring on or after October 1, 2004. Consistent with this change in operating IPPS payment to hospitals in Puerto Rico for FY 2005, as we discuss in section V.B. of this Addendum to this proposed rule, we are proposing to revise methodology for computing capital IPPS payments to hospitals located in Puerto Rico. We are proposing that we would compute capital payments to hospitals located in Puerto Rico based on a blend of 25 percent of the Puerto Rico capital rate and 75 percent of the capital Federal rate for discharges occurring on or after October 1, 2004.

Section 412.374 provides for the use of a blended payment system for payments to Puerto Rico hospitals under the PPS for acute care hospital inpatient capital-related costs. Accordingly, under the capital IPPS, we compute a separate payment rate specific to Puerto Rico hospitals using the same methodology used to compute the national Federal rate for capital-related costs.

A. Determination of Proposed Federal Hospital Inpatient Capital-Related Prospective Payment Rate Update

In the final IPPS rule published in the **Federal Register** on August 1, 2003 (68 FR 45346), we established a capital Federal rate of $415.47 for FY 2004. However, a correction notice to the FY 2004 IPPS final rule issued in the **Federal Register** on October 6, 2003 (68 FR 57731) contains corrections and revisions to the wage index and geographic adjustment factor (GAF). In conjunction with the change to the wage index and GAF corrections, we established a revised capital PPS standard Federal rate of $414.18 effective for discharges occurring in FY 2004. Furthermore, the One-Time Notification (Change Request 3158), issued on March 26, 2004, implemented various changes in operating IPPS payments required by sections 401, 402 and 504 of Public Law 108–173. As a result of these changes to payments under the operating IPPS, the fixed loss amount for determining the cost outlier threshold was revised effective for discharges occurring on or after April 1, 2004, through September 30, 2004. Because the regulations at § 412.312(c) establish a unified outlier methodology for inpatient operating and capital-related costs, a single set of thresholds are used to identify outlier cases under both the operating IPPS and the capital IPPS. As a result of the revision to the fixed loss amount used for determining the cost outlier threshold effective for discharges occurring on or after April 1, 2004, through September 30, 2004, we established a new capital IPPS standard Federal rate of $413.48 effective for discharges occurring on or after April 1, 2004, through September 30, 2004.

Because there are two capital IPPS standard Federal rates in effect during FY 2004 ($414.18 from October 2003 through March 2004 and $413.48 from April 2004 through September 2004), we are proposing to use an average of the rates effective for the first half of FY 2004 (October 1, 2003 through March 31, 2004) ($414.18) and the second half FY 2004 (April 1, 2004 through September 30, 2004) ($413.48) to determine the proposed FY 2005 capital Federal rate. (The proposed average is $413.83 (($414.18 + $413.48)/2.) As a result of the changes that we are proposing to the factors used to determine the proposed capital Federal rate that are explained in this Addendum, the proposed FY 2005 capital standard Federal rate is $416.59.

In the discussion that follows, we explain the factors that were used to determine the proposed FY 2005 capital Federal rate. In particular, we explain why the proposed FY 2005 capital Federal rate has increased 0.67 percent compared to the FY 2004 capital Federal rate. We also estimate aggregate capital payments will remain constant from FY 2004 to FY 2005. We are projecting aggregate capital PPS to remain unchanged primarily due to a projected decrease in Medicare Part A (fee-for-service) admissions. We are projecting a decrease in Medicare Part A enrollment, in part, because we are projecting an increase in Medicare managed care (M+C) enrollment as a result of implementing several sections of Public Law 108–173.

Total payments to hospitals under the IPPS are relatively unaffected by changes in the capital prospective payments. Since capital payments constitute about 10 percent of hospital payments, a 1-percent change in the capital Federal rate yields only about 0.1 percent change in actual payments to hospitals. Aggregate payments under the capital PPS are estimated to increase in FY 2005 compared to FY 2004.

1. Proposed Capital Standard Federal Rate Update

a. Description of the Update Framework

Under § 412.308(c)(1), the capital standard Federal rate is updated on the basis of an analytical framework that takes into account changes in a capital input price index (CIPI) and several other policy adjustment factors. Specifically, we have adjusted the projected CIPI rate of increase as appropriate each year for case-mix index-related changes, for intensity, and for errors in previous CIPI forecasts. The proposed update factor for FY 2005 under that framework is 0.7 percent based on the best data available at this time. The proposed update factor is based on a projected 0.7 percent increase in the CIPI, a 0.0 percent adjustment for intensity, a 0.0 percent adjustment for case-mix, a 0.0 percent adjustment for the FY 2003 DRG reclassification and recalibration, and a forecast error correction of 0.0 percent. We explain the basis for the FY 2005 CIPI projection in section III.C. of this Addendum. Below we describe the proposed policy adjustments that have been applied.

The case-mix index is the measure of the average DRG weight for cases paid under the IPPS. Because the DRG weight determines the prospective payment for each case, any percentage increase in the case-mix index corresponds to an equal percentage increase in hospital payments.

The case-mix index can change for any of several reasons:

- The average resource use of Medicare patients changes (''real'' case-mix change);
- Changes in hospital coding of patient records result in higher weight DRG assignments (''coding effects''); and
- The annual DRG reclassification and recalibration changes may not be budget neutral (''reclassification effect'').

We define real case-mix change as actual changes in the mix (and resource requirements) of Medicare patients as opposed to changes in coding behavior that result in assignment of cases to higher weighted DRGs but do not reflect higher resource requirements. In the update framework for the PPS for operating costs, we adjust the update upwards to allow for real case-mix change, but remove the effects of coding changes on the case-mix index. We also remove the effect on total payments of prior year changes to the DRG classifications and relative weights, in order to retain budget neutrality for all case-mix index-related changes other than patient severity. (For example, we adjusted for the effects of the FY 2003 DRG reclassification and recalibration as part of our update for FY 2005.) We have adopted this case-mix index adjustment in the capital update framework as well.

For FY 2005, we are projecting a 1.0 percent total increase in the case-mix index. We estimate that the real case-mix increase would equal 1.0 percent in FY 2005. The net adjustment for change in case-mix is the difference between the projected total increase in case-mix and the projected increase in real case-mix change. Therefore, the net adjustment for case-mix change in FY 2005 is 0.0 percentage points.

We estimate that FY 2003 DRG reclassification and recalibration would result in a 0.0 percent change in the case-mix when compared with the case-mix index that would have resulted if we had not made the reclassification and recalibration changes to the DRGs. Therefore, we are making a 0.0 percent adjustment for DRG reclassification and recalibration in the update for FY 2005 to maintain budget neutrality.

The capital update framework contains an adjustment for forecast error. The input price index forecast is based on historical trends and relationships ascertainable at the time the update factor is established for the upcoming year. In any given year, there may be unanticipated price fluctuations that may result in differences between the actual increase in prices and the forecast used in calculating the update

factors. In setting a prospective payment rate under the framework, we make an adjustment for forecast error only if our estimate of the change in the capital input price index for any year is off by 0.25 percentage points or more. There is a 2-year lag between the forecast and the measurement of the forecast error. A forecast error of 0.0 percentage points was calculated for the FY 2003 update. That is, current historical data indicate that the forecasted FY 2003 CIPI used in calculating the FY 2003 update factor (0.7 percent) slightly overstated the actual realized price increases (0.6 percent) by 0.1 percentage points. This slight overprediction was mostly due to an underestimation of the interest rate cuts by the Federal Reserve Board in 2003, which impacted the interest component of the CIPI. However, since this estimation of the change in the CIPI is less than 0.25 percentage points, it is not reflected in the update recommended under this framework. Therefore, we are making a 0.0 percent adjustment for forecast error in the update for FY 2005.

Under the capital PPS system framework, we also make an adjustment for changes in intensity. We calculate this adjustment using the same methodology and data that are used in the framework for the operating PPS. The intensity factor for the operating update framework reflects how hospital services are utilized to produce the final product, that is, the discharge. This component accounts for changes in the use of quality-enhancing services, for changes in within-DRG severity, and for expected modification of practice patterns to remove noncost-effective services.

We calculate case-mix constant intensity as the change in total charges per admission, adjusted for price level changes (the CPI for hospital and related services) and changes in real case-mix. The use of total charges in the calculation of the intensity factor makes it a total intensity factor, that is, charges for capital services are already built into the calculation of the factor. Therefore, we have incorporated the intensity adjustment from the operating update framework into the capital update framework. Without reliable estimates of the proportions of the overall annual intensity increases that are due, respectively, to ineffective practice patterns and to the combination of quality-enhancing new technologies and within-DRG complexity, we assume, as in the operating update framework, that one-half of the annual increase is due to each of these factors. The capital update framework thus provides an add-on to the input price index rate of increase of one-half of the estimated annual increase in intensity, to allow for within-DRG severity increases and the adoption of quality-enhancing technology.

We have developed a Medicare-specific intensity measure based on a 5-year average. Past studies of case-mix change by the RAND Corporation (''Has DRG Creep Crept Up? Decomposing the Case Mix Index Change Between 1987 and 1988'' by G. M. Carter, J. P. Newhouse, and D. A. Relles, R–4098–HCFA/ProPAC (1991)) suggest that real case-mix change was not dependent on total change, but was usually a fairly steady 1.0 to 1.4 percent per year. We use 1.4 percent as the upper bound because the RAND study did not take into account that hospitals may have induced doctors to document medical records more completely in order to improve payment.

We calculate case-mix constant intensity as the change in total charges per admission, adjusted for price level changes (the CPI for hospital and related services), and changes in real case-mix. As we noted above, in accordance with § 412.308(c)(1)(ii), we began updating the capital standard Federal rate in FY 1996 using an update framework that takes into account, among other things, allowable changes in the intensity of hospital services. For FYs 1996 through 2001, we found that case-mix constant intensity was declining and we established a 0.0 percent adjustment for intensity in each of those years. For FYs 2001 and 2002, we found that case-mix constant intensity was increasing and we established a 0.3 percent adjustment and 1.0 percent adjustment for intensity, respectively.

Using the methodology described above, for FY 2005 we examined the change in total charges per admission, adjusted for price level changes (the CPI for hospital and related services), and changes in real case-mix for FYs 1999 through 2003. We found that, over this period and in particular the last 4 years of this period (FYs 2000 through 2003), the charge data appear to be skewed. More specifically, we found a dramatic increase in hospital charges for FYs 2000 through 2003 without a corresponding increase in hospital case-mix index. These findings are similar to the considerable increase in hospitals charges we found when we were determining the intensity factor in the FY 2004 update recommendation as discussed in the August 1, 2003 final rule (69 FR 45482). If hospitals were treating new or different types of cases, which would result in an appropriate increase in charges per discharge, then we would expect hospitals' case-mix to increase proportionally.

As we discussed in the August 1, 2003 final rule (68 FR 45482), because our intensity calculation relies heavily upon charge data and we believe that this charge data may be inappropriately skewed, we established a 0.0 percent adjustment for intensity for FY 2004. In that same final rule, we stated that we believe that it is appropriate to propose a zero intensity adjustment until we believe that any increase in charges can be tied to intensity rather then to attempts to maximize outlier payments. As discussed above, based on the most recent available data, we believe that the charge data used to make this determination may still be inappropriately skewed. Since our intensity calculation relies heavily upon charge data (which may be inappropriately skewed), we are proposing a 0.0 percent adjustment for intensity for FY 2005 in this proposed rule. We note that, in past FYs (1996 through 2000) when we found intensity to be declining, we believed a zero (rather then negative) intensity adjustment was appropriate. Similarly, we believe that it is appropriate to propose a zero intensity adjustment for FY 2005 until we believe that any increase in charges can be tied to intensity rather than to attempts to maximize outlier payments.

Above we described the basis of the components used to develop the proposed 0.7 percent capital update factor for FY 2005 as shown in the table below.

CMS'S PROPOSED FY 2005 UPDATE FACTOR TO THE CAPITAL FEDERAL RATE

Capital Input Price Index	0.7.
Intensity	0.0.
Case-Mix Adjustment Factors:.	
Projected Case-Mix Change	1.0
Real Across DRG Change	−1.0.
Subtotal	0.0.
Effect of FY 2003 Reclassification and Recalibration	0.0
Forecast Error Correction	0.0.
Total Proposed Update	0.7

b. Comparison of CMS and MedPAC Update Recommendation

In the past, MedPAC has included update recommendations for capital PPS in a Report to Congress. In its March 2004 Report to Congress, MedPAC did not make an update recommendation for capital PPS payments for FY 2005. However, in that same report, MedPAC made an update

recommendation for hospital inpatient and outpatient services (page 87). MedPAC reviews inpatient and outpatient services together since they are so closely interrelated. MedPAC's recommendation of the full market basket update for both the inpatient and outpatient PPSs is based on their assessment of beneficiaries' access to care, volume growth, access to capital, quality, and the relationship of Medicare payments to costs in the hospital sector.

2. Outlier Payment Adjustment Factor

Section 412.312(c) establishes a unified outlier methodology for inpatient operating and inpatient capital-related costs. A single set of thresholds is used to identify outlier cases for both inpatient operating and inpatient capital-related payments. Section 412.308(c)(2) provides that the standard Federal rate for inpatient capital-related costs be reduced by an adjustment factor equal to the estimated proportion of capital related outlier payments to total inpatient capital-related PPS payments. The outlier thresholds are set so that operating outlier payments are projected to be 5.1 percent of total operating DRG payments.

In the August 1, 2003 IPPS final rule (68 FR 45482), we estimated that outlier payments for capital in FY 2004 would equal 4.79 percent of inpatient capital-related payments based on the FY 2004 capital Federal rate. Accordingly, we applied an outlier adjustment factor of 0.9521 to the FY 2004 capital Federal rate. However, as we noted above, we published a correction notice in the **Federal Register** on October 6, 2003 (68 FR 57731), which established revised rates and factors for FY 2004. In that same correction notice (68 FR 57734), we estimated that outlier payments for capital in FY 2004 would equal 4.77 percent of inpatient capital-related payments based on the FY 2004 capital Federal rate. Accordingly, we established a revised outlier adjustment of 0.9523 for use in determining the FY 2004 capital Federal rate. In addition, as we noted above, a One-Time Notification (Change Request 3158) issued on March 26, 2004, implemented various changes in operating IPPS payments required by sections 401, 402, and 504 of Public Law 108–173, effective for discharges on or after April 1, 2004, through September 30, 2004. As a result of changes made to payments under the operating IPPS, the rates and some of the factors, including the outlier adjustment, under the capital IPPS were also revised effective for discharges on or after April 1, 2004, through September 30, 2004. The revised outlier adjustment effective for the second half of FY 2004 (April 2004 through September 2004) is 0.9508.

Based on the thresholds as set forth in section II.A.4.c. of this Addendum, we estimate that outlier payments for capital would equal 5.03 percent of inpatient capital-related payments based on the proposed capital Federal rate in FY 2005. Therefore, we are proposing an outlier adjustment factor of 0.9497 to the capital Federal rate. Thus, the percentage of capital outlier payments to total capital standard payments for FY 2005 is higher than the percentages estimated for the first half (4.77 percent for October 2003 through March 2004) and the second half (4.92 percent for April 2004 through September 2004) of FY 2004.

The outlier reduction factors are not built permanently into the capital rates; that is, they are not applied cumulatively in determining the capital Federal rate. As we discussed above, there were two outlier adjustment factors applied during FY 2004 (0.9523 from October 2003 through March 2004 and 0.9508 from April 2004 through September 2004). The proposed FY 2005 outlier adjustment of 0.9497 is a –0.19 percent change from the average FY 2004 outlier adjustment of 0.9515 (the mean of the factors for the first half of FY 2004 (0.9523) and the second half of FY 2004 (0.9508) calculated from unrounded numbers). The proposed net change in the outlier adjustment to the capital Federal rate for FY 2005 is 0.9981 (0.9497/0.9515). Thus, the proposed outlier adjustment decreases the FY 2005 capital Federal rate by 0.19 percent compared with the average FY 2004 outlier adjustment.

3. Budget Neutrality Adjustment Factor for Changes in DRG Classifications and Weights and the Geographic Adjustment Factor

Section 412.308(c)(4)(ii) requires that the capital Federal rate be adjusted so that aggregate payments for the fiscal year based on the capital Federal rate after any changes resulting from the annual DRG reclassification and recalibration and changes in the geographic adjustment factor (GAF) are projected to equal aggregate payments that would have been made on the basis of the capital Federal rate without such changes.

Since we implemented a separate geographic adjustment factor for Puerto Rico, we apply separate budget neutrality adjustments for the national geographic adjustment factor and the Puerto Rico geographic adjustment factor. We apply the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. Separate adjustments were unnecessary for FY 1998 and earlier fiscal years since the geographic adjustment factor for Puerto Rico was implemented in FY 1998.

In the past, we used the actuarial capital cost model (described in Appendix B of the August 1, 2001 IPPS final rule (66 FR 40099)) to estimate the aggregate payments that would have been made on the basis of the capital Federal rate with and without changes in the DRG classifications and weights and in the GAF to compute the adjustment required to maintain budget neutrality for changes in DRG weights and in the GAF. During the transition period, the capital cost model was also used to estimate the regular exception payment adjustment factor. As we explain in section III.A.4. of this Addendum, beginning in FY 2002, an adjustment for regular exception payments is no longer necessary. Therefore, we are no longer using the capital cost model. Instead, we are using historical data based on hospitals' actual cost experiences to determine the exceptions payment adjustment factor for special exceptions payments.

To determine the proposed factors for FY 2005, we compared (separately for the national capital rate and the Puerto Rico capital rate) estimated aggregate capital Federal rate payments based on the FY 2004 DRG relative weights and the average FY 2004 GAF (that is, the mean of the GAFs applied from October 2003 through March 2004 and the GAFs applied from April 2004 through September 2004) to estimated aggregate capital Federal rate payments based on the proposed FY 2005 relative weights and the proposed FY 2005 GAF. For the first half of FY 2004 (October 1, 2003 through March 31, 2004), the budget neutrality adjustment factors were 0.9908 for the national capital rate and 0.9974 for the Puerto Rico capital rate (see the October 6, 2003 correction notice). For the second half of FY 2004 (April 1, 2004 through September 30, 2004), the budget neutrality adjustment factor was revised to 0.9907 for the national capital rate. The budget neutrality factor for the Puerto Rico capital rate remained unchanged (0.9974). In making the comparison, we set the regular and special exceptions reduction factors to 1.00.

To achieve budget neutrality for the changes in the national GAF, based on calculations using updated data, we are proposing to apply an incremental budget neutrality adjustment of 1.0018 for FY 2005 to the average of the previous cumulative FY 2004

adjustments of 0.9908 ((0.99083 + 0.99072)/2), yielding a proposed cumulative adjustment of 0.9925 through FY 2005 (calculations were done with unrounded numbers). For the Puerto Rico GAF, we are proposing to apply an incremental budget neutrality adjustment of 0.9989 for FY 2005 to the average of the previous cumulative FY 2004 adjustment of 0.9974, yielding a proposed cumulative adjustment of 0.9963 through FY 2005.

We then compared estimated aggregate capital Federal rate payments based on the FY 2004 DRG relative weights and the average FY 2004 GAF to estimated aggregate capital Federal rate payments based on the proposed FY 2005 DRG relative weights and the proposed FY 2005 GAF. The proposed incremental adjustment for DRG classifications and changes in relative weights is 0.9997 both nationally and for Puerto Rico. The proposed cumulative adjustments for DRG classifications and changes in relative weights and for changes in the GAF through FY 2005 are 0.9922 nationally and 0.9960 for Puerto Rico. The following table summarizes the adjustment factors for each fiscal year:

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BUDGET NEUTRALITY ADJUSTMENT FOR DRG RECLASSIFICATIONS AND RECALIBRATION AND THE GEOGRAPHIC ADJUSTMENT FACTORS

Fiscal Year	National				Puerto Rico			
	Incremental Adjustment			Cumulative	Incremental Adjustment			Cumulative
	Geographic Adjustment Factor	DRG Reclassifications and Recalibration	Combined		Geographic Adjustment Factor	DRG Reclassifications and Recalibration	Combined	
1992	---	---	---	1.00000	---	---	---	---
1993	---	---	0.99800	0.99800	---	---	---	---
1994	---	---	1.00531	1.00330	---	---	---	---
1995	---	---	0.99980	1.00310	---	---	---	---
1996	---	---	0.99940	1.00250	---	---	---	---
1997	---	---	0.99873	1.00123	---	---	---	---
1998	---	---	0.99892	1.00015	---	---	---	1.00000
1999	0.99944	1.00335	1.00279	1.00294	0.99898	1.00335	1.00233	1.00233
2000	0.99857	0.99991	0.99848	1.00142	0.99910	0.99991	0.99901	1.00134
2001[1]	0.99782	1.00009	0.99791	0.99933	1.00365	1.00009	1.00374	1.00508
2001[2]	0.99771[3]	1.00009[3]	0.99780[3]	0.99922	1.00365[3]	1.00009[3]	1.00374[3]	1.00508
2002	0.99666[4]	0.99668[4]	0.99335[4]	0.99268	0.98991[4]	0.99668[4]	0.99662[4]	0.99164
2003[5]	0.99915	0.99662	0.99577	0.98848	1.00809	0.99662	1.00468	0.99628
2003[6]	0.99896[7]	0.99662[7]	0.99558[7]	0.98830	1.00809[7]	0.99662[7]	1.00468[7]	0.99628
2004[8]	1.00175[9]	1.00081[9]	1.00256[9]	0.99083	1.00028[9]	1.00081[9]	1.00109[9]	0.9973[6]
2004[10]	1.00164[9]	1.00081[9]	1.00245[9]	0.99072	1.00028[9]	1.00081[9]	1.00109[9]	0.99736
2005	1.00175[11]	0.99970	1.00145[11]	0.99222	0.99891[11]	0.99970	0.99861[11]	0.99597

[1] Factors effective for the first half of FY 2001 (October 2000 through March 2001).
[2] Factors effective for the second half of FY 2001 (April 2001 through September 2001).
[3] Incremental factors are applied to FY 2000 cumulative factors.
[4] Incremental factors are applied to the cumulative factors for the first half of FY 2001.
[5] Factors effective for the first half of FY 2003 (October 2002 through March 2003).
[6] Factors effective for the second half of FY 2003 (April 2003 through September 2003).
[7] Incremental factors are applied to FY 2002 cumulative factors.
[8] Factors effective for the first half of FY 2004 (October 2003 through March 2004).
[9] Incremental factors are applied to the cumulative factors for the second half of FY 2003.
[10] Factors effective for the second half of FY 2004 (April 2004 through September 2004).
[11] Incremental factors are applied to average of the cumulative factors for the first half (October 1, 2003 through March 31, 2004) and second half (April 1, 2004 through September 30, 2004) of FY 2004.

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The methodology used to determine the proposed recalibration and geographic (DRG/GAF) budget neutrality adjustment factor for FY 2005 is similar to that used in establishing budget neutrality adjustments under the PPS for operating costs. One difference is that, under the operating PPS, the budget neutrality adjustments for the effect of geographic reclassifications are determined separately from the effects of other changes in the hospital wage index and the DRG relative weights. Under the capital PPS, there is a single DRG/GAF budget neutrality adjustment factor (the national capital rate and the Puerto Rico capital rate are determined separately) for changes in the GAF (including geographic reclassification) and the DRG relative weights. In addition, there is no adjustment for the effects that geographic reclassification has on the other payment parameters, such as the payments for serving low-income patients, indirect medical education payments, or the large urban add-on payments.

In the August 1, 2003 IPPS final rule (68 FR 45346), we calculated a GAF/DRG budget neutrality factor of 1.00591 for FY 2004. As we noted above, as a result of the revisions to the GAF effective for FY 2004 in the October 6, 2003 correction notice, we calculated a GAF/DRG budget neutrality factor of 1.00256 for discharges occurring in FY 2004. As we also noted above, as a result of implementing sections 401, 402, and 504 of Public Law 108–173, we calculated a GAF/DRG budget neutrality factor of 1.00245 for discharges occurring on or after April 1, 2004 through September 30, 2004. Furthermore, as noted above, the average of capital rates and factors in effect for the first half (October 2003 through March 2004) and second half (April 2004 through September 2004) of FY 2004 was used in determining the FY 2005 capital rates.

For FY 2005, we are proposing a GAF/DRG budget neutrality factor of 1.0015. The GAF/DRG budget neutrality factors are built permanently into the capital rates; that is, they are applied cumulatively in determining the capital Federal rate. This follows from the requirement that estimated aggregate payments each year be no more or less than they would have been in the absence of the annual DRG reclassification and recalibration and changes in the GAF. The proposed incremental change in the adjustment from FY 2004 to FY 2005 is 1.0015. The proposed cumulative change in the capital Federal rate due to this adjustment is 0.9922 (the product of the incremental factors for FY 1993, FY 1994, FY 1995, FY 1996, FY 1997, FY 1998, FY 1999, FY 2000, FY 2001, FY 2002, FY 2003, average FY 2004 and the proposed incremental factor for FY 2005: $0.9980 \times 1.0053 \times 0.9998 \times 0.9994 \times 0.9987 \times 0.9989 \times 1.0028 \times 0.9985 \times 0.9979 \times 0.9934 \times 0.9956 \times 1.0025 \times 1.0015 = 0.9922$).

This proposed factor accounts for DRG reclassifications and recalibration and for changes in the GAF. It also incorporates the effects on the GAF of FY 2005 geographic reclassification decisions made by the MGCRB compared to FY 2004 decisions. However, it does not account for changes in payments due to changes in the DSH and IME adjustment factors or in the large urban add-on.

4. Exceptions Payment Adjustment Factor

Section 412.308(c)(3) requires that the capital standard Federal rate be reduced by an adjustment factor equal to the estimated proportion of additional payments for both regular exceptions and special exceptions under § 412.348 relative to total capital PPS payments. In estimating the proportion of regular exception payments to total capital PPS payments during the transition period, we used the actuarial capital cost model originally developed for determining budget neutrality (described in Appendix B of the August 1, 2001 IPPS final rule (66 FR 40099)) to determine the exceptions payment adjustment factor, which was applied to both the Federal and hospital-specific capital rates.

An adjustment for regular exception payments is no longer necessary in determining the FY 2005 capital Federal rate because, in accordance with § 412.348(b), regular exception payments were only made for cost reporting periods beginning on or after October 1, 1991 and before October 1, 2001. Accordingly, as we explained in the August 1, 2001 IPPS final rule (66 FR 39949), in FY 2002 and subsequent fiscal years, no payments will be made under the regular exceptions provision. However, in accordance with § 412.308(c), we still need to compute a budget neutrality adjustment for special exception payments under § 412.348(g). We describe our methodology for determining the special exceptions adjustment used in calculating the FY 2005 capital Federal rate below.

Under the special exceptions provision specified at § 412.348(g)(1), eligible hospitals include SCHs, urban hospitals with at least 100 beds that have a disproportionate share percentage of at least 20.2 percent or qualify for DSH payments under § 412.106(c)(2), and hospitals with a combined Medicare and Medicaid inpatient utilization of at least 70 percent. An eligible hospital may receive special exceptions payments if it meets (1) a project need requirement as described at § 412.348(g)(2), which, in the case of certain urban hospitals, includes an excess capacity test as described at § 412.348(g)(4); (2) an age of assets test as described at § 412.348(g)(3); and (3) a project size requirement as described at § 412.348(g)(5).

Based on information compiled from our fiscal intermediaries, six hospitals have qualified for special exceptions payments under § 412.348(g). Since we have cost reports ending in FY 2003 for all of these hospitals, we calculated the proposed adjustment based on actual cost experience. Using data from cost reports ending in FY 2003 from the March 2004 update of the HCRIS data, we divided the capital special exceptions payment amounts for the six hospitals that qualified for special exceptions by the total capital PPS payment amounts (including special exception payments) for all hospitals. Based on the data from cost reports ending in FY 2003, this ratio is rounded to 0.0004. Because we have not received all cost reports ending in FY 2003, we also divided the FY 2003 special exceptions payments by the total capital PPS payment amounts for all hospitals with cost reports ending in FY 2002. This ratio also rounds to 0.0004. Because special exceptions are budget neutral, we are proposing to offset the capital Federal rate by 0.04 percent for special exceptions payments for FY 2005. Therefore, the proposed exceptions adjustment factor is equal to 0.9996 (1–0.0004) to account for special exceptions payments in FY 2005.

In the August 1, 2003 IPPS final rule (68 FR 45384) for FY 2004, we estimated that total (special) exceptions payments would equal 0.05 percent of aggregate payments based on the capital Federal rate. Therefore, we applied an exceptions adjustment factor of 0.9995 (1–0.0005) in determining the FY 2004 capital Federal rate. (We note that the special exceptions adjustment factor for FY 2004 was not revised in either the October 6, 2003 correction notice or the March 26, 2004 One-Time Notification.) As we stated above, we estimate that exceptions payments in FY 2005 would equal 0.04 percent of aggregate payments based on the FY 2005 capital Federal rate. Therefore, we are proposing to apply an exceptions payment adjustment factor of 0.9996 to the capital Federal rate for FY 2005. The proposed exceptions adjustment factor for FY 2005 is 0.01 percent higher than the factor for FY 2004 published in the August 1, 2003 IPPS final rule (68 FR 45346). The exceptions reduction factors are not built permanently into the capital rates; that is, the factors are not applied cumulatively in determining the capital Federal rate. Therefore, the proposed net change in the exceptions adjustment factor used in determining the proposed FY 2005 capital Federal rate is 1.0001 (0.9996/0.9995).

5. Proposed Capital Standard Federal Rate for FY 2005

In the August 1, 2003 IPPS final rule (68 FR 45346) we established a capital Federal rate of $415.47 for FY 2004. As we noted above, as a result of the revisions to the GAF for FY 2004, in the October 6, 2003 correction notice, we established a capital Federal rate of $414.18 for discharges occurring in FY 2004. As we also discussed above, a One-Time Notification issued on March 26, 2004, which implemented various

changes in operating IPPS payments required by sections 401, 402, and 504 of Public Law 108–173, resulted in a revised capital Federal rate of $413.48 effective for discharges occurring on or after April 1, 2004 through September 30, 2004. Because there are two capital IPPS standard Federal rates in effect during FY 2004 ($414.18 from October 2003 through March 2004 and $413.48 from April 2004 through September 2004), we are proposing to use an average of the rates effective for the first half ($414.18) and the second half ($413.48) of FY 2004 of $413.83 (($414.18 + $413.48)/2) in determining the proposed FY 2005 capital Federal rate. In this proposed rule, we are proposing to establish a capital Federal rate of $416.59 for FY 2005. The proposed capital Federal rate for FY 2005 was calculated as follows:

- The proposed FY 2005 update factor is 1.007; that is, the update is 0.7 percent.
- The proposed FY 2005 budget neutrality adjustment factor that is applied to the capital standard Federal payment rate for changes in the DRG relative weights and in the GAF is 1.0015.
- The proposed FY 2005 outlier adjustment factor is 0.9497.
- The proposed FY 2005 (special) exceptions payment adjustment factor is 0.9996.

Because the proposed capital Federal rate has already been adjusted for differences in case-mix, wages, cost-of-living, indirect medical education costs, and payments to hospitals serving a disproportionate share of low-income patients, we are proposing to make no additional adjustments in the capital standard Federal rate for these factors, other than the budget neutrality factor for changes in the DRG relative weights and the GAF.

We are providing a chart that shows how each of the proposed factors and adjustments for FY 2005 affected the computation of the proposed FY 2005 capital Federal rate in comparison to the average FY 2004 capital Federal rate. The proposed FY 2005 update factor has the effect of increasing the capital Federal rate by 0.70 percent compared to the average FY 2004 Federal rate. The proposed GAF/DRG budget neutrality factor has the effect of increasing the capital Federal rate by 0.15 percent. The proposed FY 2005 outlier adjustment factor has the effect of decreasing the capital Federal rate by 0.19 percent compared to the average FY 2004 capital Federal rate and the proposed FY 2005 exceptions payment adjustment factor has the effect of increasing the capital Federal rate by 0.01 percent compared to the exceptions payment adjustment factor for the FY 2004 capital Federal rate. The combined effect of all the proposed changes is to increase the capital Federal rate by 0.67 percent compared to the average FY 2004 capital Federal rate.

COMPARISON OF FACTORS AND ADJUSTMENTS: FY 2004 CAPITAL FEDERAL RATE [1] AND PROPOSED FY 2005 CAPITAL FEDERAL RATE

	FY 2004 [1]	Proposed FY 2005	Change	Percent change
Update factor [2]	1.0070	1.0070	1.0070	0.70
GAF/DRG Adjustment Factor [2]	1.0025	1.0015	1.0015	0.15
Outlier Adjustment Factor [3]	0.9515	0.9497	0.9981	−0.19
Exceptions Adjustment Factor [3]	0.9995	0.9996	1.0001	0.01
Capital Federal Rate	$413.83	$416.59	1.0067	0.67

[1] Because there are two capital IPPS standard Federal rates in effect during FY 2004 ($414.18 from October 2003 through March 2004 and $413.48 from April 2004 through September 2004), an average of the rates and factors effective for the first half (October 2003 through March 2004) and the second half (April 2004 through September 2004)) of FY 2004 were used.

[2] The update factor and the GAF/DRG budget neutrality factors are built permanently into the capital rates. Thus, for example, the incremental change from FY 2004 to FY 2005 resulting from the application of the proposed 1.0015 GAF/DRG budget neutrality factor for FY 2005 is 1.0015.

[3] The outlier reduction factor and the exceptions adjustment factor are not built permanently into the capital rates; that is, these factors are not applied cumulatively in determining the capital rates. Thus, for example, the net change resulting from the application of the proposed FY 2005 outlier adjustment factor is 0.9497/0.9515, or 0.9981.

6. Special Capital Rate for Puerto Rico Hospitals

As discussed above, beginning in FY 1998, hospitals in Puerto Rico are currently paid based on 50 percent of the Puerto Rico capital rate and 50 percent of the capital Federal rate. The Puerto Rico capital rate is derived from the costs of Puerto Rico hospitals only, while the capital Federal rate is derived from the costs of all acute care hospitals participating in the PPS (including Puerto Rico). Section 504 of Public Law 108–173 increases the national portion of the operating IPPS payment for Puerto Rico hospitals from 50 percent to 75 percent and decreases the Puerto Rico portion of the operating IPPS payments for hospitals located in Puerto Rico from 50 percent to 37.5 percent for discharges occurring on or after April 1, 2004, through September 30, 2004. In addition, section 504 of Public Law 108–173 provides that the national portion of operating IPPS payments for Puerto Rico hospitals is equal to 75 percent and the Puerto Rico portions of the operating IPPS payments is equal to 37.5 percent for discharges occurring on or after October 1, 2004. As discussed in section V.B. of the preamble of this proposed rule, under the broad authority of section 1886(g) of the Act, we are proposing for FY 2005 to increase the national portion of the capital IPPS payment to hospitals located in Puerto Rico from 50 percent to 75 percent, as well. Therefore, for discharges occurring on or after October 1, 2004, capital payments to hospitals in Puerto Rico would be based on a blend of 25 percent of the Puerto Rico capital rate and 75 percent of the capital Federal rate.

To adjust hospitals' capital payments for geographic variations in capital costs, we apply a GAF to both portions of the blended capital rate. The GAF is calculated using the operating PPS wage index and varies, depending on the MSA or rural area in which the hospital is located. We use the Puerto Rico wage index to determine the GAF for the Puerto Rico part of the capital-blended rate and the national wage index to determine the GAF for the national part of the blended capital rate.

Because we implemented a separate GAF for Puerto Rico in FY 1998, we also apply separate budget neutrality adjustments for the national GAF and for the Puerto Rico GAF. However, we apply the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. As we stated above in section III.A.4. of this Addendum, for Puerto

Rico the proposed GAF budget neutrality factor is 0.9989, while the proposed DRG adjustment is 0.9997, for a proposed combined cumulative adjustment of 0.9960.

In computing the payment for a particular Puerto Rico hospital, the Puerto Rico portion of the capital rate (currently 50 percent; 25 percent proposed for FY 2005 and thereafter) is multiplied by the Puerto Rico-specific GAF for the MSA in which the hospital is located, and the national portion of the capital rate (currently 50 percent; 75 percent proposed for FY 2005 and thereafter) is multiplied by the national GAF for the MSA in which the hospital is located (which is computed from national data for all hospitals in the United States and Puerto Rico). In FY 1998, we implemented a 17.78 percent reduction to the Puerto Rico capital rate as a result of Public Law 105–33. In FY 2003, a small part of that reduction was restored.

For FY 2004, before application of the GAF, the special capital rate for Puerto Rico hospitals was $203.17 for discharges occurring on or after October 1, 2003 through March 31, 2004 (see the October 6, 2003 correction notice) and $202.96 for discharges occurring on or after April 1, 2004 through September 30, 2004 (see the March 26, 2004 One-Time Notification). With the changes we are proposing to the factors used to determine the capital rate, the proposed FY 2005 special capital rate for Puerto Rico is $200.52.

B. Calculation of Inpatient Capital-Related Prospective Payments for FY 2005

Because the 10-year capital PPS transition period ended in FY 2001, all hospitals (except ''new'' hospitals under § 412.324(b) and under § 412.304(c)(2)) are paid based on 100 percent of the capital Federal rate in FY 2005. The applicable proposed capital Federal rate was determined by making adjustments as follows:

- For outliers, by dividing the proposed capital standard Federal rate by the proposed outlier reduction factor for that fiscal year; and
- For the payment adjustments applicable to the hospital, by multiplying the hospital's proposed GAF, disproportionate share adjustment factor, and IME adjustment factor, when appropriate.

For purposes of calculating payments for each discharge during FY 2005, the capital standard Federal rate is adjusted as follows: (Standard Federal Rate) × (DRG weight) × (GAF) × (Large Urban Add-on, if applicable) × (COLA adjustment for hospitals located in Alaska and Hawaii) × (1 + Disproportionate Share Adjustment Factor + IME Adjustment Factor, if applicable). The result is the adjusted capital Federal rate.

Hospitals also may receive outlier payments for those cases that qualify under the thresholds established for each fiscal year. Section 412.312(c) provides for a single set of thresholds to identify outlier cases for both inpatient operating and inpatient capital-related payments. The proposed outlier thresholds for FY 2005 are in section II.A.4.c. of this Addendum. For FY 2005, a case qualifies as a cost outlier if the cost for the case plus the IME and DSH payments is greater than the prospective payment rate for the DRG plus $35,085.

An eligible hospital may also qualify for a special exceptions payment under § 412.348(g) for up through the 10th year beyond the end of the capital transition period if it meets: (1) a project need requirement described at § 412.348(g)(2), which in the case of certain urban hospitals includes an excess capacity test as described at § 412.348(g)(4); and (2) a project size requirement as described at § 412.348(g)(5). Eligible hospitals include sole community hospitals, urban hospitals with at least 100 beds that have a DSH patient percentage of at least 20.2 percent or qualify for DSH payments under § 412.106(c)(2), and hospitals that have a combined Medicare and Medicaid inpatient utilization of at least 70 percent. Under § 412.348(g)(8), the amount of a special exceptions payment is determined by comparing the cumulative payments made to the hospital under the capital PPS to the cumulative minimum payment level. This amount is offset by: (1) Any amount by which a hospital's cumulative capital payments exceed its cumulative minimum payment levels applicable under the regular exceptions process for cost reporting periods beginning during which the hospital has been subject to the capital PPS; and (2) any amount by which a hospital's current year operating and capital payments (excluding 75 percent of operating DSH payments) exceed its operating and capital costs. Under § 412.348(g)(6), the minimum payment level is 70 percent for all eligible hospitals.

During the transition period, new hospitals (as defined under § 412.300) were exempt from the capital PPS for their first 2 years of operation and were paid 85 percent of their reasonable costs during that period. Effective with the third year of operation through the remainder of the transition period, under § 412.324(b) we paid the hospital under the appropriate transition methodology. If the hold-harmless methodology were applicable, the hold-harmless payment for assets in use during the base period would extend for 8 years, even if the hold-harmless payments extend beyond the normal transition period. As discussed in section VI.A. of the preamble of this proposed rule, under § 412.304(c)(2), for cost reporting periods beginning on or after October 1, 2002, we pay a new hospital 85 percent of their reasonable costs during the first 2 years of operation unless it elects to receive payment based on 100 percent of the capital Federal rate. Effective with the third year of operation, we pay the hospital based on 100 percent of the capital Federal rate (that is, the same methodology used to pay all other hospitals subject to the capital PPS).

C. Capital Input Price Index

1. Background

Like the operating input price index, the capital input price index (CIPI) is a fixed-weight price index that measures the price changes associated with capital costs during a given year. The CIPI differs from the operating input price index in one important aspect—the CIPI reflects the vintage nature of capital, which is the acquisition and use of capital over time. Capital expenses in any given year are determined by the stock of capital in that year (that is, capital that remains on hand from all current and prior capital acquisitions). An index measuring capital price changes needs to reflect this vintage nature of capital. Therefore, the CIPI was developed to capture the vintage nature of capital by using a weighted-average of past capital purchase prices up to and including the current year.

We periodically update the base year for the operating and capital input prices to reflect the changing composition of inputs for operating and capital expenses. The CIPI was last rebased to FY 1997 in the August 1, 2002 final rule (67 FR 50044).

2. Forecast of the CIPI for Federal Fiscal Year 2005

Based on the latest forecast by Global Insight, Inc. (first quarter of 2004), we are forecasting the CIPI to increase 0.7 percent in FY 2005. This reflects a projected 1.2 percent increase in vintage-weighted depreciation prices (building and fixed equipment, and movable equipment) and a 3.0 percent increase in other capital expense prices in FY 2005, partially offset by a 2.5 percent decline in vintage-weighted

interest expenses in FY 2005. The weighted average of these three factors produces the 0.7 percent increase for the CIPI as a whole in FY 2005.

IV. Proposed Changes to Payment Rates for Excluded Hospitals and Hospital Units: Rate-of-Increase Percentages

[If you choose to comment on issues in this section, please include the caption ''Excluded Hospitals Rate of Increase'' at the beginning of your comment.]

As discussed in section VI. of the preamble of this proposed rule, in accordance with section 1886(b)(3)(H)(i) of the Act and effective for cost reporting periods beginning on or after October 1, 2002, payments to existing psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals excluded from the IPPS are no longer subject to limits on a hospital-specific target amount (expressed in terms of the inpatient operating cost per discharge) that are set for each hospital, based on the hospital's own historical cost experience trended forward by the applicable rate-of-increase percentages (update factors).

Effective for cost reporting periods beginning on or after October 1, 2002, rehabilitation hospitals and units are paid 100 percent of the IRF PPS Federal rate. Effective for cost reporting periods beginning on or after October 1, 2002, LTCHs also are no longer paid on a reasonable cost basis, but are paid under a LTCH DRG-based PPS. As part of the payment process for LTCHs, we established a 5-year transition period from reasonable cost-based reimbursement to a fully Federal PPS. However, a LTCH may elect to be paid based on 100 percent of the Federal prospective payment rate. We have proposed, but not finalized, an IPF PPS under which psychiatric hospitals and units would no longer be paid on a reasonable cost basis but would be paid on a prospective per diem basis. (68 FR 66920, November 28, 2003)

In accordance with existing §§ 413.40(c)(4)(ii) and (d)(1)(i) and (ii), where applicable, excluded psychiatric hospitals and units continue to be paid on a reasonable cost basis, payments are based on their Medicare inpatient operating costs, not to exceed the ceiling (as defined in § 413.40(a)(3)). In addition, LTCHs that are paid under a blend methodology will have the TEFRA portion subject to the ceiling as well.

Section 1886(b)(7) of the Act had established a payment limitation for new rehabilitation hospitals and units, psychiatric hospitals and units, and long-term care hospitals that first received payment as a hospital or unit excluded from the IPPS on or after October 1, 1997. However, effective for cost reporting periods beginning on or after October 1, 2002, this payment limitation is no longer applicable to new rehabilitation hospitals or units because they are paid 100 percent of the Federal prospective rate under the IRF PPS. Also, effective for cost reporting periods beginning on or after October 1, 2002, new LTCHs are paid based on 100 percent of the fully Federal prospective rate. In contrast, those ''new'' LTCHs that meet the definition of ''new'' under § 412.40(f)(2)(ii) and that have their first cost reporting periods beginning on or after October 1, 1997 and before October 1, 2002, may be paid under the LTCH PPS transition methodology. Since those hospitals by definition would have been considered new before October 1, 2002, they would have been subject to the updated payment limitation on new hospitals that was published in the FY 2003 IPPS final rule (67 FR 50103). A discussion of how the payment limitation was calculated can be found in the August 29, 1997 final rule with comment period (62 FR 46019); the May 12, 1998 final rule (63 FR 26344); the July 31, 1998 final rule (63 FR 41000); and the July 30, 1999 final rule (64 FR 41529).

The amount of payment for a ''new'' psychiatric hospital or unit would be determined as follows:

- Under existing § 413.40(f)(2)(ii), for the first 12-month cost reporting periods beginning on or after October 1, 1997, the amount of payment for a new hospital or unit that was not paid as an excluded hospital or unit before October 1, 1997, is the lower of: (1) The hospital's net inpatient operating costs per case; or (2) 110 percent of the national median of the target amounts for the same class of excluded hospitals and units, adjusted for differences in wage levels and updated to the first cost reporting period in which the hospital receives payment. The second 12-month cost reporting period is subject to the same target amount applied to the first cost reporting period.
- In the case of a hospital that received payments under § 413.40(f)(2)(ii) as a newly created hospital or unit, to determine the hospital's or unit's target amount for the hospital's or unit's third 12-month cost reporting period, the payment amount determined under § 413.40(f)(2)(ii)(A) for the preceding cost reporting period is updated to the third cost reporting period.

The amounts included in the following table reflect the proposed updated 110 percent of the national median target amounts of new excluded psychiatric hospitals and units for cost reporting periods beginning during FY 2005. These figures are updated with the most recent data available to reflect the projected market basket increase percentage of 3.3 percent. This projected percentage change in the market basket reflects the average change in the price of goods and services purchased by hospitals to furnish inpatient hospital services (as projected by CMS' Office of the Actuary based on its historical experience with the IPPS). For a new provider, the labor-related share of the target amount is multiplied by the appropriate geographic area wage index, without regard to IPPS reclassifications, and added to the nonlabor-related share in order to determine the per case limit on payment under the statutory payment methodology for new providers.

Class of excluded hospital or unit	Proposed FY 2005 labor-related share	Proposed FY 2005 nonlabor-related share.
Psychiatric	$7,534.70	$2,994.67

This payment limitation is no longer applicable to new LTCHs that meet the definition of § 412.23(e)(4) since they will be paid 100 percent of the Federal rate. (Section 412.23(e)(4) states that for purposes of payment under the LTCH PPS, a new LTCH is a provider of inpatient services that meets the qualifying criteria in paragraphs (e)(1) and (e)(2) of this section and, under present or previous ownership (or both), its first cost reporting period as a LTCH begins on or after October 1, 2002). Under the LTCH PPS, new LTCHs are based on 100 percent of the fully Federal prospective rate (they may not participate in the 5-year transition from cost-based reimbursement to

prospective payment). In contrast, those ''new'' LTCHs that meet the definition of ''new'' under § 413.40(f)(2)(ii) and that have their first cost reporting periods beginning on or after October 1, 1997, and before October 1, 2002, may be paid under the LTCH PPS transition methodology. Because those hospitals by definition would have been considered new before October 1, 2002, they would have been subject to the updated payment limitation on new hospitals that was published in the FY 2003 IPPS final rule (67 FR 50103). Under existing regulations at § 413.40(f)(2)(ii), the ''new'' hospital would be subject to the same cap in its second cost reporting period; this cap would not be updated for the new hospital's second cost reporting year. Thus, since the same cap is to be used for the ''new'' LTCH's first two cost reporting periods, it is no longer necessary to publish an updated cap.

V. Payment for Blood Clotting Factor Administered to Hemophilia Inpatients

[If you choose to comment on issues in this section, please include the caption ''Payment for Blood Clotting Factor'' at the beginning of your comment.]

In December 2002, the Department implemented a policy that established the Single Drug Pricer (SDP) to correct identified discrepancies, further the legislative goal of establishing a uniform payment allowance as a reflection of the average wholesale price (AWP), and otherwise apply the existing stature and regulation more accurately and efficiently (CMS Program Memorandum AB–02–174, December 3, 2002, which can be accessed at: *http://www.cms.hhs.gov/manuals*). Under the SDP, CMS will establish prices centrally, thereby resulting in greater consistency in drug pricing nationally. The SDP instruction applies to blood clotting factors furnished to hospital inpatients. The payment allowance for the single national drug price for each Medicare covered drug is based on 95 percent of the AWP, except for drugs billed to durable medical equipment regional carriers (DMERCs) and hospital outpatient drugs billed to fiscal intermediaries. We are publishing this notice here because we previously have addressed the add-on payment for the costs of administering blood clotting factor in the IPPS annual rule (see the August 1, 2000 IPPS final rule (65 FR 47116).

On a quarterly basis, CMS will furnish three SDP files to all fiscal intermediaries. Each fiscal intermediary must accept the SDP files and process claims for any drug identified on the files on the basis of the price shown on the applicable file. Previously, the fiscal intermediary performed annual update calculations based on the most recent AWP data available to the carrier. The fiscal intermediary should use the SDP to price the blood clotting factors.

VI. Tables

This section contains the tables referred to throughout the preamble to this proposed rule and in this Addendum. Tables 1A, 1B, 1C, 1D, 2, 3A, 3B, 4A, 4B, 4C, 4F, 4G, 4H, 4J, 5, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H, 7A, 7B, 8A, 8B, 9A, 9B, 10, and 11 are presented below. The tables presented below are as follows:

Table 1A--National Adjusted Operating Standardized Amounts, Labor/Nonlabor (71.1 Percent Labor Share/28.9 Percent Nonlabor Share if Wage Index Is Greater than 1)

Table 1B-- National Adjusted Operating Standardized Amounts, Labor/Nonlabor (62 Percent Labor Share/38 Percent Nonlabor Share If Wage Index Is Less Than or Equal To 1)

Table 1C--Adjusted Operating Standardized Amounts for Puerto Rico, Labor/Nonlabor

Table 1D--Capital Standard Federal Payment Rate

Table 2--Hospital Case-Mix Indexes for Discharges Occurring in Federal Fiscal Year 2003; Hospital Average Hourly Wage for Federal Fiscal Years 2003 (1999 Wage Data), 2004 (2000 Wage Data), and 2005 (2001 Wage Data) Wage Indexes and 3-Year Average of Hospital Average Hourly Wages

Table 3A--3-Year Average Hourly Wage for Urban Areas

Table 3B--3-Year Average Hourly Wage for Rural Areas

Table 4A--Wage Index and Capital Geographic Adjustment Factor (GAF) for Urban Areas

Table 4B--Wage Index and Capital Geographic Adjustment Factor (GAF) for Rural Areas

Table 4C--Wage Index and Capital Geographic Adjustment Factor (GAF) for Hospitals That Are Reclassified

Table 4F--Puerto Rico Wage Index and Capital Geographic Adjustment Factor (GAF)

Table 4G--Pre-Reclassified Wage Index for Urban Areas

Table 4H--Pre-Reclassified Wage Index for Rural Areas

Table 4J--Wage Index Adjustment for Commuting Hospital Employees (Out-Migration) in Qualifying Counties--FY 2005

Table 5--List of Diagnosis Related Groups (DRGs), Relative Weighting Factors, Geometric and Arithmetic Mean Length of Stay

Table 6A--New Diagnosis Codes

Table 6B--New Procedure Codes

Table 6C--Invalid Diagnosis Codes

Table 6D--Invalid Procedure Codes

Table 6E--Revised Diagnosis Code Titles

Table 6F--Revised Procedure Code Titles

Table 6G--Additions to the CC Exclusions List

Table 6H--Deletions from the CC Exclusions List

Table 7A--Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 2003 MedPAR Update December 2003 GROUPER V21.0

Table 7B--Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 2003 MedPAR Update December 2003 GROUPER V22.0

Table 8A--Statewide Average Operating Cost-to-Charge Ratios--March 2004

Table 8B--Statewide Average Capital Cost-to-Charge Ratios--March 2004

Table 9A--Hospital Reclassifications and Redesignations by Individual Hospital--FY 2005

Table 9B--Hospital Reclassifications and Redesignations by Individual Hospital Under Section 508 of Pub. L. 108-173--FY 2004

Table 10--Geometric Mean Plus the Lesser of .75 of the National Adjusted Operating Standardized Payment Amount (Increased to Reflect the Difference Between Costs and Charges) or .75 of One Standard Deviation of Mean Charges by Diagnosis-Related Groups (DRGs)--March 2004

Table 11--Proposed FY 2005 LTC-DRGs, Relative Weights, Geometric Average Length of Stay, and 5/6ths of the Geometric Average Length of Stay

TABLE 1A.--NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR

(71.1 Percent Labor Share/28.9 Percent Nonlabor Share If Wage Index Greater Than 1)

Full Update (3.3 Percent)		Reduced Update (2.9 Percent)	
Labor-related	**Nonlabor-related**	**Labor-related**	**Nonlabor-related**
$3,243.10	$1,318.22	$3,230.55	$1,313.12

TABLE 1B.--NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR

(62 Percent Labor Share/38 Percent Nonlabor Share If Wage Index Less Than or Equal to 1)

Full Update (3.3 Percent)		Reduced Update (2.9 Percent)	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$2,828.02	$1,733.30	$2,817.08	$1,726.59

Table 1C.--ADJUSTED OPERATING STANDARDIZED AMOUNTS FOR PUERTO RICO, LABOR/NONLABOR

	Rates if Wage Index Greater Than 1		Rates if Wage Index Less Than or Equal to 1	
	Labor	Nonlabor	Labor	Nonlabor
National	$3,243.10	$1,318.22	$2,828.02	$1,733.30
Puerto Rico	1,559.07	627.57	1,355.72	830.92

TABLE 1D.--CAPITAL STANDARD FEDERAL PAYMENT RATE

	Rate
National	$416.59
Puerto Rico	$200.52

Table 2.--HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES

Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
010001	1.4637	17.9841	19.4061	20.6491	19.3568
010004	***	20.1613	22.2674	22.7585	21.6609
010005	1.1675	19.9733	19.6063	20.4656	20.0195
010006	1.3939	18.3931	19.0976	21.0729	19.5183
010007	1.1120	16.0781	17.5462	16.8668	16.8314
010008	1.0019	19.0182	19.6573	23.7870	20.8787
010009	1.0257	19.7273	20.4309	21.6421	20.5897
010010	1.0196	17.7348	19.2644	22.2640	19.7233
010011	1.6227	24.8922	25.8231	24.7868	25.1453
010012	1.2100	20.3375	20.0896	21.7702	20.7452
010015	0.9478	19.8205	18.8890	20.4628	19.7642
010016	1.2929	20.3175	21.7918	23.0466	21.7904
010018	1.3120	19.5519	19.2071	20.5734	19.7665
010019	1.2196	17.6414	18.9177	20.0986	18.8712
010021	1.1852	25.3335	17.7596	20.7947	20.7098
010022	0.9282	22.1250	22.2267	25.8599	23.4393
010023	1.7460	18.4567	20.4901	23.7739	20.7059
010024	1.6397	17.3746	18.5942	19.9864	18.6204
010025	1.2132	17.4702	19.3649	20.2596	19.0036
010027	0.7657	16.5157	14.0975	18.5904	16.4412
010029	1.5332	19.3393	20.9868	21.6392	20.7095
010031	***	19.2612	21.0176	20.9463	20.4044
010032	0.8719	16.3968	16.4713	18.4657	17.1465
010033	2.0684	21.9828	24.5088	25.5277	23.9953
010034	0.9861	14.9379	14.9333	16.8073	15.5467
010035	1.1993	20.7808	21.6182	23.1319	21.8768
010036	1.0900	18.7157	19.2501	20.5001	19.4694
010038	1.1722	19.6887	18.6578	20.3646	19.6017
010039	1.6402	21.3550	23.0339	23.4156	22.6372
010040	1.4862	20.4486	20.7779	21.6657	20.9781
010043	0.9615	17.3567	19.9012	19.5358	18.9628
010044	1.0235	23.4576	25.8560	23.0008	24.0434
010045	1.1021	18.7569	22.7713	18.8154	19.9260
010046	1.6180	18.8741	19.6754	20.8465	19.8858

[1] Based on salaries adjusted for occupational mix, according to the calculation in section III.F. of the preamble of this proposed rule.
*Denotes wage data not available for the provider for that year.
**Based on the sum of the salaries and hours computed for Federal FYs 2003, 2004, and 2005.
***Denotes MedPAR data not available for the provider for FY 2003.

Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
010047	0.9111	13.4130	16.1695	19.5927	16.1762
010049	1.1146	16.3349	16.2973	17.7737	16.8052
010050	1.0485	20.3028	20.7398	21.5311	20.8821
010051	0.8835	12.3280	14.3006	14.7000	13.7705
010052	0.8885	19.8289	11.9019	21.2748	16.4680
010053	1.0735	15.4156	17.3238	17.4020	16.6975
010054	1.0487	20.9656	20.6382	23.2022	21.5932
010055	1.4922	19.5667	18.9664	19.1769	19.2269
010056	1.4728	20.5645	21.1104	22.7087	21.5157
010058	0.8802	16.1265	17.7800	20.3710	18.0149
010059	1.0553	19.1270	20.5534	23.6575	21.1101
010061	1.0170	18.5320	17.0447	20.7779	18.7145
010062	1.0887	16.9721	17.1786	18.1202	17.4289
010064	1.7182	20.5650	22.2280	22.5727	21.7158
010065	1.3826	17.0557	17.2698	19.9799	18.1332
010066	0.8084	14.8904	14.8696	17.0110	15.5840
010068	1.2158	23.4322	18.3308	17.5471	20.1766
010069	1.0382	15.4497	17.0957	19.6377	17.4498
010072	1.1042	16.5652	18.8807	21.5354	18.9480
010073	0.9208	13.5594	14.9826	16.4093	14.9392
010078	1.2364	18.5127	20.1447	21.0576	19.8871
010079	1.1551	17.1612	20.7401	20.4172	19.3304
010083	1.2137	18.4282	19.8524	20.1972	19.4438
010084	1.5505	19.8773	21.6522	22.5131	21.4068
010085	1.2551	21.5860	22.5282	23.6946	22.6186
010086	1.0347	16.8886	18.0122	19.4214	18.0598
010087	1.8021	18.7915	19.7620	21.6082	20.0002
010089	1.2093	19.5241	19.5783	22.2443	20.4301
010090	1.6809	19.5635	20.0287	21.4326	20.3545
010091	0.9693	17.1775	17.4672	19.4122	18.0392
010092	1.4405	18.5478	19.9351	22.0602	20.1795
010095	0.8398	12.3064	12.5243	13.4245	12.7641
010097	0.7697	14.2675	15.1593	17.1350	15.4735
010098	0.9775	15.5763	15.1629	19.7955	16.5605
010099	1.0669	15.9232	16.3307	18.2047	16.8448
010100	1.5258	18.3755	19.8146	19.9973	19.4260
010101	1.1217	18.9525	19.0718	21.0036	19.6847
010102	0.9253	15.7778	16.4637	19.8843	17.3425
010103	1.8015	22.0802	22.5709	24.2124	22.9343

[1] Based on salaries adjusted for occupational mix, according to the calculation in section III.F. of the preamble of this proposed rule.

*Denotes wage data not available for the provider for that year.

**Based on the sum of the salaries and hours computed for Federal FYs 2003, 2004, and 2005.

***Denotes MedPAR data not available for the provider for FY 2003.