the hospital's cost reporting period, divided by the number of days in the cost reporting period. The regulations specify certain types of beds to be excluded from this count (for example, beds or bassinets in the healthy newborn nursery, custodial care beds, and beds in excluded distinct part hospital units).

Further instructions for counting beds are detailed in section 2405.3, Part I, of the Medicare Provider Reimbursement Manual (PRM). That section states that a bed must be permanently maintained for lodging inpatients and it must be available for use and housed in patient rooms or wards. Thus, beds in a completely or partially closed wing of the facility are considered available only if the hospital can put the beds into use when they are needed.

Currently, if a bed can be staffed for inpatient care either by nurses on staff or from a nurse registry within 24 to 48 hours, the unoccupied bed is determined available.[5] In most cases, it is a straightforward matter to determine whether unoccupied beds can be staffed within this timeframe because they are located in a unit that is otherwise staffed and occupied (an unoccupied bed is available for patient care but it is not occupied by a patient on a particular day). The determination is not as simple in situations where a room in an otherwise occupied unit has been altered for other purposes, such as for a staff lounge or for storage.

Section 2405.3 of the PRM states that beds in unoccupied rooms or wards are to be excluded from the bed count if the associated costs are excluded from depreciable plant assets because the area is not available for patient use. However, issues continue to arise with regard to how to treat entire units or even entire floors that are unoccupied over a period of time. For example, in one recent Provider Reimbursement Review Board (PRRB) decision, the hospital acknowledged that an entire floor was temporarily unoccupied for approximately 2 years. Rooms on the floor were used for office space, storage and outpatient services. The PRRB ruled that current rules allowed these beds to be counted. Specifically, the PRRB found the beds could reasonably be made ready for inpatient use within 24 to 48 hours, the rooms were counted on the hospital's cost report as depreciable plant assets available for patient care, and the hospital could adequately provide patient care in the beds using staff nurses or nurses from a nurse registry. Upon review, the Administrator also ultimately upheld this decision based on existing policies and instructions.

We do not believe that an accurate bed count should include beds that are essentially hypothetical in nature; for example, when the beds are on a floor that is not used for inpatient care throughout the entire cost reporting period (and, indeed, may have been used for other purposes). Followed to the extreme, a hospital could count every bed in its facility, even if it had no intention of ever using a bed for inpatient care, as long as it would be theoretically possible to place an inpatient in the bed. We do not believe such a result would accurately reflect a hospital's inpatient bed capacity. Even though some teaching hospitals have an incentive to minimize the bed count for payment purposes, some DSH hospitals have an incentive to maximize the bed count for the same reason. Our current policy is intended to reflect a hospital's bed count as accurately as possible, achieving a balance between capturing short-term shifts in occupancy and long-term changes in capacity. Therefore, we believe further clarification and refinement of our policies relating to counting available beds is necessary.

In the FY 2003 IPPS proposed rule published on May 9, 2002 (67 FR 31462), we proposed that, if a hospital's reported bed count results in an occupancy rate (average daily census of patients divided by the number of beds) below 35 percent, the applicable bed count, for purposes of establishing the number of available beds for that hospital would exclude beds that would result in an average annual occupancy rate below 35 percent. However, at the time the FY 2003 IPPS final rule was published on August 1, 2002 (67 FR 50060), we decided not to proceed with the proposed changes as final and to reconsider the issue as part of a future comprehensive analysis of our bed and patient day counting policies.

In this proposed rule, rather than establish a minimum standard occupancy rate, we are proposing to determine whether beds in a unit are available based upon whether the unit was used to provide patient care of a level generally payable under the IPPS (''IPPS level of care'') *at any time* during the 3 preceding months. If any of the beds in the unit were used to provide an IPPS level of care at any time during the preceding 3 months, all of the beds in the unit are counted for purposes of determining available bed days during the current month. If no patient care of a type generally payable under the IPPS was provided in that unit during the 3 preceding months, the beds in the unit are to be excluded from the determination of available bed days during the current month (proposed §§ 412.105(b)(2) and 412.106(a)(1)(ii)(C)).

For example, our policy as to how to count beds during minor renovations of units, wards, or individual rooms has been that unless the space costs are treated as nonallowable, the beds would be counted. Under the policy we are proposing, beds in an otherwise unoccupied unit that are occupied (for purposes of providing IPPS-level care) at any time during the 3 preceding months would be counted as available for the current month. This would apply even if the rooms were undergoing renovation during a portion of that 3-month period.

We believe a unit or ward can be defined as a group of rooms staffed by nurses assigned to a single nursing station. In most cases, the patients treated within a single unit or ward will receive a similar level of care (that is, acute, intensive, rehabilitation, psychiatric, or skilled nursing). However, we encourage comments on the most useful definition of a unit or ward.

We believe this proposed policy would provide a clear standard for both hospitals and fiscal intermediaries to use to determine whether otherwise unoccupied beds should be counted. We note that if the required time period for excluding the unoccupied beds were to be set too low, hospitals could potentially manipulate their available bed count by not admitting any patients to a unit during low occupancy periods, thereby distorting the measure of hospital size. We believe 3 months, one quarter of a hospital's fiscal year, represents a reasonable standard for determining that a unit is not being used to provide patient care and may be excluded from the hospital's available bed count.

It is also necessary to consider our policy with respect to individual beds within rooms located in an otherwise occupied unit when those beds are used for alternative purposes. For example, section 2405.3 of the PRM states that beds used for the following are excluded from the definition (of a bed): Postanesthesia or postoperative recovery rooms, outpatient areas, emergency rooms, ancillary departments nurses' and other staff residences, and other such areas as are regularly maintained and utilized for only a portion of the stay of patients or for purposes other than inpatient lodging. In some situations, beds used for these excluded

[5] This policy was first articulated in correspondence to the Blue Cross and Blue Shield Association (BCBSA) on November 2, 1988, and published in BCBSA's Administrative Bulletin #1841, 88.01, on November 18, 1988.

purposes may be intermingled with acute care inpatient beds.

Beds being used to provide specific categories of nonacute services, such as outpatient services in an observation bed or skilled nursing services in a swing-bed, are excluded from the count. As discussed later, this flows from our policy that the bed days are treated consistently with the assignment of the costs on the Medicare cost report of the services provided in the bed.

In the case of individual rooms in an otherwise occupied unit that are altered to be used for other uses besides inpatient care, we are proposing the bed(s) should be counted if a patient could be admitted to the room within 24 hours (proposed § 412.105(b)(3)). This would apply even if the bed(s) were not currently located in the room, as long as a bed could be physically placed in the room and made available within 24 hours. We are proposing that it would no longer be necessary for the hospital to determine whether a bed could be staffed within 24 to 48 hours. For example, in the case of a room that has been altered for use as a staff lounge, if the room could be made available to house a patient merely by replacing the lounge furniture with a patient bed, the bed should be counted as available.

Under this proposal, other than when an inpatient room is used to provide observation services, labor/delivery room services, or skilled nursing services in a swing-bed (all discussed later in this proposed rule), the alternative purpose of the room is only relevant if it impacts whether the room could be made available for patient occupancy within 24 hours. If the hospital was fully occupied (no other room was available), and the room still was not put into service when needed, that would provide evidence that the room could not be made available and beds in the room should be excluded from the bed count.

Therefore, we are proposing to amend § 412.105(b) to indicate that the bed days in a unit that is unoccupied by patients receiving IPPS-level care for the 3 preceding months are to be excluded from the available bed day count for the current month. We are further proposing the beds in a unit that was occupied for IPPS-level care during the 3 preceding months should be counted unless they could not be made available for patient occupancy within 24 hours, or they are used to provide outpatient observation services or swing-bed skilled nursing care.

3. Nonacute Care Beds and Days

As noted above, these policies are consistent with the reporting of the days, costs, and beds that are used to calculate the costs of hospital inpatient care in individual cost centers on the Medicare cost report. Furthermore, since the IME and DSH adjustments are part of the IPPS, we read the statute to apply only to inpatient beds and days.

Under the existing provisions of § 412.105(b), the regulations specifically exclude beds or bassinets in the healthy newborn nursery, custodial care beds, or beds in excluded distinct part hospital units as types of beds excluded from the count of available beds.

Existing regulations at § 412.106(a)(1)(ii) state that the number of patient days used in the DSH percentage calculation includes only those days attributable to areas of the hospital that are subject to the IPPS and excludes all others. This regulation was added after being proposed in the March 22, 1988 **Federal Register** (53 FR 9339), and made final in the September 30, 1988 **Federal Register** (53 FR 38479). At that time, we indicated that, ''based on a reading of the language in section 1886(d)(5)(F) of the Act, which implements the disproportionate share provision, we are in fact required to consider only those inpatient days to which the prospective payment system applies in determining a prospective payment hospital's eligibility for a disproportionate share adjustment.'' Using this reasoning, we stated that the DSH patient percentage calculation should only include patient days associated with the types of services paid under the IPPS.

As noted previously, a recent decision in the Ninth Circuit Court of Appeals (*Alhambra* v. *Thompson*) ruled that days attributable to groups of beds that are not separately certified as distinct part beds (that is, nonacute care beds in which care provided is at a level below the level of routine inpatient acute care), but are adjacent to or in an acute care ''area,'' are included in the ''areas of the hospital that are subject to the prospective payment system'' and should be counted in calculating the Medicare DSH patient percentage.

In light of the Ninth Circuit decision that our rules were not sufficiently clear to permit exclusion of bed days based on the area where the care is provided, we are proposing to revise our regulations to be more specific. Therefore, in this proposed rule, we are proposing to clarify that beds and patient days are excluded from the calculations at § 412.105(b) and § 412.106(a)(1)(ii) if the nature of the care provided in the unit or ward is inconsistent with what is typically furnished to acute care patients, regardless of whether these units or wards are separately certified or are located in the same general area of the hospital as a unit or ward used to provide an acute level of care. Although the intensity of care may vary within a particular unit, such that some patients may be acute patients while others are nonacute, we understand that a patient-by-patient review of whether the care received would be paid under the IPPS would be unduly burdensome. Therefore, we believe it is more practical to permit the application of this principle based upon the location at which the services were furnished.

In particular, we are proposing to revise our regulations to clarify that the beds and patient days attributable to a nonacute care unit or ward should not be included in the calculations at § 412.105(b) and § 412.106(a)(1)(ii), even if the unit is not separately certified by Medicare as a distinct-part unit and even if the unit or ward is within the same general location of the hospital as areas that are subject to the IPPS.

Exceptions to this policy are outpatient observation and swing-bed days, which are excluded from the count of available bed days even if the care is provided in an acute care unit. Our policies pertaining to these beds are discussed further below. Another exception is healthy newborn nursery days. The costs, days, and beds of a healthy newborn nursery are excluded from inpatient calculations for Medicare purposes. Meanwhile, for the purpose of computing the Medicaid patient share computation of the DSH patient percentages, these days are included both as Medicaid patient days and as total patient days. Nursery costs are not directly included in calculating Medicare hospital inpatient care costs because Medicare does not generally cover services for infants. However, Medicaid does offer extensive coverage to infants, and nursery costs would be directly included in calculating Medicaid hospital inpatient care costs. Therefore, these costs, days, and beds are excluded for Medicare purposes, but included for determining the Medicaid DSH percentage. (This policy was previously communicated through a memorandum to CMS Regional Offices on February 27, 1997.)

Generally, as discussed previously, if the nature of the care provided in the unit or ward is consistent with what is typically furnished to acute care patients, and, therefore, would be characteristic of services paid under the IPPS, the patient days, beds, and costs of that unit or ward would be classified as inpatient acute care (except for observation bed days and swing bed days, as discussed later in this

preamble). Conversely, if the intensity and type of care provided in the unit or ward are not typical of a service that would be paid under the IPPS (for example, nonacute care), we are proposing that the beds and patient days attributable to a nonacute care unit or ward should not be included in the calculations of beds and patient days at § 412.105(b) and § 412.106(a)(1)(ii).

This proposed policy is not intended to focus on the level or type of care provided to individual patients in a unit, but rather on the level and type of care provided in the unit as a whole. For example, the bed days for a patient participating in an experimental procedure that is not covered under the IPPS should be counted as long as the patient is treated in a unit of the hospital that generally provides acute inpatient care normally payable under the IPPS. The expectation is that a patient located in an acute care unit or ward of the hospital is receiving a level of care that is consistent with what would be payable under the IPPS.

There are instances where services that are provided in units excluded from the IPPS (such as rehabilitation and psychiatric distinct-part units) are consistent with the level of care that would qualify for payment under the IPPS. However, §§ 412.105(b) and 412.106(a)(1)(ii) specifically exclude the beds and patient days associated with these excluded units. That exclusion is because the costs of care provided in these units are paid outside the IPPS, even though some of the care provided is of a type that would be payable under the IPPS if the care was provided in an IPPS unit.

We are proposing to revise § 412.105(b) to clarify that beds in units or wards established or used to provide a level of care that is not consistent with what would be payable under the IPPS cannot be counted (proposed paragraph (b)(1)). We also are proposing to revise the DSH regulations at § 412.106(a)(1)(ii) to clarify that the number of patient days includes only those attributable to patients that receive care in units or wards that furnish a level of care that would generally be payable under the IPPS (proposed paragraph (a)(1)(ii)(C)).

We note these proposed revisions are clarifications of our regulations to reflect our longstanding interpretation of the statutory intent, especially relating to the calculation of the Medicare DSH patient percentage.

4. Observation Beds and Swing-Beds

Observation services are those services furnished by a hospital on the hospital's premises that include use of a bed and periodic monitoring by a hospital's nursing or other staff in order to evaluate an outpatient's condition or to determine the need for a possible admission to the hospital as an inpatient. When a hospital places a patient under observation but has not formally admitted him or her as an inpatient, the patient initially is treated as an outpatient. Consequently, the observation bed days are not recognized under the IPPS as part of the inpatient operating costs of the hospital.

Observation services may be provided in a distinct observation bed area, but they may also be provided in a routine inpatient care area. In either case, our policy is the bed days attributable to beds used for observation services are excluded from the counts of available bed days and patient days at §§ 412.105(b) and 412.106(a)(1)(ii). This policy was clarified in a memorandum that was sent to all CMS Regional Offices (for distribution to fiscal intermediaries) dated February 27, 1997, which stated that if a hospital provides observation services in beds that are generally used to provide hospital inpatient services, the equivalent days that those beds are used for observation services should be excluded from the count of available bed day count (even if the patient is ultimately admitted as an acute inpatient).

A swing-bed is a bed otherwise available for use to provide acute inpatient care that is also occasionally used to provide SNF care. The criteria to qualify as a swing-bed hospital are located under § 482.66, and for a swing-bed CAH under § 485.645. Under § 413.114(a)(1), payment for posthospital SNF care furnished in swing-beds is in accordance with the provisions of the prospective payment system for SNF care (effective for services furnished in cost reporting periods beginning on and after July 1, 2002). Similar to observation beds and patient days, swing-beds and patient days are excluded from the counts of available bed days and patient days at §§ 412.105(b) and 412.106(a)(1)(ii) when the swing-bed is used to furnish SNF care.[6]

Observation beds and swing-beds are both special, frequently temporary, alternative uses of acute inpatient care beds. That is, only the days an acute inpatient care unit bed is used to provide outpatient observation services are to be deducted from the available bed count under § 412.105(b). Otherwise, the bed is considered available for acute care services (as long as it otherwise meets the criteria to be considered available). This same policy applies for swing-beds. The policies to exclude observation bed days and swing-bed days stem from the fact that these bed days are not payable under the IPPS (unless the patient is ultimately admitted, in the case of observation bed days).

Some hospitals have contested our policy excluding swing-beds and patient days and observation beds and patient days under existing §§ 412.105(b) and 412.106(a)(1)(ii). For example, in *Clark Regional Medical Center* v. *United States Department of Health & Human Services,* 314 F.3d 241 (6th Cir. 2002), the court upheld the district court's ruling that all bed types not specifically excluded from the definition of available bed days in the regulations must be included in the count of available bed days. The hospitals involved in this decision wanted to include observation and swing-bed days in their bed count calculation in order to qualify for higher DSH payments as 100 bed hospitals. The Court found that ''the listing of beds to be excluded from the count restricts the class of excluded beds only to those specifically listed.'' Because observation beds and swing-beds are not currently specifically mentioned in § 412.105(b) as being excluded from the bed count, the Court ruled that these beds must be included in the count.

The list of the types of beds excluded from the count under existing § 412.105(b) was never intended to be an exhaustive list of all of the types of beds to be excluded from the bed count under this provision. In fact, over the years, specific bed types have been added to the list as clarifications of the types of beds to be excluded, not as new exclusions (see the September 1, 1994 **Federal Register** (59 FR 45373) and September 1, 1995 **Federal Register** (60 FR 45810), where we clarified exclusions under our policy that were not previously separately identified in the regulation text).

Courts also have recently found that observation and swing-bed days are included under the 'plain meaning' of § 412.106(a)(1)(ii), which reads: ''The number of patient days includes only those days attributable to areas of the hospital that are subject to the prospective payment system and excludes all others.'' However, the preamble language when this provision was promulgated clarified its meaning (53 FR 38480):

• ''Although previously the Medicare regulations did not specifically define the inpatient days for use in the computation of a hospital's disproportionate share patient percentage, we believe that, based on a

[6] *Ibid.*

reading of the language in section 1886(d)(5)(F) of the Act, which implements the disproportionate share provision, we are in fact required to consider only those inpatient days to which the prospective payment system applies in determining a prospective payment hospital's eligibility for a disproportionate share adjustment.''

Our policy excluding outpatient observation and swing-bed days is consistent with this regulatory interpretation of days to be counted under § 412.106(a)(1)(ii). That is, the services provided in these beds are not payable under the IPPS (unless the patient is admitted, in the case of observation bed days).

As outlined previously, our consistent and longstanding policy, which has been reviewed and upheld previously by several courts, including the United States District Court for the District of Columbia, is based on the principle of counting beds in the same manner as the patient days and costs are treated. Our policy to exclude observation and swing-bed days under the regulations at § 412.105(b) and § 412.106(a)(1)(ii) stems from this policy.

However, we are proposing to amend our policy with respect to observation bed days of patients who ultimately are admitted. As noted previously, our current policy is that these bed days are excluded from the available bed day and the patient day counts. This policy was communicated in a memorandum to all CMS Regional Offices on February 27, 1997. Specifically, we are proposing that, if a patient is admitted as an acute inpatient subsequent to receiving outpatient observation services, because the charges of the observation ancillary services the patient receives are currently treated as inpatient charges on the cost report, in order to be consistent with our policy to treat the costs and patient days consistently, we will begin to include the patient bed days associated with the observation services in the inpatient bed day count.

In order to avoid any potential future misunderstandings about our policies regarding the exclusion of observation and swing-bed days under the regulations at § 412.105(b) and § 412.106(a)(1)(ii), we are proposing to revise our regulations to specify our policy that observation and swing-bed bed days are to be excluded from the counts of both available beds and patient days, unless a patient treated in an observation bed is ultimately admitted, in which case the beds and days would be included in those counts.

5. Labor, Delivery, Recovery, and Postpartum Beds and Days

Prior to December 1991, Medicare's policy on counting days for maternity patients required an inpatient day to be counted for an admitted maternity patient in the labor/delivery room at the census taking hour. This is consistent with Medicare policy for counting days for admitted patients in any other ancillary department at the census-taking hour. However, based on decisions adverse to the government regarding this policy in a number of Federal courts of appeal, including the United States Court of Appeals for the District of Columbia Circuit, the policy regarding the counting of inpatient days for maternity patients was revised.

Therefore, our current policy regarding the treatment of labor and delivery bed days was initially described in Section 2205.2 of the PRM. Section 2205.2. of the PRM states that a maternity inpatient in the labor/delivery room at midnight is not included in the census of inpatient routine care if the patient has not occupied an inpatient routine bed at some time since admission. For example, if a Medicaid patient is in the labor room at the census and has not yet occupied a routine bed, the bed day is not counted as a routine bed day of care in Medicaid or total days and, therefore, is not included in the counts under existing §§ 412.105(b) and 412.106(a)(1)(ii). If the patient is in the labor room at the census but had first occupied a routine bed, a routine bed day is counted, in Medicaid and total days, for DSH purposes and for apportioning the cost of routine care on the cost report (consistent with our longstanding policy to treat days, costs, and beds similarly).

Increasingly, hospitals are redesigning their maternity areas from separate labor and delivery rooms apart from the postpartum rooms, to single labor, delivery room, and postpartum (LDRP) rooms. In order to appropriately track the days and costs of LDRP rooms, it is necessary to apportion them between the labor and delivery ancillary cost center and the routine adults and pediatrics cost center. This is done by determining the proportion of the patient's stay in the LDRP room that the patient was receiving ancillary services (labor and delivery) as opposed to routine adult and pediatric services (recovery and postpartum).

An example of this would be if 25 percent of the patient's time in the LDRP room was for labor/delivery services and 75 percent for routine care, over the course of a 4-day stay in the LDRP room. In that case, 75 percent of the time the patient spent in the LDRP room is applied to the total bed days and costs (resulting in 3 routine adults and pediatrics bed days for this patient, 75 percent of 4 total days). The resulting days (or portion of days) are included in total days and in Medicaid days for all purposes. For purposes of determining hospital bed count, the time when the beds are unoccupied should be counted as available bed days using an average percentage (for example, 75 percent adults and pediatrics and 25 percent ancillary) based on all patients. In other words, 75 percent of the days the bed is unoccupied would be counted in the available bed count.

We realize that it may be burdensome for a hospital to determine for each patient in this type of room the amount of time spent in labor/delivery and the amount of time spent receiving routine care. Alternatively, the hospital could calculate an average percentage of time patients receive ancillary services, as opposed to routine inpatient care during a typical month, to apply the rest of the year.

6. Days Associated with Demonstration Projects Under Section 1115 of the Act

Some States extend medical benefits to a given population that could not have been made eligible for Medicaid under a State plan amendment under section 1902(r)(2) or section 1931(b) of the Act, under a demonstration under a section 1115(a)(2) demonstration project (also referred to as a section 1115 waiver). These populations are specific, finite populations identifiable in the award letters and special terms and conditions for the demonstrations.

On January 20, 2000, we issued an interim final rule with comment period (65 FR 3136), followed by a final rule issued on August 1, 2000 (65 FR 47086 through 47087), to allow hospitals to include the patient days of all populations that receive benefits under a section 1115 demonstration project in calculating the Medicare DSH adjustment. Previously, hospitals were to include only those days for populations under the section 1115 demonstration project who were, or could have been made, eligible under a State plan. Patient days of those expansion waiver groups who could not be made eligible for medical assistance under the State plan were not to be included for determining Medicaid patient days in calculating the Medicare DSH patient percentage. Under the January 20, 2000 interim final rule with comment period (65 FR 3137), hospitals could include in the numerator of the Medicaid fraction those patient days for individuals who receive benefits under

a section 1115 expansion waiver demonstration project (effective with discharges occurring on or after January 20, 2000).

In the January 20, 2000 interim final rule with comment period, we explained that including the section 1115 expansion populations ''in the Medicare DSH calculation is fully consistent with the Congressional goals of the Medicare DSH adjustment to recognize the higher costs to hospitals of treating low-income individuals covered under Medicaid.''

Since that revision, we have become aware that there are certain section 1115 demonstration projects that serve expansion populations with benefit packages so limited that the benefits are not similar to the medical assistance available under a Medicaid State plan. These section 1115 demonstration projects extend coverage only for specific services and do not include inpatient care in the hospital. Because of the limited nature of the coverage offered, the population involved may have a significantly higher income than traditional Medicaid beneficiaries.

In allowing hospitals to include patient days related to section 1115 expansion waiver populations, our intention was to include patient days of section 1115 expansion waiver populations who receive benefits under the demonstration project that are similar to those available to traditional Medicaid beneficiaries, including inpatient benefits. Because of the differences between expansion populations in these limited benefit demonstrations and traditional Medicaid beneficiaries, we are proposing that the Medicare DSH calculation should exclude from treatment as Medicaid patient days those patient days attributable to limited benefit section 1115 expansion waiver populations (proposed § 412.106(b)(4)(i)).

For example, a State may extend a family planning benefit to an individual for 2 years after she has received the 60-day postpartum benefit under Medicaid, or a State may choose to provide a family planning benefit to all individuals below a certain income level, regardless of having previously received the Medicaid postpartum benefit. This is a limited, temporary benefit that is generally administered in a clinic setting (see section 1905(a)(4)(C) of the Act). Also, a number of States are developing demonstrations that are limited to providing beneficiaries an outpatient prescription drug benefit. Generally, these limited benefits under a demonstration project do not include inpatient benefits. If a hospital were to include the days attributable to patients receiving benefits under such a limited benefit, the hospital would be able to receive higher DSH payments, perhaps substantially, for patients who may otherwise be insured for inpatient care. For example, these limited demonstrations provide benefits that may be needed to supplement private insurance coverage for individuals who do not have incomes low enough to qualify for Medicaid under the State plan. We do not believe such patients should be counted in the DSH patient percentage as eligible for title XIX.

As we have noted previously, at the time the Congress enacted the Medicare DSH adjustment provision, there were no approved section 1115 demonstration projects involving expansion populations and the statute does not address the treatment of these days. Although we did not initially include patient days for individuals who receive extended benefits only under a section 1115 demonstration project, we nevertheless expanded our policy in the January 20, 2000 revision to these rules to include such patient days. We now believe that this reading is warranted only to the extent that those individuals receive inpatient benefits under the section 1115 demonstration project.

Therefore, we are proposing to revise § 412.106(b)(4)(i) to clarify that patients must be eligible for medical assistance inpatient hospital benefits under an approved State Medicaid plan (or similar benefits, including inpatient hospital benefits, under a section 1115 demonstration project) in order for their hospital inpatient days to be counted as Medicaid days in the calculation of a hospital's DSH patient percentage. Under this proposed clarification, hospital inpatient days attributed to patients who do not receive coverage for inpatient hospital benefits either under the approved State plan or through a section 1115 demonstration would not be counted in the calculation of Medicaid days for purposes of determining a hospital's DSH patient percentage.

Under this reading, in the examples given above, the days associated with a hospital inpatient who receives coverage of prescription drugs or family planning services on an outpatient basis, but no inpatient hospital coverage, through either a Medicaid State plan or a section 1115 demonstration, would not be counted as Medicaid days for purposes of determining the DSH patient percentage.

This proposed revision would address an unintended potential consequence of our interpretation that hospitals may include in the DSH calculation patient days associated with section 1115 demonstration populations (65 FR 3136). As discussed above, that interpretation was based on our finding that individuals receiving a comprehensive benefit package under a section 1115 demonstration project could appropriately be included in the numerator of the Medicaid fraction even though the statute does not require such an inclusion, but did not address individuals who were receiving limited benefit packages under a section 1115 demonstration project.

7. Dual-Eligible Patient Days

As described above, the DSH patient percentage is equal to the sum of the percentage of Medicare inpatient days attributable to patients entitled to both Medicare Part A and SSI benefits, and the percentage of total inpatient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits. If a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered dual-eligible and the patient days are included in the Medicare fraction of the DSH patient percentage but not the Medicaid fraction. This is consistent with the language of section 1886(d)(5)(F)(vi)(II) of the Act, which specifies that patients entitled to benefits under Part A are excluded from the Medicaid fraction.

This policy currently applies even after the patient's Medicare coverage is exhausted. In other words, if a dual-eligible patient is admitted without any Medicare Part A coverage remaining, or the patient exhausts Medicare Part A coverage while an inpatient, his or her patient days are counted in the Medicare fraction before and after Medicare coverage is exhausted. This is consistent with our inclusion of Medicaid patient days even after the patient's Medicaid coverage is exhausted.

We are proposing to change our policy, to begin to count in the Medicaid fraction of the DSH patient percentage the patient days of dual-eligible Medicare beneficiaries whose Medicare coverage has expired. We note the statute referenced above stipulates that patient days attributable to patients entitled to benefits under Medicare Part A are to be excluded from the Medicaid fraction, while the statute specifies the Medicaid fraction is to include patients who are eligible for Medicaid.

As noted above, our current policy regarding dual-eligible patient days is that they are counted in the Medicare fraction and excluded from the

Medicaid fraction, even if the patient's Medicare Part A coverage has been exhausted. We believe this interpretation is consistent with the statutory intent of section 1886(d)(5)(F)(vi)(II) of the Act. However, we recognize there are other plausible interpretations. In addition, on a more practical level, we recognize it is often difficult for fiscal intermediaries to differentiate the days for dual-eligible patients whose Part A coverage has been exhausted. The degree of difficulty depends on the data provided by the States, which may vary from one State to the next. Some States identify all dual-eligible beneficiaries in their lists of Medicaid patient days provided to the hospitals, while in other States the fiscal intermediary must identify patient days attributable to dual-eligible beneficiaries by matching Medicare Part A bills with the list of Medicaid patients provided by the State. The latter case is problematic when Medicare Part A coverage is exhausted because no Medicare Part A bill may be submitted for these patients. Thus, the fiscal intermediary has no data by which to readily verify any adjustment for these cases in the Medicaid data provided by the hospital. Currently, the fiscal intermediaries are reliant on the hospitals to identify the days attributable to dual-eligible beneficiaries so these days can be excluded from the Medicaid patient days count.

Therefore, in order to facilitate consistent handling of these days across all hospitals, we are proposing that the days of patients who have exhausted their Medicare Part A coverage will no longer be included in the Medicare fraction. Instead, we are proposing these days should be included in the Medicaid fraction of the DSH calculation. (We note that not all SSI recipients are Medicaid eligible. Therefore, it will not be automatic that the patient days of SSI recipients will be counted in the Medicaid fraction when their Part a coverage expires.)

Under this proposed change, before a hospital could count patient days attributable to dual-eligible beneficiaries in the Medicaid fraction, the hospital must submit documentation to the fiscal intermediary that justifies including the days in the Medicaid fraction after the Medicare Part A benefits have been exhausted. That is, if the State provides data on all the days associated with all dual-eligible patients treated at a hospital, regardless of whether the beneficiary had Medicare Part A coverage, the hospital is responsible for providing documentation showing which days should be included in the Medicaid fraction because Medicare Part A coverage was exhausted.

8. Medicare+Choice (M+C) Days

Under § 422.1, an M+C plan ''means health benefits coverage offered under a policy or contract by an M+C organization that includes a specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area of the M+C plan.'' Generally, each M+C plan must provide coverage of all services that are covered by Medicare Part A and Part B (or just Part B if the M+C plan enrollee is only entitled to Part B).

We have received questions whether patients enrolled in an M+C Plan should be counted in the Medicare fraction or the Medicaid fraction of the DSH patient percentage calculation. The question stems from whether M+C plan enrollees are entitled to benefits under Medicare Part A since M+C plans are administered through Medicare Part C.

We note that, under § 422.50, an individual is eligible to elect an M+C plan if he or she is entitled to Medicare Part A and enrolled in Part B. However, once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A.

Therefore, we are proposing to clarify that once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction.

D. Medicare Geographic Classification Review Board (MGCRB) Reclassification Process (§ 412.230)

With the creation of the MGCRB, beginning in FY 1991, under section 1886(d)(10) of the Act, hospitals could request reclassification from one geographic location to another for the purpose of using the other area's standardized amount for inpatient operating costs or the wage index value, or both (September 6, 1990 interim final rule with comment period (55 FR 36754), June 4, 1991 final rule with comment period (56 FR 25458), and June 4, 1992 proposed rule (57 FR 23631)). Implementing regulations in subpart L of part 412 (§§ 412.230 *et seq.*) set forth criteria and conditions for redesignations for purposes of the wage index or the average standardized amount, or both, from rural to urban, rural to rural, or from an urban area to another urban area, with special rules for SCHs and rural referral centers.

Effective with reclassifications for FY 2003, section 1886(d)(10)(D)(vi)(II) of the Act provides that the MGCRB must use the average of the 3 years of hourly wage data from the most recently published data for the hospital when evaluating a hospital's request for reclassification. The regulations at § 412.230(e)(2)(ii) stipulate that the wage data are taken from the CMS hospital wage survey used to construct the wage index in effect for prospective payment purposes. To evaluate applications for wage index reclassifications for FY 2004, the MGCRB used the 3-year average hourly wages published in Table 2 of the August 1, 2002 IPPS final rule (67 FR 50135). These average hourly wages are taken from data used to calculate the wage indexes for FY 2001, FY 2002, and FY 2003, based on cost reporting periods beginning during FY 1997, FY 1998, and FY 1999, respectively.

Last year, we received a comment suggesting that we allow for the correction of inaccurate data from prior years as part of a hospital's bid for geographic reclassification (67 FR 50027). The commenter suggested that not to allow corrections to the data results in inequities in the calculation in the average hourly wage for purposes of reclassification. In the August 1, 2002 IPPS final rule, we responded:

''Hospitals have ample opportunity to verify the accuracy of the wage data used to calculate their wage index and to request revisions, but must do so within the prescribed timelines. We consistently instruct hospitals that they are responsible for reviewing their data and availing themselves to the opportunity to correct their wage data within the prescribed timeframes. Once the data are finalized and the wage indexes published in the final rule, they may not be revised, except through the mid-year correction process set forth in the regulations at § 412.63(x)(2). Accordingly, it has been our consistent policy that if a hospital does not request corrections within the prescribed timeframes for the development of the wage index, the hospital may not later seek to revise its data in an attempt to qualify for MGCRB reclassification.

''Allowing hospitals the opportunity to revise their data beyond the timelines required to finalize the data used to calculate the wage index each year would lessen the importance of complying with those deadlines. The likely result would be that the data used to compute the wage index would not be as carefully scrutinized because

hospitals would know they may change it later, leading to inaccuracy in the data and less stability in the wage indexes from year to year.''

Since responding to this comment in the FY 2003 IPPS final rule, we have become aware of a situation in which a hospital does not meet the criteria to reclassify because its wage data were erroneous in prior years, and these data are now being used to evaluate its reclassification application. In addition, in this situation, the hospital's wage index was subject to the rural floor because the hospital was located in an urban area with an actual wage index below the statewide rural wage index for the State, and it was for a time period preceding the requirement for using 3 years of data. Therefore, the hospital contends, it had no incentive to ensure its wage data were completely accurate. (However, we would point out that hospitals are required to certify that their cost reports submitted to CMS are complete and accurate. Furthermore, inaccurate or incomplete reporting may have other payment implications beyond the wage index.)

While we continue to have all of the concerns we expressed in last year's final rule, we now more fully understand this particular hospital's situation. Although we do have administrative authority to establish a policy allowing corrections for this particular set of circumstances, we are concerned about establishing a precedent that could reduce the importance of ensuring that the final wage data published in the annual IPPS final rule are complete and accurate. As we indicated in our response last year, we are concerned this could lead to less accuracy and stability in the wage indexes from year to year.

However, we are soliciting comments on whether it may be appropriate to establish a policy whereby, for the limited purpose of qualifying for reclassification based on data from years preceding the establishment of the 3-year requirement (that is, cost reporting years beginning before FY 2000), a hospital in an urban area that was subject to the rural floor for the period during which the wage data the hospital wishes to revise were used to calculate the wage index, a hospital may request that its wage data be revised.

E. Costs of Approved Nursing and Allied Health Education Activities (§ 413.85)

1. Background

Medicare has historically paid providers for the share of the costs that providers incur in connection with approved educational activities. The activities may be divided into the following three general categories to which different payment policies apply:

- Approved graduate medical education (GME) programs in medicine, osteopathy, dentistry, and podiatry. Medicare makes direct and indirect medical education payments to hospitals for residents training in these programs. Existing policy on direct GME payment is found at 42 CFR 413.86, and for indirect GME payment at 42 CFR 412.105.
- Approved nursing and allied health education programs operated by the provider. The costs of these programs are excluded from the definition of inpatient hospital operating costs and are not included in the calculation of payment rates for hospitals paid under the IPPS or in the calculation of payments to hospitals and hospital units excluded from the IPPS that are subject to the rate-of-increase ceiling. These costs are separately identified and ''passed through'' (that is, paid separately on a reasonable cost basis). Existing regulations on nursing and allied health education program costs are located at 42 CFR 413.85.
- All other costs that can be categorized as educational programs and activities are considered to be part of normal operating costs and are included in the per discharge amount for hospitals subject to the IPPS, or are included as reasonable costs that are subject to the rate-of-increase limits for hospitals and hospital units excluded from the IPPS.

In this section, we are proposing to clarify our policy governing payments to hospitals for provider-operated nursing and allied health education programs. Under the regulations at § 413.85 (''Cost of approved nursing and allied health educational activities''), Medicare makes reasonable cost payment to hospitals for provider-operated nursing and allied health education programs. A program is considered to be provider-operated if the hospital meets the criteria specified in § 413.85(f), which means the hospital directly incurs the training costs, controls the curriculum and the administration of the program, employs the teaching staff, and provides and controls both clinical training and classroom instruction (where applicable) of a nursing or allied health education program.

In the January 12, 2001 **Federal Register** (66 FR 3358), we published a final rule that clarified the policy for payments for approved nursing and allied health education activities in response to section 6205(b)(2) of the Omnibus Budget Reconciliation Act of 1989 (Pub. L. 101–239) and sections 4004(b)(1) and (2) of the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 101–508).

Section 6205(b)(2) of Public Law 101–239 directed the Secretary to publish regulations clarifying the rules governing allowable costs of approved educational activities. The Secretary was directed to publish regulations to specify the conditions under which those costs are eligible for pass-through, including the requirement that there be a relationship between the approved nursing or allied health education program and the hospital. Section 4004(b)(1) of Public Law 101–508 provides an exception to the requirement that programs be provider-operated to receive pass-through payments. The section provides that, effective for cost reporting periods beginning on or after October 1, 1990, if certain conditions are met, the costs incurred by a hospital (or by an educational institution related to the hospital by common ownership or control) for clinical training (as defined by the Secretary) conducted on the premises of the hospital under an approved nursing or allied health education program that is *not* operated by the hospital are treated as pass-through costs and paid on the basis of reasonable cost. Section 4004(b)(2) of Public Law 101–508 sets forth the conditions that a hospital must meet to receive payment on a reasonable cost basis under section 4004(b)(1).

2. Continuing Education Issue for Nursing and Allied Health Education

Since publication of the January 12, 2001 final rule on nursing and allied health education, we have encountered questions concerning the substantive difference between provider-operated continuing education programs for nursing and allied health education (which would *not* be reimbursable under Medicare on a reasonable cost basis) and provider-operated approved programs that are eligible to receive Medicare reasonable cost payment. In that final rule, we stated that Medicare would generally provide reasonable cost payment for ''programs of long duration designed to develop trained practitioners in a nursing or allied health discipline, such as professional nursing or occupational therapy. This is contrasted with a continuing education program of a month to a year in duration in which a practitioner, such as a registered nurse, receives training in a specialized skill such as enterostomal therapy. While such training is undoubtedly valuable in enabling the nurse to treat patients with special needs and in improving the level of

patient care in a provider, the nurse, upon completion of the program, continues to function as a registered nurse, albeit one with special skills. Further distinction can be drawn between this situation and one in which a registered nurse undergoes years of training to become a CRNA. For these reasons, the costs of continuing education training programs are not classified as costs of approved educational activities that are passed-through and paid on a reasonable cost basis. Rather, they are classified as normal operating costs covered by the prospective payment rate or, for providers excluded from the IPPS, as costs subject to the target rate-of-increase limits'' (66 FR 3370).

Accordingly, upon publication of the final rule, we revised § 413.85(h)(3) to include continuing education programs in the same category as ''educational seminars and workshops that increase the quality of medical care or operating efficiency of the provider.'' Costs associated with continuing education programs, as stated above, are recognized as normal operating costs and are paid in accordance with applicable principles.

We received an inquiry requesting further clarification on what is meant by continuing education. It is our belief that provider-operated programs that do not lead to any specific certification in a specialty would be classified as continuing education. By certification, we do not mean certification in a specific skill, such as when an individual is certified to use a specific piece of machinery or perform a specific procedure. Rather, we believe certification would mean the ability to perform in the specialty as a whole.

Although, in the past, we believe we have allowed hospitals to be paid for operating a pharmacy ''residency'' program, it has come to our attention that those programs do not meet the criteria for approval as a certified program. Once individuals have finished their undergraduate degree in pharmacy, there are *some* individuals who go on to participate in 1-year hospital-operated postundergraduate programs. It is our understanding that many individuals complete the 1-year postundergraduate program practice pharmacy inside the hospital setting. However, we also understand that there are pharmacists who *do not* complete the 1-year postundergraduate program, but have received the undergraduate degree in pharmacy, who also practice pharmacy inside the hospital setting. Because pharmacy students need not complete the 1-year residency program to be eligible to practice pharmacy in the hospital setting, the 1-year programs that presently are operated by hospitals would be considered continuing education, and therefore, would be ineligible for pass-through reasonable cost payment.

We understand that *all* individuals who wish to be nurses practicing in a hospital must either complete a 4-year degree program in a university setting, a 2-year associate degree in a community or junior college setting, or a diploma program traditionally offered in a hospital setting. Since participants that complete a provider-operated diploma nursing program could not practice as nurses without that training, the diploma nursing programs are *not* continuing education programs and, therefore, may be eligible for pass-through treatment.

Because of the apparent confusion concerning continuing education programs in the nursing and allied health reasonable cost context, we are proposing to revise § 413.85(h)(3) to state that educational seminars, workshops, and continuing education programs in which the employees participate that enhance the quality of medical care or operating efficiency of the provider and, effective October 1, 2003, do not lead to certification required to practice or begin employment in a nursing or allied health specialty, would be treated as educational activities that are part of normal operating costs. We also are proposing to add a conforming definition of ''certification'' for purposes of nursing and allied health education under § 413.85(c) to mean ''the ability to practice or begin employment in a specialty as a whole.''

3. Programs Operated by Wholly Owned Subsidiary Educational Institutions of Hospitals

Another matter that has come to CMS' attention since publication of the January 12, 2001 final rule (66 FR 3363) on nursing and allied health education concerns the preamble language of the rule, which states:

''Concerning those hospitals that have established their own educational institution to meet accrediting standards, we believe that, in some cases, these providers can be eligible to receive payment for the classroom and clinical training of students in approved programs. If the provider demonstrates that the educational institution it has established is wholly within the provider's control and ownership and that the provider continues to incur the costs of both the classroom and clinical training portions of the program, the costs would continue to be paid on a reasonable cost basis. An independent college would not meet these criteria.

''An example of a program that could be considered provider-operated would be one in which the hospital is the sole corporate member of the college, elects the board of trustees, has board members in common, employs the faculty and pays the salaries, controls the administration of the program and the curriculum, and provides the site for the clinical and classroom training on the premises of the hospital. We believe that, in these situations, the community has not undertaken to finance the training of health professionals; the provider has merely restructured its provider-operated program to meet certain State or accrediting requirements. In most cases, providers have aligned themselves with already established educational institutions. We note that a program operated by an educational institution that is related to the provider through common ownership or control would not be considered to meet the criteria for provider operated.'' (66 FR 3363)

We have received a question from a hospital that pertains to the cited preamble language in the narrow circumstance where the hospital previously received Medicare reasonable cost payment for direct operation of nursing or allied health education programs and then established its own wholly owned subsidiary college to operate the programs, in order to meet accreditation standards. The hospital has continued to receive Medicare payments after the hospital moved operation of the programs to the wholly owned subsidiary college. The hospital believes that, based on the cited preamble language regarding wholly owned subsidiary colleges and the lack of prior specific guidance on this particular organizational structure (as well as its continued receipt of pass-through payments) and because the hospital continues to pay all of the costs of the nursing and allied health education programs, the hospital is still the direct operator of the programs and should continue to receive pass-through treatment. However, we believe that once the hospital moved the direct operation of its nursing and allied health education programs to the college, the programs no longer met our provider-operated criteria at § 413.85(f). At the very least, it appears that the hospital did not hire the faculty for the program(s) and did not have direct control of the curriculum of the program(s) after operation was transferred to the wholly owned subsidiary college. As we stated in the

preamble language quoted above: ''a program operated by an educational institution that is related to the provider through common ownership or control would not be considered to meet the criteria for provider operated'' (66 FR 3363).

However, we understand that some hospitals, including this hospital, may have interpreted the preamble language that stated, ''if the provider demonstrates that the educational institution it has established is wholly within the provider's control and ownership and that the provider continues to incur the costs of both the classroom and clinical training portions of the program, the costs would continue to be paid on a reasonable cost basis'' (Ibid.), to mean that hospitals that establish wholly owned subsidiary colleges or educational institutions would continue to receive Medicare reasonable cost payment if the hospitals incur the costs of the classroom instruction and clinical training. We are proposing to clarify that transferring operation of previously provider-operated programs to educational institutions, even if the institutions are wholly owned by the hospital, does *not* necessarily mean that the programs continue to meet our provider-operated criteria under § 413.85(f). In order to remain provider operated, the hospital must have *direct control* of the program; the hospital itself must employ the teaching staff, have direct control of the program curriculum, and meet other requirements, as stated at § 413.85(f).

While we are proposing to clarify that merely operating programs through a wholly owned subsidiary college does not constitute direct operation of nursing or allied health education programs unless the hospital itself meets the requirements of the regulations at § 413.85(f), we believe it would be unfair to recoup Medicare payments that have already been made to hospitals that meet this very narrow fact pattern. Therefore, we are proposing that Medicare would not recoup reasonable cost payment from hospitals that have received pass-through payments for portions of cost reporting periods occurring on or before October 1, 2003 (the effective date of finalizing this proposed rule) for the nursing or allied health education program(s) where the program(s) had originally been operated by the hospital, and then operation of the program(s) had been transferred by the hospital to a wholly owned subsidiary educational institution in order to meet accreditation standards prior to October 1, 2003, and where the hospital had continuously incurred the costs of both the classroom and clinical training portions of the programs at the educational institution.

In addition, we are proposing that, for portions of cost reporting periods occurring on or after October 1, 2003, such a hospital would continue to receive reasonable cost payments for the clinical training costs incurred by the hospital for the program(s) described above that were previously provider operated. However, we are further proposing that, with respect to classroom costs, only those classroom costs incurred by the hospital for the courses that were paid by Medicare on a reasonable cost basis and included in the hospital's provider-operated program(s) could continue to be reimbursed on a reasonable cost basis. That is, Medicare would pay on a reasonable cost basis for the classroom costs associated with the courses provided as part of the nursing and allied health education programs (for example, the courses relating to the theory and practice of the particular nursing and allied health discipline(s)) that were offered by the hospital when the hospital was the direct operator of the program(s).

We believe this proposed policy is appropriate since continued pass-through payment will allow these hospitals to maintain equal footing with other hospitals that receive pass-through payments and have maintained their provider-operated programs. In addition, it would not be equitable to discontinue longstanding Medicare pass-through payment to these hospitals (in fact, reasonable cost payment to at least one of these hospitals for nonprovider-operated programs preceded the publication of the January 12, 2001 final rule on nursing and allied health education payments by many years) that restructured operation of their nursing and allied health education program(s) as wholly owned subsidiaries in order to meet accreditation standards while relying on their understanding of CMS' prior expressions of provider-operated requirements and the recent preamble language. If these providers were now forced to restructure in order to meet the requirements of § 413.85(f), they would not be able to maintain their accreditation.

We note that Congress has specifically expressed its intent that providers that have restructured their programs to be operated by a wholly owned subsidiary educational institution in order to meet accreditation standards should continue to receive Medicare reasonable cost payment. In the conference report accompanying the Consolidated Appropriations Resolution for FY 2003, Congress stated:

''The conferees are particularly concerned about nursing and allied health educational programs that cannot meet the regulations set forth at 42 CFR 413.85(f) solely as a result of regional educational accrediting criteria. Given the shortage of nursing and allied health professionals, the conferees support the payment of costs on a reasonable cost basis for a hospital that has historically been the operator of nursing and allied health education programs(s) that qualified for Medicare payments under 42 CFR 413.85, but, solely in order to meet educational standards, subsequently relinquishes some control over the program(s) to an educational institution, which meets regional accrediting standards; is wholly owned by the provider; and is supported by the hospital, that is, the hospital is incurring the costs of both the classroom and clinical training of the program.'' (H.R. Rep. No. 108–10, 108th Cong., 1st Sess., 1115 (2003).)

However, the proposed policy does not allow these hospitals to be paid for additional classroom costs for courses that were not paid on a reasonable cost basis to the hospitals in conjunction with their provider-operated programs (for example, additional classes needed to meet degree requirements). We believe that to allow pass-through payment for those additional costs would provide these hospitals with an unfair advantage over other hospitals with provider-operated programs.

We note that any hospital that chooses to restructure its programs to be operated by a wholly owned subsidiary educational institution on or after the effective date of this proposal when finalized (October 1, 2003) would not be eligible for pass-through payments under this proposed provision unless the hospital continues to meet the requirements of § 413.85(f). We believe it is appropriate to limit the proposed payments to hospitals that restructured before this proposed rule is made final because our policy with respect to programs by a wholly owned subsidiary of a hospital will have been clarified in that final rule.

We are proposing to revise § 413.85 by adding new paragraphs (d)(1)(iii) and (g)(3) to reflect this proposed payment policy.

F. Payment for Direct Costs of Graduate Medical Education (§ 413.86)

1. Background

Under section 1886(h) of the Act, Medicare pays hospitals for the direct costs of graduate medical education

(GME). The payments are based in part on the number of residents trained by the hospital. Section 1886(h)(4)(F) of the Act caps the number of allopathic and osteopathic residents that hospitals may count for direct GME.

Section 1886(h) of the Act, as added by section 9202 of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (Pub. L. 99–272) and implemented in regulations at § 413.86(e), establishes a methodology for determining payments to hospitals for the costs of approved GME programs. Section 1886(h)(2) of the Act, as added by COBRA, sets forth a payment methodology for the determination of a hospital-specific, base-period per resident amount (PRA) that is calculated by dividing a hospital's allowable costs of GME for a base period by its number of residents in the base period. The base period is, for most hospitals, the hospital's cost reporting period beginning in FY 1984 (that is, the period of October 1, 1983 through September 30, 1984). The PRA is multiplied by the weighted number of full-time equivalent (FTE) residents working in all areas of the hospital complex (or nonhospital sites, when applicable), and the hospital's Medicare share of total inpatient days to determine Medicare's direct GME payments.

Existing regulations at § 413.86(e)(4) specify the methodology for calculating each hospital's weighted average PRA and the steps for determining whether a hospital's PRA will be revised.

2. Prohibition Against Counting Residents Where Other Entities First Incur the Training Costs

a. General Background on Methodology for Determining FTE Resident Count. As we explain earlier in this preamble, Medicare makes both direct and indirect GME payments to hospitals for the training of residents. Direct GME payments are reimbursed in accordance with section 1886(h) of the Act, based generally on hospital-specific PRAs, the number of FTE residents a hospital trains, and the hospital's Medicare patient share. The indirect costs of GME are reimbursed in accordance with section 1886(d)(5)(B) of the Act, based generally on the ratio of the hospital's FTE residents to the number of hospital beds. It is well-established that the calculation of both direct GME and IME payments is affected by the number of FTE residents that a hospital is allowed to count; generally, the greater the number of FTE residents a hospital counts, the greater the amount of Medicare direct GME and IME payments the hospital will receive. In an attempt to end the implicit incentive for hospitals to increase the number of FTE residents, Congress instituted a cap on the number of allopathic and osteopathic residents a hospital is allowed to count for direct GME and IME purposes under the provisions of section 1886(h)(4)(F) (direct GME) and section 1886(d)(5)(B)(v) (IME) of the Act. Dental and podiatric residents were not included in this statutorily mandated cap.

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 separate reimbursement of direct GME costs ''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 on 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 non-hospital 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 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. Inappropriate Counting of FTE Residents. As we stated above, dental residents, along with podiatric residents, are excepted from the statutory cap on the count of FTE residents for both direct GME and IME payment purposes. We have become aware of a practice pertaining to the counting of FTE residents at a nonhospital site, particularly dental residents, that we see as inappropriate under Medicare policy. Most often, the situation involves dental schools that, for a number of years, have been training dental residents in programs at the dental schools of universities affiliated with teaching hospitals, and the schools have been directly incurring the costs of the dental residents training at the dental schools (for example, the teaching faculty costs, the resident salary costs, the office space costs, and

any overhead expenses of the programs). We also understand that there are dental clinics at these dental schools that treat patients (that is, are involved in ''patient care activities'').

As a result of the provisions that Congress added to allow hospitals to count FTE residents and receive IME payment, as well as direct GME payment, if the hospital incurs ''all or substantially all'' the costs of training residents in nonhospital settings, a significant number of dental schools are shifting the resident training costs of the dental programs from the schools to the hospital, and thus to the Medicare program, when the hospitals count the FTE dental residents training in these dental schools (that is, ''nonhospital sites'') under the regulations at § 413.86(f)(4). Furthermore, in the case of training dentists at dental school clinics, as a result of this cost-shifting and because dental residents are excepted from the cap, hospitals are receiving significant amounts of Medicare direct GME and IME payments when they have incurred relatively small costs of the residents training in a dental school.

The following actual situations are illustrative of the inappropriate application of Medicare direct GME and IME policy that we have found:

• An academic medical center hospital associated with a university has been training allopathic residents for at least 20 years. Prior to 1999, the university s affiliated dental school had always incurred the costs of dental residency programs at the dental school. Beginning with the hospital's cost report for its fiscal year ending in 1999, for the first time ever, the hospital has requested direct GME and IME payment for an additional 67 FTE residents because the hospital claims it has begun to incur ''all or substantially all'' of the costs of the dental residents training in the university's affiliated dental school, in accordance with the regulations at § 413.86(f)(4).

• A university dental school in one State has been incurring the costs of dental residency programs at its dental school for several years. Beginning in FY 1999, a teaching hospital in a neighboring State decided to begin incurring ''all or substantially all'' of the costs of the dental residents training in the dental clinics in the program (which is located in a different State from the hospital) in order to receive Medicare direct GME and IME payment for an additional 60 FTE residents.

• In another situation, a teaching hospital on the East Coast of the United States has requested direct GME and IME payment for an additional 60 FTE dental residents, some of whom are training in dental programs at nonhospital sites located in Hawaii, New Mexico, and the Netherlands, because it has begun to incur ''all or substantially all'' of the costs of dental residents training in those remote ''nonhospital sites''. Prior to 1999, the costs for these dental programs were funded by nonhospital sources.

We note that such inappropriate cost-shifting practices are by no means limited to the dental school context. Indeed, we understand that there are some hospitals with resident counts below their direct GME and IME FTE resident caps that have recently (as of October 1, 1997, when it became possible to receive significant IME payments under the amendment made by Pub. L. 105–33) started to incur ''all or substantially all'' of the costs of residents who had been training at sites outside of the hospital without any financial assistance from the hospital, in order for the hospital to count those FTE residents and receive Medicare direct GME and IME payments for the additional residents. The actual costs of the programs that are being shifted from nonhospital entities to hospitals are relatively small, compared to the direct GME and IME payments that hospitals receive as a result of incurring ''all or substantially all'' of the training costs.

• In another example, an academic medical center hospital in one State asked Medicare to allow it to count an additional 10 FTEs for both direct GME and IME payment, beginning with its fiscal year ending 1999 cost report, because the hospital claims it is incurring all or substantially all of the costs of training osteopathic family practice residents in a walk-in clinic. The osteopathic family practice residency program had previously been sponsored by this clinic for several years and the residents do not participate in any training at the hospital.

c. Congressional Intent. Congress has delegated broad authority to the Secretary to implement a policy on the count of FTE residents for purposes of calculating direct GME and IME payments. For IME payment, section 1886(d)(5)(B) of the Act simply states that ''the Secretary shall provide for an additional payment amount'' which includes ''the ratio of the hospital's full-time equivalent interns and residents to beds.'' The methodology to compute the count of FTE residents for IME is not established in the statute. Similarly, for direct GME, section 1886(h)(4)(A) of the Act states that ''the Secretary shall establish rules consistent with this paragraph for the computation of the number of full-time equivalent residents in an approved medical residency training program.''

Although not in the context of the general rules for counting FTE residents, Congress similarly acknowledged its intent to defer to the Secretary with respect to the rules for implementing ''limits'' or caps on the number of FTE residents hospitals may count for purposes of direct GME and IME payment. The conference agreement that accompanied Pub. L. 105–33, which established a cap on the number of allopathic and osteopathic residents a hospital may count, states—

''[T]he Conferees recognize that such limits raise complex issues, and provide for specific authority for the Secretary to promulgate regulations to address the implementation of this provision. The Conferees believe that rulemaking by the Secretary would allow careful but timely consideration of this matter, and that the record of the Secretary's rulemaking would be valuable when Congress revisits this provision.'' (H.R. Conf. Rep. No. 105–217, 105th Cong., 1st Sess., 821 (1997).

The absence of statutory specificity on determining FTE counts in these situations and the declared Congressional delegations of authority to the Secretary on the subject are clear indications that Congress has given the Secretary broad discretion to promulgate reasonable regulations in order to implement the policy on the counting of residents for direct GME and IME payments.

When Congress enacted the nonhospital site provisions for both direct GME and IME, Congress intended to address application of the FTE count policy to situations where the training site had been the hospital. The intent was to create incentives for hospitals to move resident training from the hospital to nonhospital settings. We believe that Congress did *not* intend for hospitals to be able to add to their FTE counts residents that had historically trained outside the hospital in other settings. Training in those nonhospital settings had historically occurred without Congress offering any financial incentive to hospitals to move the training out of the hospital.

This Congressional intent is evident in the legislative history of both the direct GME and the IME provisions on nonhospital settings. First, legislative history associated with passage of the direct GME provision (as part of Pub. L. 99–509) indicates that Congress intended to broaden the scope of settings in which a hospital could train its residents and still receive separate direct GME cost reimbursement, and to

provide incentives to hospitals for training residents in primary care programs. The Conference committee report indicates that ''[s]ince it is difficult to find sufficient other sources of funding [than hospitals and Medicare] for the costs of such training, [that is, training in freestanding primary care settings such as family practice clinics or ambulatory surgery centers] *assignments to these settings* are discouraged. It is the Committee's view that training in these settings is desirable, because of the growing trend to treat more patients *out of the inpatient hospital setting* and because of the encouragement it gives to primary care.'' (Emphasis added.) (H.R. Rep. No. 99–727, 99th Cong., 1st Sess., 70 (1986).)

Thus, from the start of the policy allowing payment for training in nonprovider sites, we believe Congress intended to create a monetary incentive for hospitals to rotate residents from the hospital to the nonhospital settings. We believe Congress did not intend for hospitals to be paid for residents who had previously been training at nonhospital sites without hospital funding.

Further, in the Conference committee report accompanying the provision of Pub. L. 105–33 on IME payment for training in nonhospital settings, Congress stated that ''[t]he conference agreement includes new permission for *hospitals to rotate residents through nonhospital settings,* without reduction in indirect medical education funds.'' (Emphasis added.) (H.R. Conf. Rep. No. 105–217, 105th Cong., 1st Sess., 817 (1997).)

We note that, prior to enactment of Pub. L. 105–33, if a hospital rotated a resident to train at a nonhospital site, the hospital could not count the time the resident spent at the nonhospital site for purposes of Medicare IME payments. As a result, the lack of IME payments acted as a disincentive and discouraged hospitals from rotating residents out of the hospital. Therefore, Congress authorized hospitals to count residents in nonhospital sites for IME purposes as a specific incentive to encourage hospitals to rotate their residents to nonhospital sites (and not to encourage hospitals to incur the costs of a program at a nonhospital site that had already been funded by other sources). This legislative intent becomes more apparent when the nature of the Medicare IME payment is considered. The Medicare IME payment is inherently a payment that reflects the increased operating costs of treating inpatients as a result of the hospital having a residency program. For example, as explained in the September 29, 1989 final rule (54 FR 40286), the indirect costs of medical education might include added costs resulting from an increased number of tests ordered by residents as compared to the number of tests normally ordered by more experienced physicians.

The IME payment is an adjustment that is made for each Medicare discharge from the areas subject to the IPPS in a teaching hospital. The authorization by Congress for IME payments relating to nonhospital services while residents are training at nonhospital sites would be absurd if not viewed as an incentive to transfer existing residency training from the hospital to the nonhospital setting. We do not believe Congress intended to permit such IME payments to be allowable to the hospital that is incurring ''all or substantially all the costs'' of residents training in nonhospital sites except in the situation where the hospital rotated residents from the hospital to the nonhospital settings. The illustrative situations described above in which nonhospital sites, such as dental schools, are shifting the costs of existing programs to the hospitals are not consistent with the intent of Congress to encourage hospitals to rotate residents from the hospital setting to nonhospital sites.

Thus, we believe Congress intended both cited provisions of the Act on counting residents in nonhospital sites for purposes of direct GME and IME payments to be limited to situations in which hospitals rotate residents from the hospital to the nonhospital settings, and *not* situations in which nonhospital sites transfer the costs of an existing program at a nonhospital site to the hospital.

d. Medicare Principles on Redistribution of Costs and Community Support. It is longstanding Medicare policy that if the community has undertaken to bear the costs of medical education, these costs are not to be assumed by the Medicare program. In addition, medical education costs that have been incurred by an educational institution may not be redistributed to the Medicare program. Indeed, these concepts, community support and redistribution of costs, have been a part of Medicare GME payment policy since the inception of the Medicare program. Both the House and Senate Committee reports accompanying Pub. L. 89–97 (the authorizing Medicare statute) indicate that Congress intended Medicare to share in the costs of medical education *only* in situations in which the community has not stepped in to incur them:

''Many hospitals engage in substantial education activities, including the training of medical students, internship and residency programs, the training of nurses and the training of various paramedical personnel. Educational activities enhance the quality of care in an institution and it is intended, *until the community undertakes to bear such education costs in some other way,* that a part of the net cost of such activities * * * should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program. (Emphasis added.) (S. Rep. No. 404, 89th Cong., 1st Sess., 36 (1965); H.R. Rep. No. 213, 89th Cong., 1st Sess., 32 (1965).)

The principle behind the congressional committee report language for Pub. L. 89–97 that Medicare would share in the costs of educational activities until communities bore them in some other way has guided Medicare policy on educational activities from the inception of the Medicare program. The principles of community support and redistribution of costs associated with payment for GME have been continually reiterated in various regulations, manual provisions, and implementing instructions to fiscal intermediaries. As recently as the final rule published in the **Federal Register** on January 12, 2001, we stated:

''We note that the proposed revisions in the proposed rule inadvertently did not include community support as the basis for an offset from the allowed cost of a GME or nursing and allied health program. In this final rule, we restate our longstanding policy that Medicare will share in the costs of educational activities of providers where communities have not assumed responsibility for financing these programs. Medicare's policy is to offset from otherwise allowable education costs, community funding for these activities.'' (66 FR 3368)

We note the instructions that CMS (then HCFA) gave to its Regional Offices in the 1990 audit instructions for purposes of calculating the direct GME base period PRA specifically addressed redistribution of costs and community support in the GME context:

''Where costs for services related to medical education activities have historically been borne by the university, it is assumed the community has undertaken to support these activities, and subsequent allocation of these costs to a hospital constitutes a redistribution of costs from an educational institution to a patient care institution. In such a situation, these costs are not allowable under the Medicare program. (*See* 42 CFR

413.85(c) and HCFA Pub. L. 15–1, § 406). For example, if in the past the hospital did not identify and claim costs attributable to the time teaching physicians spent supervising I&Rs [interns and residents] working at the hospital, it is assumed that these costs were borne by the university. Therefore, the hospital may not claim these costs in subsequent cost reports.'' (Instructions for Implementing Program Payments for Graduate Medical Education to ARAs for Medicare, Director of Office of Financial Operations of the Health Care Financing Administration, BPO–F12, February 12, 1990.)

Furthermore, the regulation at § 413.85(c) that was originally issued in the **Federal Register** on September 30, 1986 (51 FR 34793) (which was further refined, but conceptually left unchanged, as of March 12, 2001) addressed the Congressional intent not to increase program costs, as well. That paragraph (c) stated:

''*Educational Activities*. Many providers engage in education activities including training programs for nurses, medical students, interns and residents, and various paramedical specialties * * * . Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with operations, it is not intended that this program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units.''

The Secretary of Health and Human Services interpreted this provision to deny reimbursement of educational costs that were borne in prior years by a hospital's affiliated medical school. The U.S. Supreme Court affirmed the Secretary's interpretation of the redistribution of costs regulation in *Thomas Jefferson University* v. *Shalala* (''*Thomas Jefferson*''), 512 U.S. 504 (1994). The Court found of § 413.85(c) that:

''The regulation provides, *in unambiguous terms,* that the 'costs' of these educational activities will not be reimbursed when they are the result of a 'redistribution,' or shift, of costs of an 'educational' facility to a 'patient care' facility.'' (Emphasis added.) (*Thomas Jefferson,* 512 U.S. at 514). Thus, the Supreme Court in *Thomas Jefferson* held that it is well within the Secretary's discretion to interpret the language at § 413.85(c), which was specifically derived from the legislative history of the original enacting Medicare legislation quoted above, to impose a substantive limitation on medical education payment.

The Supreme Court's opinion in *Thomas Jefferson* lends substantial support and credibility to CMS' longstanding policy on community support and redistribution of costs in the GME context.

e. Application of Redistribution of Costs and Community Support Principles. As we have described above, we have discovered an inappropriate application of Medicare direct GME and IME payment policies relating to the counting of FTE residents in nonhospital settings. As stated previously, we believe that: (1) Congress has given the Secretary broad discretion to implement policy on FTE resident counts; (2) Congress intended that the nonhospital site policy for both direct GME and IME would encourage hospitals to move resident training from the hospital to nonhospital settings, not to enable nonhospital sites to shift the costs of already established residency programs in the nonhospital site to the hospital; and (3) since the inception of the Medicare program, CMS' policy has been consistent with the intent of Congress that Medicare would only share in the costs of medical education until the community assumes the costs. The Supreme Court has specifically found that CMS' implementation of the redistribution of costs and community support principles is ''reasonable.'' (*Thomas Jefferson*, 512 U.S. at 514.)

Accordingly, we are proposing that residents training at nonhospital sites may be counted in a hospital's FTE resident count only where the principles of redistribution of costs and community support are not violated. We are proposing this policy at this time to address the inappropriate practice of nonhospital sites shifting costs to hospitals solely to allow the hospitals to count residents training in the nonhospital sites. However, we believe the concepts of redistribution of costs and community support are equally relevant to the counting of FTEs residents by a hospital in general.

We note again that the Medicare program has a long tradition of applying redistribution of costs and community support principles to medical education payments. As we have stated above, both the House and Senate Committee reports accompanying Pub. L. 89–97 (the 1965 authorizing Medicare statute) indicate that Congress intended Medicare to share in the costs of medical education only where the community has not stepped in to incur them.

We believe it is appropriate to employ the principles of redistribution of costs and community support to specifically address the inappropriate scenarios described above whereby hospitals attempt to inflate their FTE resident counts by assuming payment of training costs for residents in nonhospital sites that were previously funded by a nonhospital entity. Therefore, we are proposing to specify the application of the redistribution of costs and community support principles by adopting the definitions (with some modification to reflect the methodology for counting FTE residents applicable to GME) of ''community support'' and ''redistribution of costs'' at § 413.85(c), which relate to nursing and health education program costs, for use at § 413.86(b), which relates to GME. In addition, we are proposing a general rule at proposed § 413.86(i) on the application of community support and redistribution of costs principles to the counting of FTE residents for GME. We are proposing to (1) make the provisions under § 413.86(f) relating to determining the number of FTE residents subject to the provisions of the proposed § 413.86(i); (2) add a proposed § 413.86(f)(4) in order to clarify that the principles of redistribution of costs and community support are applicable to the counting of FTE residents, including when the residents are training in nonhospital settings; and (3) making the provisions of the proposed § 413.86(i) specifically applicable to determining the number of FTE residents under § 413.86(g)(4) through (6) and (g)(12).

The general rule at proposed § 413.86(i) contains two provisions. Proposed § 413.86(i)(1) states the principles of community support and redistribution of costs: In relation to community support, we are proposing that if the community has undertaken to bear the costs of medical education through community support, the training costs of residents that are paid through community support are not considered GME costs to the hospital for purposes of Medicare payment. In relation to redistribution of costs, we are proposing that 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.

In applying the redistribution of costs and community support principles, we are proposing under § 413.86(i)(2) to state that a hospital must continuously incur direct GME costs of residents training in a particular program at a training site since the date the residents first began training in that site in order for the hospital to count the FTE residents in accordance with the

provisions of paragraphs (f) and (g)(4) through (g)(6), and (g)(12) of § 413.86.

We note that our reasons for specifically referencing the applicability of the principles of community support and redistribution of costs at § 413.86(f)(4), the paragraph concerning counting residents training in nonhospital settings for direct GME purposes, are twofold. First, although we are already making the proposed § 413.86(i) applicable to § 413.86(f), which would make the principles applicable to each paragraph under § 413.86(f), in consideration of the inappropriate applications we have identified of the GME FTE-counting policy with respect to counting residents in nonhospital sites, we believe it is appropriate to also specifically address the applicability of the redistribution of costs and community support principles to § 413.86(f)(4). In addition, we note that the proposed reference at § 413.86(f)(4) has implications for IME payment as well, as explained below.

Under existing § 412.105(f)(1)(ii)(C), the rule for the counting of FTE residents training in nonhospital settings for IME payment, there is a specific reference indicating that the criteria set forth in § 413.86(f)(4) must be met in order for a hospital to count the FTE residents training in nonhospital settings for purposes of IME payments. Thus, if under proposed § 413.86(f)(4)(iv) (the paragraph making redistribution of costs and community support principles applicable) a hospital is not permitted to count the FTE residents training in a nonhospital site because of redistribution of costs or community support, the hospital would not be permitted to count the FTE residents for purposes of IME payment as well, because the IME regulation at § 412.105(f)(1)(ii)(C) requires the criteria under § 413.86(f)(4) to be met.

As we have stated above, payment for IME is based on the concept that, as a direct result of the hospital's resident training program, the costs the hospital incurs for patient care are increased. When Congress included section 1886(d)(5)(B)(iv) of the Act as part of Public Law 105–33, the statute expanded the circumstances under which IME payments to a hospital could be made by allowing the hospital to count the number of residents training outside the hospital setting under certain conditions. Even though it is clear that those residents training outside the hospital cannot have any impact on patient care costs to the hospital, Congress nevertheless allowed the hospital to receive IME payments when the hospital counts FTE residents training in a nonhospital setting in accordance with section 1886(d)(5)(B)(iv) of the Act, where those residents would otherwise have trained in the hospital setting. As we have stated, Congress created an incentive (or removed a disincentive) with the provisions of Public Law 105–33 for hospitals to rotate residents to nonhospital settings by allowing hospitals to continue to receive IME payment as if the residents continued to train in the hospital setting. If there is a redistribution of costs or community support, we believe IME payment to the hospital would be contrary to Congressional intent to encourage the hospital to rotate residents from the hospital to the nonhospital site.

In addition, when Congress included section 1886(d)(5)(B)(iv) of the Act as part of Public Law 105–33, the statutory authority for IME payment was premised on the hospital incurring the direct GME costs of the residents: ''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.'' (Emphasis added.) (Section 4621(b)(2) of Public Law 105–33; section 1886(d)(5)(B)(iv) of the Act.) We believe Congress intended the hospital to incur direct GME costs of the program in the nonhospital site in order to count the FTE residents training in nonhospital settings for purposes of IME payment. Thus, in the situation where a hospital incurred direct GME costs but there was redistribution of costs or community support, a disallowance of direct GME payments as well as a disallowance of IME payments is appropriate.

Although we are stating generally that the principles of community support and redistribution of cost have applied since the inception of Medicare to graduate medical education payment, as we have stated above, we have identified relatively recent inappropriate application of the nonhospital site policy for counting FTE residents. Therefore, we believe it is appropriate to propose to identify January 1, 1999, as the date our fiscal intermediaries should use to determine whether a hospital or another entity has been incurring the costs of training in a particular program at a training setting for purposes of determining whether there has been a redistribution of costs or community support. We are proposing that January 1, 1999 be used as the date the fiscal intermediaries should use for determinations, since it may be difficult for our fiscal intermediaries to obtain from hospitals contemporaneous documentation that the hospitals have appropriately been incurring the direct GME costs in earlier fiscal years. We believe the January 1, 1999 date should simplify confirmation by our fiscal intermediaries and hospitals of whether the hospital or another entity had been incurring the costs of the program in particular training settings and whether redistribution of costs or community support had occurred. We have chosen the January 1, 1999 date because of administrative convenience and feasibility, so that necessary data are both valid and available, and in recognition of the fact that our fiscal intermediaries must prioritize their limited audit resources. While we are not requiring our fiscal intermediaries to determine whether a hospital had been incurring the training costs of a program prior to the January 1, 1999 date, if the fiscal intermediaries determine that there is a redistribution of costs or community support exists with respect to certain residents prior to January 1, 1999, a disallowance of direct GME and IME payments with respect to those FTE residents would certainly be required.

Since calculation of a hospital's FTE resident count is dependent upon whether the hospital incurred the training costs, we are proposing to require each teaching hospital and its fiscal intermediary to determine which entity had been incurring the training costs at least since January 1, 1999. For example, if a nonhospital entity, such as a school of medicine or dentistry, had incurred the costs of training the residents anytime on or after January 1, 1999, and a hospital subsequently begins to incur direct GME costs of training those FTE residents, the hospital would not qualify to count those FTE residents for purposes of direct GME and IME payments.

We note that the proposal states that a hospital must have been *continuously* incurring the costs of the training since the date the residents first began training in that program. Accordingly, if a hospital had at one time incurred the costs of training residents in a particular program, whether at the hospital or in a nonhospital setting, but a nonhospital institution later assumed the costs of training in that setting, even if the hospital assumed payment for the training costs again, the hospital could not then count those residents for purposes of direct GME and IME payments.

We note that if a hospital incurs the direct GME costs, whether training takes

place inside the hospital or in a nonhospital setting, in a new residency program, the hospital may be eligible to count the FTE residents as specified by the regulations under § 413.86(g)(6).

Consistent with the policy on redistribution of costs and community support discussed above, if a hospital incurs the direct GME costs of *additional* FTE residents training in an existing program in a hospital setting where the costs of the existing program had been incurred by a nonhospital entity and the hospital has continuously funded the *additional* residents in the existing program in the hospital setting since the date the residents first began training there, the redistribution of costs or community support principles would not prohibit the hospital from counting the additional FTE residents for purposes of direct GME and IME payments.

We note that, under existing policy, to count residents in a nonhospital setting, a hospital is required to incur for ''all or substantially all of the costs of the *program*'' in that setting. In other words, a hospital is required to assume financial responsibility for the *full* complement of residents training in a nonhospital site in a particular program in order to count any FTE residents training there for purposes of IME payment. A hospital cannot count any FTE residents if it incurs ''all or substantially all of the costs'' for only a portion of the FTE residents in that program training setting. This policy is derived from the language of the IME and direct GME provisions of the statute on counting residents in nonhospital settings; both sections 1886(d)(5)(B)(iv) and 1886(h)(4)(E) of the Act state that the hospital must incur ''all, or substantially all, of the costs for the training *program* in that setting.'' (Emphasis added.) In contrast, as explained earlier, it is permissible under the proposed policy on the application of the redistribution of costs and community support principles for the hospital to count FTE residents where the hospital incurs direct GME costs of FTE residents that are *added* to an existing program, even though the hospital may not count the existing FTE residents due to the application of the redistribution of costs or community support rules. In the nonhospital setting, as a result of the interaction of these two separate FTE counting requirements—(1) that the hospital must not violate the redistribution of costs and the community support principles in order to count the resident FTEs in the nonhospital settings, and (2) that the hospital must incur ''all or substantially all'' of the costs for the training program in that setting—a hospital would be prohibited from counting FTE residents added to an existing program at a nonhospital site unless the hospital incurs all or substantially all of the costs of training *all* of the residents in that program at that setting. That is, even if the hospital incurs all or substantially of the costs for all of the training program at the nonhospital site, the hospital would only be able to count the additional FTE residents who were not excluded by application of the redistribution of costs or community support principles.

For example, training in a general dentistry program with 10 FTE residents has taken place at a school of dentistry for 20 years. The school of dentistry has been incurring the training costs of the general dentistry residents since the inception of the program. Beginning in 2003, the school of dentistry has decided to add an additional 5 FTE residents to the program, and Hospital A decides to incur ''all or substantially all'' the costs of those 5 additional FTE residents only. Applying the policy concerning redistribution of costs and community support in combination with the policy on incurring all or substantially all of the costs, the hospital could not count the additional 5 FTE residents in the dental school since it is not paying for all or substantially all of the costs of the program. Even if the hospital were to incur all or substantially all of the costs for the training program for all 15 FTE residents, the hospital could not count the 10 FTEs that were part of the existing general dentistry program because of the redistribution of costs and community support principles; it would be a redistribution of costs for the hospital to begin to incur direct GME costs of the 10 FTE residents when the dental school had previously been incurring those costs.

We note that such a result does not occur when a *new program* is established in the nonhospital site. If, from the outset of the program, the hospital incurs direct GME costs and also incurs ''all or substantially all'' of the costs for the training program for all the new residents training at the site, there would be no redistribution of costs or community support, and the hospital could count all of those residents in the new program in its FTE count (subject, of course, to the hospital's 1996 FTE resident cap).

We also note that the interaction of the two provisions discussed above—redistribution of costs and community support, and ''all or substantially all''—does not occur when counting FTE residents training inside the hospital, since a hospital is not required to incur ''all or substantially all'' of the costs for the training program inside the hospital.

Furthermore, if one hospital had incurred the direct GME costs of training residents in a particular program in a nonhospital site from one point in time, for example, 1995 through 1999, and then another hospital consecutively incurs the costs from 2000 and thereafter, the second hospital may be eligible to receive direct GME and IME payments for training the FTE residents from the point in time where the second hospital incurred the direct GME costs, and the redistribution and community support exclusions would not apply. The second hospital may be eligible to receive Medicare direct GME and IME payments because the costs were incurred previously by a hospital, and not either the community or the university. Therefore, there was neither community support nor redistribution of costs.

The following are some examples to clarify how these proposed policies would be implemented:

Example 1

Since 1995, 10 FTE residents in an internal medicine program have been training in the Community Clinic. In accordance with the current provisions of § 413.86(f), Hospital A has incurred all or substantially all of the costs of training the 10 FTE residents since 1995. Assuming the current provisions of the regulations at §§ 412.105(f)(1)(ii)(C) and 413.86(f)(3) and (f)(4) are met, Hospital A may continue to receive IME and direct GME payments for 10 FTE residents because Hospital A had incurred direct GME costs continuously (as evidenced by contemporaneous documentation since January 1, 1999), as specified in our proposed regulation.

Beginning July 1, 2004, in addition to continuing to incur all or substantially all of the costs of the first 10 FTE internal medicine residents training in the nonhospital site, Hospital A also incurs all or substantially all of the costs of training an additional 3 FTE internal medicine residents at that site. Accordingly, beginning July 1, 2004, Hospital A may count all 13 FTE residents training in the Community Clinic for purposes of direct GME and IME payments, assuming Hospital A does not exceed its FTE cap for IME and direct GME.

Example 2

Since 1995, 2.25 dental FTE residents in a dental school program were training in a dental clinic at the dental school. While the 2.25 FTEs were training at the

clinic, the dental school paid for all of the costs of the dental program. Prior to July 1, 2000, Hospital A signed a written agreement with the clinic to incur all or substantially all of the costs of training the 2.25 FTE residents, from July 1, 2000 and onward. Thus, beginning with July 1, 2000, the dental school no longer incurred the costs of the program at this nonhospital site. In this scenario (even if Hospital A inappropriately received direct GME and IME payments for the 2.25 FTEs since July 1, 2000), Hospital A may not receive direct GME or IME payment for the 2.25 FTE residents training in the clinic because there would have been a redistribution of costs associated with training these 2.25 FTE residents from the dental school to the hospital.

Example 3

Since 1995, 2.25 FTE residents in a family practice program were training in a physicians' group practice. While the 2.25 FTEs were training at the physicians' practice, a school of medicine paid for the costs of the family practice residency program. Prior to July 1, 2000, Hospital A signed a written agreement with the physicians' practice to send 1 additional family practice FTE resident to the physicians' practice and to incur all or substantially all of the costs of training the original 2.25 FTE residents *and* the 1 additional FTE, from July 1, 2000 and onward. Thus, beginning with July 1, 2000, the school of medicine no longer incurred the costs of the program at this nonhospital site. Hospital A may not count the 2.25 FTE residents that had been training since 1995 in that physicians' practice for purposes of direct GME and IME payments because the training costs were shifted from the school of medicine to the hospital. However, Hospital A may count the 1 FTE resident the hospital began to rotate for training in the physicians' practice because there was no cost-shifting for that resident and Hospital A incurred ''all or substantially all'' of the costs of the entire family practice program in the physicians' office setting.

Example 4

Residents in a surgery program have been rotating from a hospital to two nonhospital clinics, Clinic A and Clinic B, since 1996. The training of the surgery residents in Clinic A has been supported by a nonhospital institution since 1996, while the hospital has incurred all or substantially all of the costs of the surgery residents in Clinic B since 1996. The hospital cannot count the surgery FTE residents training in Clinic A, even if it begins to pay for all of the costs of the program at that site, since a nonhospital institution had supported the training in Clinic A since 1996 (in other words, the redistribution of costs and community support principles would prohibit the hospital from counting these FTE residents). However, if the hospital continues to incur all or substantially all of the costs of the surgery residents in Clinic B, the hospital may count the FTE residents training in Clinic B for purposes of direct GME and IME payments because there would be no cost-shifting to the hospital for these residents and the hospital would incur all or substantially all of the costs for the training program in that setting.

3. Rural Track FTE Limitation for Purposes of Direct GME and IME for Urban Hospitals that Establish Separately Accredited Approved Medical Programs in a Rural Area (§§ 412.105(f)(1)(x) and 413.86(g)(12)) a. Change in the Amount of Rural Training Time Required for an Urban Hospital to Qualify for an Increase in the Rural Track FTE Limitation. To encourage the training of physicians in rural areas, section 407(c) of Pub. L. 106–113 amended sections 1886(d)(5)(B) and 1886(h)(4)(H) of the Act to add a provision that, in the case of an urban hospital that establishes separately accredited approved medical residency training programs (or rural tracks) in a rural area or has an accredited training program with an integrated rural track, an adjustment shall be made to the urban hospital's cap on the number of residents. For direct GME, the amendment applies to payments to hospitals for cost reporting periods beginning on or after April 1, 2000; for IME, the amendment applies to discharges occurring on or after April l, 2000.

Section 407(c) of Pub. L. 106–113 did not define a ''rural track'' or an ''integrated rural track,'' nor are these terms defined elsewhere in the Act or in any applicable regulations.

Currently, there are a number of accredited 3-year primary care residency programs in which residents train for 1 year of the program at an urban hospital and are then rotated for training for the other 2 years of the 3-year program to a rural facility(ies). These separately accredited ''rural track'' programs are recognized by the Accreditation Council of Graduate Medical Education (ACGME) as ''1–2'' rural track programs. As far as CMS is able to determine, ACGME is the only accrediting body to ''separately accredit'' rural track residency programs, a requirement specified in Pub. L. 106–113.

We implemented the rural track program provisions of section 1886(d)(5)(B) and 1886(h)(4)(H) of the Act to address these ''1–2'' programs and to account for other programs that are not specifically ''1–2'' programs but that include rural training components. As stated above, since there is no existing definition of ''rural track'' or ''integrated rural track,'' we define at § 413.86(b) a ''rural track'' and an ''integrated rural track'' as 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 to a rural nonhospital site(s). We have previously noted that the terms ''rural track'' and ''integrated rural track,'' for purposes of this definition, are synonymous.

To implement these provisions, we revised § 413.86 to add paragraph (g)(11) (since redesignated as (g)(12)), and § 412.105 to add paragraph (f)(1)(x) to specify that, for direct GME, for cost reporting periods beginning on or after April 1, 2000, or, for IME, for discharges occurring on or after April 1, 2000, 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, under certain circumstances, include in its FTE count residents in those rural tracks, in addition to the residents subject to the FTE cap at § 413.86(g)(4). (See the August 1, 2000 interim final rule with comment period (65 FR 47033) and the August 1, 2001 IPPS final rule (66 FR 39902)). These regulations specify that an urban hospital may count the residents in the rural track in excess of the hospital's FTE cap up to a ''rural track FTE limitation'' for that hospital. We defined this rural track FTE limitation at § 413.86(b) as the maximum number of residents (as specified in § 413.86(g)(12)) training in a rural track residency program that an urban hospital may include in its FTE count, in addition to the number of FTE residents already included in the hospital's FTE cap.

Generally, the rural track policy is divided into two categories: rural track programs in which residents are rotated to a rural area for at least two-thirds of the duration of the program; and rural track programs in which residents are rotated to a rural area for less than two-thirds of the duration of the program. Currently, family practice is the only specialty that has separately accredited rural track programs. As previously noted, to account for other specialties that have program lengths greater than

or less than 3 years, or that are not ''1–2'' programs, but may establish separately accredited rural track residency programs that are longer than 3 years, our regulations specify that residents must train in the rural area for ''two-thirds of the duration of the program,'' rather than ''2 out of 3 program years,'' in order for the urban hospital to count FTEs in the rural track (up to the rural track FTE limitation) in addition to the residents included in the hospital's FTE limitation. Thus, for example, under current policy, if a surgery program, which is a 5-year program, were to establish a separately accredited rural track, the urban hospital must rotate the surgery residents to the rural area for at least two-thirds of the duration of the 5-year program in order to qualify to count those FTEs in excess of the hospital's FTE cap, as provided in § 413.86(g)(12) and § 412.105(f)(1)(x).

Accordingly, our policy for determining whether an urban hospital qualifies for an adjustment to the FTE cap for training residents in rural areas is dependent upon the proportion of time the residents spend training in the rural areas. If the time spent training in rural areas (either at a rural hospital or a rural nonhospital site) constitutes *at least two-thirds* of the duration of the program, then the urban hospital may include the time the residents train *at that urban hospital* in determining GME payments. However, if the urban hospital rotates residents to rural areas for a period of time that is *less than two-thirds* of the duration of the program, although the rural hospital may count the time the residents train at the rural hospital if the program is new, the urban hospital may *not* include the time the residents train at the urban hospital for GME payment purposes (unless it can do so within the hospital's FTE cap).

When we first implemented this policy on rural tracks, it was consistent with our understanding of how the ACGME accredits rural track ''1–2'' programs, in which residents train for 1 year of the program at an urban hospital and are then rotated for training years 2 and 3 to a rural facility. We believed that the ACGME did not separately accredit an approved program as a rural track program unless it met this ''1–2'' condition; that is, the residents were spending one-third of program training in the urban area and two-thirds of the program training in the rural area. However, we have recently learned that there are a few rural track programs that are separately accredited by the ACGME as ''1–2'' rural track programs, but the residents in these programs are not training in rural areas for at least two-thirds of the duration of the program. We understand that in certain instances in which the case-mix of the rural facilities might not be sufficiently broad to provide the residents with an acceptable range of training opportunities, the ACGME allows the residents in program years 2 and 3 to return to the urban hospital for some training in both years. However, because the training in years 2 and 3 is predominantly occurring at the rural locations, the ACGME still separately accredits the urban and rural portions as a ''1–2'' program.

The existing regulations at §§ 412.105(f)(1)(x) and 413.86(g)(12) specify two main criteria for an urban hospital to count the time spent by residents training in a rural track while at the urban hospital in excess of the hospital's FTE limitation: (1) The program must be separately accredited by the ACGME; *and* (2) the time spent training in rural areas (either at a rural hospital or a rural nonhospital site) must constitute *at least two-thirds* of the duration of the program.

We believe that an urban hospital that operates a program that is separately accredited by the ACGME as a ''1–2'' program, but in which residents train in rural areas for more than half but less than two-thirds of the duration of the program, should still be allowed to count those FTE residents for GME payment purposes. Therefore, to be consistent with the ACGME accreditation practices, we are proposing to revise our regulations. Proposed § 413.86(g)(12) would still address our policy that an urban hospital qualifies for an adjustment to the FTE cap for training in rural areas based upon the proportion of time the residents spend training in the rural areas. However, instead of using a ''two-thirds'' model to specify the amount of time residents are training in the rural areas, as the framework exists under current policy, the proposal would use, at §§ 413.86(g)(12)(i) through (iv), a ''one-half of the time'' model to specify the amount of time residents are training in rural areas. This proposal would address the limited cases where ACGME separately accredits programs as ''1–2'' rural tracks but residents in those programs train in the rural areas less than two-thirds of the time, although greater than one-half of the time. Specifically, we are proposing at § 413.86(g)(12) to state:

- 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.
- 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 § 413.86(f)(4).
- 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, 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, the rural hospital may not include those residents it its FTE count (if the rural track is not a new program under § 413.86(g)(6)(iii), 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.
- If an urban hospital rotates residents in the rural track program to a rural nonhospital site(s) for a period of time 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, the urban hospital may include those residents in its FTE count, subject to the requirements under § 413.86(f)(4).

We also are proposing to make a conforming change to § 412.105(f)(1)(x) to make these proposed provisions applicable to IME payments for discharges occurring on or after October 1, 2003.

We believe this proposal produces a more equitable result than the existing policy; the proposal encompasses what we believe to be all situations in which the ACGME separately accredits rural track programs and in which residents in the programs spend a majority of the time training in rural settings, fulfilling the intent of Congress for Medicare to

provide GME payments for significant rural residency training.

b. Inclusion of Rural Track FTE Residents in the Rolling Average Calculation. Section 1886(h)(4)(G) of the Act, as added by section 4623 of Public Law 105–33, provides that, for a hospital's first cost reporting period beginning on or after October 1, 1997, the hospital's FTE resident count for direct GME payment purposes equals the average of the actual FTE resident count for that cost reporting period and the preceding cost reporting period. Section 1886(h)(4)(G) of the Act requires that, for cost reporting periods beginning on or after October 1, 1998, a hospital's FTE resident count for direct GME payment purposes equals the average of the actual FTE resident count for the cost reporting period and the preceding two cost reporting periods (that is, a 3-year rolling average). This provision phases in over a 3-year period any reduction in direct GME payments to hospitals that results from a reduction in the number of FTE residents below the number allowed by the FTE cap. We first implemented this provision in the August 29, 1997 final rule with comment period (62 FR 46004) and revised § 413.86(g)(5) accordingly. Because hospitals may have two PRAs, one for residents in primary care and obstetrics and gynecology (the ''primary care PRA''), and a lower PRA for nonprimary care residents, we revised our policy for computing the rolling average for direct GME payment purposes (*not* for IME) in the August 1, 2001 final rule (66 FR 39893) to create two separate rolling averages, one for primary care and obstetrics and gynecology residents (the ''primary care rolling average''), and one for nonprimary care residents. Effective for cost reporting periods beginning on or after October 1, 2001, direct GME payments are calculated based on the sum of: (1) The product of the primary care PRA and the primary care rolling average; and (2) the product of the nonprimary care PRA and the nonprimary care FTE rolling average. (This sum is then multiplied by the Medicare patient load to determine Medicare direct GME payments).

Section 407(c) of Public Law 106–113, which amended sections 1886(d)(5)(B) and 1886(h)(4)(H) of the Act to create the rural track provision, provided that, in the case of an urban hospital that establishes a separately accredited rural track, ''* * * the Secretary shall *adjust the limitation under subparagraph (F)* in an appropriate manner insofar as it applies to such programs in such rural areas in order to encourage the training of physicians in rural areas'' (emphasis added). Subparagraph (F) of the Act is the provision that establishes a cap on the number of allopathic and osteopathic FTE residents that may be counted at each hospital for Medicare direct GME payment purposes. Thus, the provision authorizes the Secretary to allow for an increase to an urban hospital's FTE cap on allopathic and osteopathic residents in certain instances when an urban hospital establishes a rural track program. Although the rural track provision effectively allows an increase to the urban hospital's FTE cap by adjusting the FTE limitation under subparagraph (F), the statute makes no reference to subparagraph (G), the provision concerning the rolling average count of residents. That is, the statute does not provide for an exclusion from the rolling average for the urban hospital for those FTE residents training in a rural track.

Since we implemented this rural track provision in the August 1, 2000 interim final rule with comment period (65 FR 47033), we have interpreted this provision to mean that, except for new rural track programs begun by urban teaching hospitals that are establishing an FTE cap for the first time under § 413.86(g)(6)(i), when an urban hospital establishes a new rural track program or expands an existing rural track program, FTE residents in the rural track that are counted by the urban hospital are included in the hospital's rolling average calculation immediately. Although we have not specified in the regulations that rural track FTE residents counted by an urban hospital are included in the hospital's rolling average FTE resident count, this has been our policy. The Medicare cost report, Form CMS–2552–96 (line 3.05 on Worksheet E, Part A, for IME payments, and on line 3.02 on Worksheet E–3, Part IV, for direct GME payments), reflects this policy. Accordingly, FTE residents in a rural track program are to be included in the urban hospital's rolling average count for IME and direct GME for cost reporting periods beginning on or after April 1, 2000.

We are proposing to revise the regulations at § 413.86(g)(5) to add a new paragraph (vii) to clarify that, subject to regulations at § 413.86(g)(12), except for new rural track programs begun by urban hospitals that are first establishing an FTE cap under § 413.86(g)(6)(i), when an urban hospital with an existing FTE cap establishes a new program with a rural track (or an integrated rural track), or expands an existing rural track (or an integrated rural track) program, the FTE residents in that program that are counted by the urban hospital are included in the urban hospital's rolling average FTE resident count immediately. We also are proposing to revise §§ 413.86(g)(12)(i)(A), (g)(12)(ii)(B), and (g)(12)(iv)(A) to indicate that 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, training in the rural track at the urban hospital.

4. Technical Change Relating to Affiliated Groups and Affiliation Agreements

Section 1886(h)(4)(H)(ii) of the Act permits, but does not require, the Secretary to prescribe rules that allow institutions that are members of the same affiliated group (as defined by the Secretary) to elect to apply the FTE resident limit on an aggregate basis. This provision allows the Secretary to give hospitals flexibility in structuring rotations within a combined cap when they share a resident's time. Consistent with the broad authority conferred by the statute, we established criteria for defining an ''affiliated group'' and an ''affiliation agreement'' in both the August 29, 1997 final rule (62 FR 45965) and the May 12, 1998 final rule (63 FR 26317). We further clarified our policy concerning affiliation agreements in the August 1, 2002 final rule (67 FR 50069).

We are aware that there has been some confusion at times among members of the provider community when using the term ''affiliation agreement,'' since the term is used in contexts other than for Medicare GME payment purposes. For example, an ''affiliation agreement'' is a term historically used in the academic community that generally relates to agreements made between hospitals and medical schools or among sponsors of medical residency education programs. To help prevent further confusion, we are proposing to change the term in the regulations to ''Medicare GME affiliation agreement.'' We believe this will help to distinguish these agreements used for purposes of GME payments from agreements used for other purposes in the provider community. We are proposing to revise the regulations at § 413.86(b) to state ''Medicare GME affiliated group,'' and ''Medicare GME affiliation agreement,'' and we are making similar revisions to § 413.86(g)(4)(iv), (g)(7)(i) through (v), and § 412.105(f)(1)(vi) for IME payment purposes.

G. Notification of Updates to the Reasonable Compensation Equivalent (RCE) Limits (§ 415.70)

1. Background

Under the Medicare program, payment for services furnished by a physician is made under either the Hospital Insurance Program (Part A) or the Supplementary Medical Insurance Program (Part B), depending on the type of services furnished. In accordance with section 1848 of the Act, physicians' charges for medical or surgical services to individual Medicare patients generally are covered under Part B on a fee-for-service basis under the Medicare physician fee schedule. The compensation that physicians receive from or through a provider for services that benefit patients generally (for example, administrative services, committee work, teaching, and supervision) can be covered under Part A or Part B, depending on the provider's setting.

As required by section 1887(a)(2)(B) of the Act, allowable compensation for services furnished by physicians to providers that are paid by Medicare on a reasonable cost basis is subject to reasonable compensation equivalent (RCE) limits. Under these limits, payment is determined based on the lower of the actual cost of the services to the provider (that is, any form of compensation to the physician) or a reasonable compensation equivalent. For purposes of applying the RCE limits, physician compensation costs means monetary payments, fringe benefits, deferred compensation and any other items of value (excluding office space or billing and collection services) that a provider or other organization furnishes a physician in return for the physician's services.

The RCE limits do not apply to the costs of physician compensation that are attributable to furnishing inpatient hospital services paid for under the IPPS or GME costs. In addition, RCE limits do not apply to the costs CAHs incur in compensating physicians for services. Furthermore, compensation that a physician receives for activities that may not be paid for under either Part A or Part B are not considered in applying the RCE limits.

The limits apply equally to all physician services to providers that are payable on a reasonable cost basis under Medicare. If a physician receives any compensation from a provider for his or her physician services to the provider (that is, those services that benefit patients generally), payment to those affected providers for the costs of such compensation is subject to the RCE limits. The RCE limits are not applied to payment for services that are identifiable medical or surgical services to individual patients and paid for under the physician fee schedule, even if the physician agrees to accept compensation (for example, from a hospital) for those services. (However, payments to teaching hospitals that have elected to be paid for these services on a reasonable cost basis in accordance with section 1861(b)(7) of the Act are subject to the limits.)

Section 415.70(b) of the regulations specifies the methodology for determining annual RCE limits, considering average physician incomes by specialty and type of location, to the extent possible using the best available data. On October 31, 1997, the revised RCE limits update methodology was published in the **Federal Register** (62 FR 59075). For cost reporting periods beginning on or after January 1, 1998, updates to the RCE limits are calculated using the Medicare Economic Index (MEI). The inflation factor used to develop the initial RCE limits and, subsequently, to update those limits to reflect increases in net physician compensation was the Consumer Price Index for All Urban Consumers (CPI–U). In 1998, we revised the RCE limits update methodology by replacing the CPI–U with the physician fee schedule's inflation factor (the MEI), to achieve a measure of consistency in the methodologies employed to determine reasonable payments to physicians for direct medical and surgical services furnished to individual patients and reasonable compensation levels for physicians' services that benefit provider patients generally.

2. Publication of the Updated RCE Limits

We intend to publish updated payment limits on the amount of allowable compensation for services furnished by physicians to providers in the FY 2004 IPPS final rule. These revised limits will be mere updates that will be calculated by applying the most recent economic index data. We are not proposing any change in the methodology. Therefore, in accordance with § 415.70(f), we are allowed to publish the revised RCE limits in a final rule without prior publication of a proposed rule for public comment. Furthermore, we believe that publication of the revised RCE limits in a proposed rule with opportunity for public comment is unnecessary, and we find good cause to waive the procedure.

V. PPS for Capital-Related Costs

In this proposed rule, we are not proposing any changes in the policies governing the determination of the payment rates for capital-related costs for short-term acute care hospitals under the IPPS. However, for the readers' benefit, in this section of this proposed rule, we are providing a summary of the statutory basis for the PPS for hospital capital-related costs, the methodology used to determine capital-related payments to hospitals, and a brief description of the payment policies under the PPS for capital-related costs for new hospitals, extraordinary circumstances, and exception (regular and special) payments. (Refer to the August 1, 2001 IPPS final rule (66 FR 39910) for a more 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 regular and special exceptions payments.)

Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of inpatient 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 capital PPS 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. Beginning in FY 2002, capital PPS payments are based solely on the Federal rate for the vast majority of hospitals. The basic methodology for determining capital prospective payments based on 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) × (Geographic Adjustment Factor (GAF)) × (Large Urban Add-on, if applicable) × (COLA Adjustment for hospitals located in Alaska and Hawaii) × (1 + DSH Adjustment Factor + IME Adjustment Factor, if applicable)

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

During the 10-year transition period, a new hospital (as defined at 412.300(b)) 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. As we discussed in the August 1, 2002 final rule (67 FR 50101), this payment provision was implemented to provide special protection to new hospitals during the transition period in response to concerns that prospective payments under a DRG system may not be adequate initially to cover the capital costs of newly built hospitals. Therefore, we believe that the rationale for this policy applies to new hospitals after the transition period as well, and in that same final rule, we established regulations under § 412.304(c)(2) that provide the same special payment to new hospitals for cost reporting periods beginning on or after October 1, 2002. Therefore, 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. (For more detailed information regarding this policy, see the August 1, 2002 IPPS final rule (67 FR 50101).)

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 established for hospitals during the 10-year transition period, but we established regulations at § 412.312(e) to specify that payment for extraordinary circumstances is also made for cost reporting periods after the transition period (that is, cost reporting periods beginning on or after October 1, 2001). (For more detailed information regarding this policy, refer to the August 1, 2002 **Federal Register** (67 FR 50102).)

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 of a percentage of its Medicare allowable capital-related costs depending on the class of hospital (§ 412.348(c)). However, after the end of the transition period, eligible hospitals can receive additional payments under the special exceptions provisions at § 412.348(g), which guarantees an eligible hospital a minimum payment of 70 percent of its Medicare allowable capital-related costs. Special exceptions payments may be made only for the 10 years after the cost reporting year in which the hospital completes its qualifying project, which can be 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).)

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))

1. Payments to Existing Excluded Hospitals and Hospital Units

Section 1886(b)(3)(H) of the Act (as amended by section 4414 of Pub. L. 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 apply 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, these excluded hospitals and hospital 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. The ceiling would be 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 100 percent of the 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 DRG-based PPS. As part of this process for LTCHs, we established a 5-year transition period from reasonable cost-based reimbursement to a fully Federal PPS. However, a LTCH, subject to the blend methodology, may elect to be paid based on a 100 percent of the Federal prospective rate. (Sections VII.A.3. and 4. of this preamble contain for a more detailed discussion of the IRF PPS and the LTCH PPS.)

2. Updated Caps for New Excluded Hospitals and Units

Section 1886(b)(7) of the Act establishes a payment limitation for new psychiatric hospitals and units, new rehabilitation hospitals and units, and new LTCHs. 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 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 third period, updated by the applicable hospital market basket increase percentage.

The proposed amounts included in the following table reflect the updated 110 percent of the national median target amounts of new excluded psychiatric hospitals and units for cost reporting periods beginning during FY 2004. These figures are updated with the most recent data available to reflect the projected market basket increase percentage of 3.5 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	FY 2004 proposed labor-related share	FY 2004 proposed nonlabor-related share
Psychiatric	$7,301	$2,902

Effective for cost reporting periods beginning on or after October 1, 2002, this payment limitation is no longer applicable to new LTCHs because they are paid 100 percent of the Federal rate. Under the LTCH PPS, a new LTCH is defined as a provider of inpatient hospital services that meets the qualifying criteria for LTCHs specified under § 412.23(e)(1) and (e)(2) and whose first cost reporting period as a LTCH begins on or after October 1, 2002 (§ 412.23(e)(4)). (We note that this definition of new LTCHs should not be confused with those LTCHs first paid under the TEFRA payment system for discharges occurring on or after October 1, 1997, and before October 1, 2002.) New LTCHs are paid 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. 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). 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, because 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 for new LTCHs.

Effective for cost reporting periods beginning on or after October 1, 2002, this payment limitation is 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 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. Under the IRF PPS, for cost reporting periods beginning on or after January 1, 2002, and before October 1, 2002, payment consisted of 33⅓ percent of the facility-specific payment amount (based on the reasonable cost-based reimbursement methodology) and 66⅔ percent of the adjusted Federal prospective payment. 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.

As part of the implementation of the system, we established a 5-year transition period from reasonable cost-based reimbursement to the fully Federal prospective rate. A blend of the reasonable cost-based reimbursement percentage and the prospective payment Federal rate percentage would be used to determine a LTCH's total payment under the LTCH PPS during the transition period. Certain LTCHs may elect to be paid based on 100 percent of the Federal prospective rate. All LTCHs will be paid under the fully Federal prospective rate for cost reporting periods beginning on or after October 1, 2006.

B. Payment for Services Furnished at Hospitals-Within-Hospitals and Satellite Facilities

Existing regulations at § 412.22(e) define a hospital-within-a-hospital as a hospital that occupies space in the same building as another hospital, or in one or more entire 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.

Sections 412.22(h) and 412.25(e), relating to satellites of hospitals and hospital units, respectively, excluded from the IPPS, define a satellite facility as a part of a hospital or unit that provides inpatient services 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. Sections 412.22(h)(3) and 412.25(e)(3) provide for the grandfathering of excluded hospitals and units that were structured as satellite facilities on September 30, 1999, to the extent they operate under

the same terms and conditions in effect on that date.

In providing for the grandfathering of satellite facilities of hospitals and hospital units, we believed it was appropriate to require that the satellite facilities operate under the same terms and conditions that were in effect on September 30, 1999. There are similarities between the definition of the two types of satellite facilities and the definition of hospitals-within-hospitals (that is, hospitals-within-hospitals and satellite facilities are both physically located in acute care hospitals that are paid for their inpatient services on a prospective payment basis). Also, satellite facilities of both excluded hospitals and hospital units and hospitals-within-hospitals provide inpatient hospital services that are paid at a higher rate than would apply if the facilities were treated by Medicare as part of an acute care hospital.

We are proposing to revise § 412.22(f) to specify that, effective with cost reporting periods beginning on or after October 1, 2003, a hospital operating as a hospital-within-a-hospital on or before September 30, 1995, is exempt from the criteria in § 412.22(e)(1) through (e)(5) only if the hospital-within-a-hospital continues to operate under the same terms and conditions in effect as of September 30, 1995. The intent of the ''grandfathering'' provision was to ensure that hospitals that had been in existence prior to the effective date of our hospital-within-hospital requirements should not be adversely affected by those requirements. To the extent hospitals were already operating as hospitals-within-hospitals without meeting those requirements, we believe it is appropriate to limit the ''grandfathering'' provision to those hospitals that continue to operate in the same manner as they had operated prior to the effective date of those rules. However, if a hospital changes the way it operates (for example, adds more beds) subsequent to the effective date of the new rules, it should no longer receive the benefit of the ''grandfathering'' provision.

Under § 412.22(e), we specify the criteria that a hospital-within-a-hospital is required to meet in order to be excluded from the IPPS. One of these criteria, under § 412.22(e)(5)(i), requires that a hospital-within-a-hospital is able to perform basic hospital functions (for example, medical record services and nursing services) that are presently included in the Medicare hospital conditions of participation under Part 482 of the Medicare regulations. These requirements were first included in Part 412 in response to hospitals organizing themselves as what is referred to as the hospital-within-a-hospital model. Thus, to avoid recognizing nominal hospitals, while allowing hospitals adequate flexibility and opportunity for legitimate networking and sharing of services, we included, by reference, certain hospital conditions of participation as additional criteria in part 412 for hospitals-within-hospitals that request exclusion from the IPPS. (Further discussion can be found in a final rule published in the **Federal Register** on September 1, 1994 (59 FR 45389).) Modifications to the conditions of participation have been made since the publication of that September 1, 1994 final rule. Thus, we need to update the references to the conditions of participation in § 412.22(e)(5)(i) to make them consistent with existing provisions under the basic hospital conditions of participation. Therefore, we are proposing to amend § 412.22(e)(5)(i) to add references to § 482.43 (discharge planning) and § 482.45 (organ, tissue, and eye procurement) as basic hospital functions that a hospital-within-a-hospital would also be required to meet.

C. Clarification of Classification Requirements for LTCHs

Under § 412.23(e)(2), to qualify to be excluded from the IPPS as a LTCH and to be paid under the LTCH PPS, a hospital must have an average Medicare length of stay of greater than 25 days (which includes all covered and noncovered days of stay for Medicare patients) as calculated under the criteria of § 412.23(e)(3). In calculating this average Medicare inpatient length of stay, data from the hospital's most recently filed cost report are used to make this determination. However, if the hospital has not yet filed a cost report or if there is an indication that the most recently filed cost report does not accurately reflect the hospital's current Medicare average length of stay, data from the most recent 6-month period are used.

Our interpretation of § 412.23(e)(3)(ii) and (e)(3)(iii) was to allow hospitals that submit data for purposes of exclusion from the IPPS to use a period of at least 5 months of the most recent data from the preceding 6-month period. This longstanding policy interpretation was necessary in order to comply with the time requirement in § 412.22(d) that specifies that, for purposes of the IPPS, status is determined at the beginning of each cost reporting period and is effective for the entire cost reporting period. Therefore, we are proposing to revise §§ 412.23(e)(3)(ii) and (iii) to reflect our longstanding interpretation of the regulations.

D. Criteria for Payment on a Reasonable Cost Basis for Clinical Diagnostic Laboratory Services Performed by CAHs

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. Section 1834(g) of the Act states that the amount of payment for outpatient services furnished by a CAH will be the reasonable costs of the CAH in providing these services.

Regulations implementing section 1834(g) of the Act are set forth at § 413.70. These regulations state, in paragraph (b)(2)(iii), that payment to a CAH for outpatient clinical diagnostic laboratory tests will be made on a reasonable cost basis only if the individuals for whom the tests are performed are outpatients of the CAH, as defined in 42 CFR 410.2, at the time the specimens are collected. The regulations also state that clinical diagnostic laboratory tests for persons who are not patients of the CAH at the time the specimens are collected will be paid for in accordance with the provisions of sections 1833(a)(1)(D) and 1833(a)(2)(D) of the Act. These provisions, which also are the basis for payment for clinical diagnostic laboratory tests performed by independent laboratories and by hospitals on specimens drawn at other locations, set payment at the least of: (1) Charges determined under the fee schedule as set forth in section 1833(h)(1) or section 1834(d)(1) of the Act; (2) the limitation amount for that test determined under section 1833(h)(4)(B) of the Act; or (3) a negotiated rate established under section 1833(h)(6) of the Act. Payments determined under this methodology are typically referred to as ''fee schedule payments,'' and are so described here both for ease of reference and to differentiate them from payments determined on a reasonable cost basis.

The definition of an ''outpatient'' in 42 CFR 410.2 states that an outpatient means a person who has not been admitted as an inpatient but who is registered on hospital or CAH records as an outpatient and receives services (rather than supplies alone) directly from the hospital or CAH.

Recently, we have received numerous questions about how Medicare pays for laboratory services that a CAH may furnish to Medicare beneficiaries in various settings other than the CAH.

Specifically, the questioners have asked whether a CAH may obtain reasonable cost payment for such services to individuals in other locations by sending a CAH employee into the setting and registering the individual as a CAH patient while the blood is drawn or other specimen collection is accomplished. The settings that have been referred to most frequently are: (1) A rural health clinic (RHC), especially one that is provider-based with respect to the CAH; (2) the individual's home; and (3) a SNF.

We have considered these suggestions and understand the position taken by those who believe that nominal compliance with the requirements for outpatient status should be enough to warrant reasonable cost payment for clinical diagnostic laboratory tests for individuals at locations outside the CAH. However, we do not agree that providing reasonable cost payment under these circumstances would be appropriate. On the contrary, we believe that extending reasonable cost payment for services furnished to individuals who are not at the CAH when the specimen is drawn would duplicate existing coverage, create confusion for beneficiaries and others by blurring the distinction between CAHs and other providers, such as SNFs and HHAs, and increase the costs of care to Medicare patients without enhancing either the quality or the availability of that care.

To clarify our policies in this area and avoid possible misunderstandings about the scope of the CAH benefit, we are proposing to revise § 413.70(b)(2)(iii) to state that payment to a CAH for outpatient clinical diagnostic laboratory tests will be made on a reasonable cost basis only if the individuals for whom the tests are performed are outpatients of the CAH, as defined in 42 CFR 410.2, ''and are physically present in the CAH'' at the time the specimens are collected. (We note that, in some cases, the CAH outpatients from whom specimens are collected at the CAH may include individuals referred to the CAH from RHCs or other facilities to receive the tests.) We are proposing to further revise this paragraph to state that clinical diagnostic laboratory tests for individuals who do not meet these criteria but meet other applicable requirements will be paid for only in accordance with the provisions of sections 1833(a)(1)(D) and 1833(a)(2)(D) of the Act, that is, payment will be made only on a fee schedule basis. By making the second proposed change, we wish to emphasize that this proposal does not mean that no payment would be made for clinical diagnostic laboratory tests performed by CAHs that do not meet the revised criteria. On the contrary, such tests would be paid, but on a fee schedule basis. We believe these clarifications are appropriate, as the CAH is not providing CAH services but is acting as an independent laboratory in providing these clinical diagnostic laboratory tests.

E. Technical Change

On July 30, 1999, we published in the **Federal Register** a final rule (64 FR 41532) that set forth criteria for a satellite facility of a hospital or hospital unit to be excluded from the IPPS under § 412.25. Section 412.25(e)(3) of the regulations specifies that any unit structured as a satellite facility on September 30, 1999, and excluded from the IPPS on that date, is grandfathered as an excluded hospital to the extent that the unit continues operating under the same terms and conditions, including the number of beds and square footage considered to be part of the unit, in effect on September 30, 1999, except as we specified in § 412.25(e)(4). When we specified the exception for the number of beds and square footage requirement under § 412.25(e)(4), we inadvertently referred to paragraph (e)(4) as being an exception to paragraph (h)(3). We should have specified that it was an exception to paragraph (e)(3). We are proposing to correct this reference.

VII. MedPAC Recommendations

We are required by section 1886(e)(4)(B) of the Act to respond to MedPAC's IPPS recommendations in our annual proposed rule. We have reviewed MedPAC's March 1, 2003 ''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: *http://www.medpac.gov.*

MedPAC's Recommendation 2A–6 concerning the update factor for inpatient hospital operating costs and for hospitals and distinct-part hospital units excluded from the IPPS is discussed in Appendix C to this proposed rule. MedPAC's other recommendations relating to payments for Medicare inpatient hospital services focused mainly on the expansion of DRGs subject to the postacute care transfer policy, a reevaluation of the labor-related share of the market basket used in determining the hospital wage index, an increase in the DSH adjustment, and payments to rural hospitals. These recommendations and our responses are set forth below:

Recommendation 2A–1: The Secretary should add 13 DRGs to the postacute transfer policy in FY 2004 and then evaluate the effects on hospitals and beneficiaries before proposing further expansions.

Response: We are proposing to expand the postacute care transfer policy to 19 additional DRGs for FY 2004. A thorough discussion of this proposal, including a summary of MedPAC's analysis, can be found at section IV.A.3. of this preamble.

Recommendation 2A–2: The Congress should enact a low-volume adjustment to the rates used in the inpatient PPS. This adjustment should apply only to hospitals that are more than 15 miles from another facility offering acute inpatient care.

Response: MedPAC's analysis ''revealed that hospitals with a small volume of total discharges have higher costs per discharge than larger facilities, after controlling for the other cost-related factors recognized in the payment system.'' Although there are special payment protections for some rural hospitals such as CAHs, SCHs, and MDHs, MedPAC believes these provisions do not sufficiently target hospitals with low discharge volume.

This recommendation, which MedPAC estimates would increase Medicare payments to hospitals by less than $50 million in FY 2004, and others requiring Congressional action, should be considered in the context of larger discussions within Congress and between Congress and the Administration regarding Medicare reform and payment refinements. Therefore, we are not responding specifically to MedPAC's recommendation regarding a low-volume adjustment to the IPPS payments at this time.

Recommendation 2A–3: The Secretary should reevaluate the labor share used in the wage index system that geographically adjusts rates in the inpatient PPS, with any resulting change phased in over 2 years.

Response: CMS defines the labor-related share to include costs that are likely related to, influenced by, or vary with local labor markets, even if they could be purchased in a national market. Since the implementation of the IPPS, the labor-related share has been determined by adding together the cost weights from categories in the hospital market basket that are influenced by local labor markets. When the hospital market basket weights are updated or rebased, the labor-related share is updated. The estimate of the labor-

related share using the most recently revised and rebased hospital market basket (1997-based) is 72.495 percent. This was the labor-related share proposed in the FY 2003 proposed rule.

In the August 1, 2002 IPPS final rule, we elected to continue to use 71.066 percent as the labor-related share applicable to the standardized amounts (67 FR 50041). At that time, we indicated that we would conduct further analysis to determine the most appropriate methodology for the labor-related share.

We are not proposing to use the updated labor-related share at this time because we have not yet completed our research into the appropriateness of this measure. Specifically, we are currently reviewing the labor-related share in two ways. First, we are updating the regression analysis that was done when the IPPS was originally developed, with the expectation that it would help give an alternative indication of the labor-related share. Second, we are reevaluating the methodology we currently use for determining the labor-related share using the hospital market basket.

Our regression analysis attempts to explain the variation in operating cost per case for a given year using many different explanatory variables, such as case-mix, DSH status, and ownership type. We described this methodology and some of our initial results in the May 9, 2002 **Federal Register** (67 FR 31447–31479). When included in the regression, the area wage index produces a coefficient that can be interpreted as the proportion of operating costs that vary with the geographic location of the hospital. The latest results on 1997 data produced a coefficient for the area wage index of 0.621, which can be interpreted as a labor share of 62.1 percent and is very close to the results reached by other groups. However, using the same specification produced coefficients of 76.7 percent for rural hospitals and 47.6 percent for urban hospitals, a disparity that cannot be supported either by theory or existing cost data. For example, the proportion of costs accounted for by wages, benefits, and contract labor is 60.8 percent for urban hospitals and 62.3 percent for rural hospitals, a spread much smaller than the regressions indicate. In addition, when the regressions were run separately by case-mix quartile and with hospital-specific wage variation (as opposed to using the area wage index), the findings were both difficult to explain and inconsistent with the underlying cost data. Thus, we believe at this point that the regression results are not robust enough to support changing the current labor-related share measurement.

A second approach was to reevaluate our methodology for determining the labor-related share using the hospital market basket. We have researched various alternative data sources for further breaking down the cost categories in the market basket and have begun to evaluate alternative methodologies. While each of these alternatives has strengths and weaknesses, it is not clear at this point that any one alternative is superior to the current methodology. We want to continue researching these alternatives, in part, because changing from the current methodology would impact the labor-related shares for SNFs, HHAs, and all of the excluded hospital payment systems, since they use a similar methodology. Our research plan includes consulting with experts on these issues, including MedPAC, to evaluate the various alternative approaches to determining the labor-related share. We plan to invite public comments on any proposed change to the labor-related share.

In conclusion, we are proposing to continue using the 71.066 percent labor-related share that was calculated from the 1992-based market basket until we have completed our research.

Recommendation 2A–4: The Congress should raise the inpatient base rate for hospitals in rural and other urban areas to the level of the rate for those in large urban areas, phased in over 2 years.

Response: This recommendation, which MedPAC estimates would increase Medicare payments to hospitals by between $200 and $600 million in FY 2004, and others requiring Congressional action, should be considered in the context of larger discussions within Congress and between Congress and the Administration regarding Medicare reform and payment refinements. Therefore, we are not responding specifically to MedPAC's recommendation regarding raising the base rate for hospitals in rural and other urban areas at this time.

Recommendation 2A–5: The Congress should raise the cap on the disproportionate share add-on a hospital can receive in the inpatient PPS from 5.25 percent to 10 percent, phased in over 2 years.

Response: This recommendation, which MedPAC estimates would increase Medicare payments to hospitals by between $50 and $200 million in FY 2004, and others requiring Congressional action, should be considered in the context of larger discussions within Congress and between Congress and the Administration regarding Medicare reform and payment refinements. Therefore, we are not responding specifically to MedPAC's recommendation regarding raising the maximum DSH adjustments at this time.

VIII. 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, PO 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 2000 used to create the proposed FY 2004 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
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 2004 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 2004 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 Area (MSA).

Media: Diskette/Internet.

File Cost: $165.00 per year.

Periods Available: FY 2004 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 2004 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	1010/01/87	10/01/88
PPS–VI	1010/01/88	10/01/89
PPS–VII	1010/01/89	10/01/90
PPS–VIII	1010/01/90	10/01/91
PPS–IX	1010/01/91	10/01/92
PPS–X	1010/01/92	10/01/93
PPS–XI	1010/01/93	10/01/94
PPS–XII	1010/01/94	10/01/95

(**Note:** The PPS–XIII, PPS–XIV, PPS–XV, PPS–XVI, PPS–XVII, and PPS–XVIII Minimum Data Sets are part of the PPS–XIII, PPS–XIV, PPS–XV, PPS–XVI, PPS–XVII, and PPS–XVIII Hospital Data Set Files (refer to item 9 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, and PPS–XVIII Capital Data Sets are part of the PPS–XIII, PPS–XIV, PPS–XV, PPS–XVI, PPS–XVII, and PPS–XVIII Hospital Data Set Files (refer to item 9 below).)

7. PPS–XIII to PPS–XVIII 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

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 2004 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 2004.

10. DRG Relative Weights (Formerly Table 5 DRG)

This file contains a listing of DRGs, DRG narrative description, 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 2004 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 2004 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 2004 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 Area (MSA). 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 2004 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 Stephen Phillips at (410) 786–4548.

B. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

List of Subjects

42 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.

For the reasons stated in the preamble of this proposed rule, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV 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 412.4 is amended by—

A. Revising paragraphs (b), (c), and (d).

B. In paragraph (f)(1), revising the reference ''paragraph (b)(1) or (c)'' to read ''paragraph (b) or (c)''.

The revisions read as follows:

§ 412.4 Discharges and transfers.

* * * * *

(b) *Acute care transfers.* A discharge of a hospital inpatient is considered to be a transfer for purposes of payment under this part if the patient is readmitted the same day (unless the readmission is unrelated to the initial discharge) to another hospital that is—

(1) Paid under the prospective payment system described in subparts A through M of this part; or

(2) Excluded from being paid under the prospective payment system described in subparts A through M of this part because of participation in an approved statewide cost control program as described in subpart C of part 403 of this chapter.

(c) *Postacute care transfers.* A discharge of a hospital inpatient is considered to be a transfer for purposes of this part when the patient's discharge is assigned, as described in § 412.60(c), to one of the qualifying diagnosis-related groups (DRGs) listed in paragraph (d) of this section and the discharge is made under any of the following circumstances:

(1) To a hospital or distinct part hospital unit excluded from the prospective payment system described in subparts A through M of this part under subpart B of this part.

(2) To a skilled nursing facility.

(3) To home under a written plan of care for the provision of home health services from a home health agency and those services begin within 3 days after the date of discharge.

(d) *Qualifying DRGs.* For purposes of paragraph (c) of this section, the qualifying DRGs are:

(1) For discharges occurring on or after October 1, 1998, DRGs 14, 113, 209, 210, 211, 236, 263, 264, 429, and 483.

(2) For discharges occurring on or after October 1, 2003, the DRGs listed in paragraph (d)(1) of this section and DRGs 12, 24, 25, 89, 90, 121, 122, 130, 131, 239, 243, 277, 278, 296, 297, 320, 321, 462, and 468.

* * * * *

3. Section 412.22 is amended by:

A. Republishing the introductory text of paragraph (e)(5) and revising the first sentence of paragraph (e)(5)(i).

B. Revising paragraph (f).

The revisions read as follows:

§ 412.22 Excluded hospitals and hospital units: General rules.

* * * * *

(e) * * *

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

(i) 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.

* * *

(f) *Application for certain hospitals.* If a hospital was excluded from the prospective payment systems under the provisions of this section on or before September 30, 1995, and at that time occupied space in a building also used by another hospital, or in one or more buildings located on the same campus as buildings used by another hospital, the criteria in paragraph (e) of this section do not apply to the hospital. However, effective for cost reporting periods beginning on or after October 1, 2003, those hospitals-within-hospitals must continue to operate under the same terms and conditions, including the number of beds and square footage considered, for purposes of Medicare participation and payment, in effect on September 30, 1995.

* * * * *

4. Section 412.23 is amended by revising paragraphs (e)(3)(ii) and (e)(3)(iii) to read as follows:

§ 412.23 Excluded hospitals: Classifications.

* * * * *

(e) *Long-term care hospitals.* * * *

(3) *Calculation of average length of stay.* * * *

(ii) If a change in the hospital's Medicare average length of stay is indicated, the calculation is made by the same method for the period of at least 5 months of the immediately preceding 6-month period.

(iii) If a hospital has undergone a change of ownership (as described in § 489.18 of this chapter) at the start of a cost reporting period or at any time within the period of at least 5 months of the preceding 6-month period, the hospital may be excluded from the prospective payment system as a long-term care hospital for a cost reporting period if, for the period of at least 5 months of the 6 months immediately preceding the start of the period (including time before the change of ownership), the hospital has the required Medicare average length of stay, continuously operated as a hospital, and continuously participated as a hospital in Medicare.

* * * * *

§ 412.25 [Amended]

5. In § 412.25(e)(4), introductory text, the reference ''paragraph (h)(3) of this section'' is revised to read ''paragraph (e)(3) of this section''.

6. 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 set at 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.

7. Section 412.105 is amended by—

A. In paragraph (a)(1), introductory text, revising the phrase ''paragraph (f) of this section'' to read ''paragraphs (f) and (h) of this section''.

B. In paragraph (a)(1)(i), revising the phrase ''affiliated groups'' to read ''Medicare GME affiliated groups''.

C. Revising paragraph (b).

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

E. In paragraph (f)(1)(vi), revising the phrase ''affiliated group'' to read ''Medicare GME affiliated group''.

F. Revising paragraph (f)(1)(x).

The revisions and additions read as follows:

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

* * * * *

(b) *Determination of number of beds.* For purposes of this section, the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period and dividing that number by the number of days in the cost reporting period. This count excludes bed days associated with—

(1) Beds in any other units or wards where the level of care provided would not be payable under the acute care hospital inpatient prospective payment system;

(2) Beds in units unoccupied for the previous 3 months;

(3) Beds that could not be made available for inpatient occupancy within 24 hours.

(4) Beds in excluded distinct part hospital units;

(5) Beds otherwise countable under this section used for outpatient observation services (unless the patient is subsequently admitted for acute inpatient care), skilled nursing swing-bed services, or ancillary labor/delivery services;

(6) Beds or bassinets in the healthy newborn nursery; and

(7) Custodial care beds;

* * * * *

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

(v) * * * Subject to the provisions of paragraph (f)(1)(x) of this section, effective for cost reporting periods beginning on or after April 1, 2000, FTE residents in a rural track program are included in the urban hospital's rolling average calculation described in this paragraph (f)(1)(v).

* * * * *

(x) An urban hospital that establishes a new residency program (as defined in § 413.86(g)(13) of this subchapter), 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 accordance with the applicable provisions of § 413.86(g)(12) of this subchapter effective for discharges occurring on or after April 1, 2002 and before October 1, 2003, and the applicable provisions of § 413.86(g)(12) of this subchapter effective for discharges occurring on or after October 1, 2003.

* * * * *

7. Section 412.106 is amended by revising paragraphs (a)(1)(ii) and (b)(4)(i) to read as follows:

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

(a) General considerations. (1) * * *

(ii) For purposes of this section, the number of patient days in a hospital includes only those days attributable to units or wards of the hospital providing acute care services generally payable under the prospective payment system and excludes patient days associated with—

(A) Beds in excluded distinct part hospital units;

(B) Beds otherwise countable under this section used for outpatient observation services (unless the patient is subsequently admitted for acute inpatient care), skilled nursing swing-bed services, or ancillary labor/delivery services; and

(C) Beds in any other units or wards where the level of care provided would not be payable under the acute care hospital inpatient prospective payment system.

* * * * *

(b) *Determination of a hospital's disproportionate payment percentage.* * * *

(4) *Second computation.* * * *

(i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan or under a waiver authorized under section 1115(a)(2) of the Act on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.

* * * * *

8. In § 412.112, the introductory text is republished and a new paragraph (d) is added to read as follows:

§ 412.112 Payments determined on a per case basis.

A hospital is paid the following amounts on a per case basis.

* * * * *

(d) Additional payments for new medical services and technologies determined under subpart F of this part.

9. Section 412.116 is amended by revising paragraph (e) to read as follows:

§ 412.116 Method of payment.

* * * * *

(e) *Outlier payment and additional payments for new medical services and technologies.* Payments for outlier cases and additional payments for new medical services and technologies (described in subpart F of this part) are not made on an interim basis. These payments are made based on submitted bills and represent final payment.

* * * * *

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 413.70 is amended by revising paragraph (b)(2)(iii), introductory text, to read as follows:

§ 413.70 Payment for services of a CAH.

* * * * *

(b) *Payment for outpatient services furnished by CAH.* * * *

(2) *Reasonable costs for facility services.* * * *

(iii) Payment for outpatient clinical diagnostic laboratory tests is not subject to the Medicare Part B deductible and coinsurance amounts. Payment to a CAH for clinical diagnostic laboratory tests will be made on a reasonable cost basis under this section only if the individuals are outpatients of the CAH, as defined in § 410.2 of this chapter, and are physically present in the CAH, at the time the specimens are collected. Clinical diagnostic laboratory tests performed for persons who are not physically present in the CAH when the specimens are collected will be made in accordance with the provisions of sections 1833(a)(1)(D) and 1833(a)(2)(D) of the Social Security Act.

* * * * *

3. Section 413.85 is amended by—

A. Adding under paragraph (c) a definition of ''Certification'' in alphabetical order.

B. Republishing the introductory text of paragraph (d)(1) and adding a new paragraph (d)(1)(iii).

C. Adding a new paragraph (g)(3).

D. Republishing the introductory text of paragraph (h) and revising paragraph (h)(3).

The addition and revision read as follows.

§ 413.85 Cost of approved nursing and allied health education activities.

* * * * *

(c) *Definitions.* * * *

Certification means the ability to practice or begin employment in a specialty as a whole.

* * * * *

(d) *General payment rules.* (1) Payment for a provider's net cost of nursing and allied health education activities is determined on a reasonable cost basis, subject to the following conditions and limitations:

* * * * *

(iii) The costs of certain nonprovider-operated programs at wholly owned subsidiary educational institutions are reimbursable on a reasonable cost basis if the provisions of paragraph (g)(3) of this section are met.

* * * * *

(g) *Payments for certain nonprovider-operated programs.* * * *

(3) *Special rule: Payment for certain nonprovider-operated programs at wholly owned subsidiary educational institutions.*

(i) Effective for portions of cost reporting periods occurring on or after October 1, 2003, a provider that incurs costs for a nursing or allied health education program(s) where those program(s) had originally been provider-operated according to the criteria at paragraph (f) of this section, and then operation of the program(s) was transferred to a wholly owned subsidiary educational institution in order to meet accreditation standards prior to October 1, 2003, and where the provider has continuously incurred the costs of both the classroom and clinical training portions of the program(s) at the educational institution, may receive reasonable cost payment for such a program(s) according to the specifications under paragraphs (g)(3)(ii) and (g)(3)(iii) of this section.

(ii) Payment for the incurred costs of educational activities identified in paragraph (g)(3)(i) of this section will be made on a reasonable cost basis if a provider, as described in paragraph (g)(3)(i) of this section, received Medicare reasonable cost payment for those nursing and allied health education program(s) both prior and subsequent to the date the provider transferred operation of the program(s) to its wholly owned subsidiary educational institution (and ceased to be a provider-operated program(s) according to the criteria under paragraph (f) of this section).

(iii) The provider that meets the requirements in paragraphs (g)(3)(i) and (g)(3)(ii) of this section will be eligible to receive payment under this paragraph for: (A) the clinical training costs incurred for the program(s) as described in paragraph (g)(3)(i) of this section; and (B) classroom costs, but only those costs incurred by the provider for the courses that were included in the programs described in paragraph (g)(3)(i) of this section.

(h) *Activities treated as normal operating costs.* The costs of the following educational activities incurred by a provider but not operated by that provider are recognized only as normal operating costs and paid in accordance with the reimbursement principles specified in part 412 of this subchapter. They include:

* * * * *

(3) Educational seminars, workshops, and continuing education programs in which the employees participate that enhance the quality of medical care or operating efficiency of the provider and, effective October 1, 2003, do not lead to certification required to practice or begin employment in a nursing or allied health specialty.

* * * * *

4. Section 413.86 is amended by—

A. Under paragraph (b)—

(1) Removing the definitions of ''Affiliated group'' and ''Affiliation agreement''.

(2) Adding definitions of ''Community support'', ''Medicare GME affiliated agreement'', ''Medicare GME affiliated group'', and ''Redistribution of costs'' in alphabetical order.

(3) Under the definition of ''Rural track FTE limitation'', revising the phrase ''paragraph (g)(11)'' to read ''paragraph (g)(12)''.

B. Revising the introductory text of paragraph (f).

C. Adding a new paragraph (f)(4)(iv).

D. In paragraph (g)(1)(i), revising the reference ''paragraphs (g)(1)(ii) and (g)(1)(iii)'' to read ''paragraphs (g)(1)(ii) through (g)(1)(iv)''.

E. Revising the introductory text of paragraph (g)(4).

F. Revising paragraph (g)(4)(iv).

G. Revising the introductory text of paragraph (g)(5).

H. Adding a new paragraph (g)(5)(vii).

I. Revising paragraphs (g)(6)(i)(D) and (g)(6)(i)(E).

J. Revising paragraph (g)(7).

K. Revising the introductory text of paragraph(g)(12).

L. Revising paragraph (g)(12)(i).

M. Revising paragraph (g)(12)(ii), introductory text.

N. Revising paragraph (g)(12)(ii)(A).

O. Revising paragraph (g)(12)(ii)(B)(*1*)(*i*).

P. Revising paragraph (g)(12)(iii).

Q. Revising paragraph (g)(12)(iv), introductory text.

R. Revising paragraph (g)(12)(iv)(A).

S. Revising paragraph (g)(12)(iv)(B)(*1*).

T. Redesignating paragraphs (i) and (j) as paragraphs (j) and (k), respectively, and adding a new paragraph (i).

The additions and revisions read as follows:

§ 413.86 Direct graduate medical education payments.

* * * * *

(b) *Definitions.* * * *

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.

* * * * *

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 paragraph (g)(7)(ii) of this section.

(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 paragraph (g)(7)(ii) of this section, 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 paragraph (g)(7)(ii) of this section.

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 one 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 members.

* * * * *

Redistribution of costs means an attempt by a hospital to increase the amount it is allowed to receive from Medicare under this section by counting FTE residents that were in medical residency programs where the costs of the programs had previously been incurred by the educational institution.

* * * * *

(f) *Determining the total number of FTE residents.* Subject to the weighting factors in paragraphs (g) and (h) of this section, and subject to the provisions of paragraph (i) of this section, the count of FTE residents is determined as follows:

* * * * *

(4) * * *

(iv) The hospital is subject to the principles of community support and redistribution of costs as specified in the provisions of paragraph (i) of this section.

(g) *Determining the weighted number of FTE residents.*

* * * * *

(4) Subject to the provisions of paragraph (i) of this section, for purposes of determining direct graduate medical education payment—

* * * * *

(iv) Hospitals that are part of the same Medicare GME affiliated group (as described under paragraph (b) of this section) may elect to apply the limit on an aggregate basis as described under paragraph (g)(7) of this section.

* * * * *

(5) Subject to the provisions of paragraph (i) of this section, for purposes of determining direct graduate medical education payment—

* * * * *

(vii) Subject to the provisions under paragraph (g)(12) 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 paragraph (g)(5) of this section.

* * * * *

(6) * * *

(i) * * *

(D) An urban hospital that qualifies for an adjustment to its FTE cap under paragraph (g)(6)(i) of this section is not permitted to be part of a Medicare GME affiliated group for purposes of establishing an aggregate FTE cap.

(E) A rural hospital that qualifies for an adjustment to its FTE cap under paragraph (g)(6)(i) of this section is permitted to be part of a Medicare GME affiliated group for purposes of establishing an aggregate FTE cap.

* * * * *

(7) A hospital may receive a temporary adjustment to its FTE cap, which is subject to the averaging rules under paragraph (g)(5)(iii) of this section, to reflect residents added or subtracted because the hospital is participating in a Medicare GME affiliated group (as defined under paragraph (b) of this section). Under this provision—

(i) Each hospital in the Medicare GME affiliated group must submit the Medicare GME affiliation agreement, as defined under paragraph (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.

(ii) Each hospital in the Medicare GME affiliated group must have a shared rotational arrangement, as defined in paragraph (b) of this section, 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.

(iii) During the shared rotational arrangements under an Medicare GME affiliation agreement, as defined in paragraph (b) of this section, 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.

(iv) 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.

(v) 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 (g)(4) of this section.

* * * * *

(12) Subject to the provisions of (i) of this section, 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 (g)(4) 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 (g)(12)(i) through (g)(12)(vi) of this section.

(i) 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:

(A) 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 (g)(5)(vii) of this section, training in the rural track at the urban hospital.

(B) 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 l, 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.

(ii) 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 paragraph (f)(4) of this section. 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:

(A) 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 (g)(5)(vii) of this section, training in the rural track at the urban hospital and the rural nonhospital site(s).

(B) * * *

(*1*) * * *

(*i*) 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

* * * * *

(iii) 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 (g)(6)(iii) 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.

(iv) 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 paragraph (f)(4) of this section. 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:

(A) 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 (g)(5)(vii) of this section, training in the rural track at the rural nonhospital site(s).

(B) * * *

(*1*) 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

* * * * *

(i) *Application of community support and redistribution of costs in determining FTE resident counts.*

(1) For purposes of determining direct graduate medical education payments, the following principles apply:

(i) *Community support.* If the community has undertaken to bear the costs of medical education through community support, the costs are not considered graduate medical education costs to the hospital for purposes of Medicare payment.

(ii) *Redistribution of costs.* The costs of training residents that constitute a redistribution of costs from an educational institution to the hospital are not considered graduate medical education costs to the hospital for purposes of Medicare payment.

(2) *Application.* A hospital must continuously incur the costs of direct graduate medical education 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 paragraphs (f) and (g)(4) through (g)(6) and (g)(12) of this section.

* * * * *

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

Dated: April 22, 2003.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services

Dated: May 8, 2003.

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 Amounts Effective with Discharges Occurring On or After October 1, 2003 and Update Factors and Rate-of-Increase Percentages Effective With Cost Reporting Periods Beginning On or After October 1, 2003

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, 2003, 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 50 percent of a Puerto Rico rate reflecting base year average costs per case of Puerto Rico hospitals and 50 percent of a blended Federal national rate (a discharge-weighted average of the national large urban and other areas standardized amounts). (*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 2004. The changes, to be applied prospectively effective with discharges occurring on or after October 1, 2003, 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 2004. 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 to 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 2004

The basic methodology for determining prospective payment rates for hospital inpatient operating costs is set forth at § 412.63. The basic methodology for determining the prospective payment rates for hospital inpatient operating costs for hospitals located in Puerto Rico is set forth at §§ 412.210 and 412.212. Below, we discuss the factors used for determining the prospective payment rates.

In summary, the proposed standardized amounts set forth in Tables 1A and 1C of section VI. of this Addendum reflect—

- Updates of 3.5 percent for all areas (that is, the full market basket percentage increase of 3.5 percent);
- An adjustment to ensure the proposed DRG recalibration and wage index update and changes, as well as the add-on payments for new technology, 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 large urban and other standardized amounts;
- 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 2003 budget neutrality factor and applying a revised factor;
- An adjustment to apply the new outlier offset by removing the FY 2003 outlier offsets and applying a new offset.

A. Calculation of Adjusted Standardized Amounts

1. Standardization of Base-Year Costs or Target Amounts

The national standardized amounts are 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, in making payments under the IPPS, the Secretary estimates from time to time the proportion of costs that are wages and wage-related costs. Based on the estimated labor-related share, the standardized amounts are divided into labor-related and nonlabor-related amounts. As discussed in section IV. of the preamble to the August 1, 2002 IPPS final rule, when we revised the market basket in FY 2003, we did not revise the labor share of the standardized amount (the proportion adjusted by the wage index). We consider 71.1 percent of costs to be labor-related for purposes of the IPPS. The average labor share in Puerto Rico is 71.3 percent.

2. Computing Large Urban and Other Area Average Standardized Amounts

Sections 1886(d)(2)(D) and (d)(3) of the Act require 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 must be 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 is 1.6 percent higher than the other area average standardized amount.

Section 402(b) of Pub. L. 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. However, for discharges occurring on or after October 1, 2003, the Federal rate will again be calculated based on separate average standardized amounts for hospitals in large urban areas and for hospitals in other areas.

Section 1886(d)(2)(D) of the Act defines ''urban area'' as those areas within a Metropolitan Statistical Area (MSA). A ''large urban area'' is defined as an urban area with a population of more than 1 million. In addition, section 4009(i) of Pub. L. 100–203 provides that a New England County Metropolitan Area (NECMA) with a population of more than 970,000 is classified as a large urban area. As required by section 1886(d)(2)(D) of the Act, population size is determined by the Secretary based on the latest population data published by the Bureau of the Census. Urban areas that do not meet the definition of a ''large urban area'' are referred to as ''other urban areas.'' Areas that are not included in MSAs are considered ''rural areas'' under section 1886(d)(2)(D) of the Act. Payment for discharges from hospitals located in large urban areas will be based on the large urban standardized amount. Payment for discharges from hospitals located in other urban and rural areas will be based on the other standardized amount.

Based on the latest available population estimates published by the Bureau of the Census, 63 areas meet the criteria to be defined as large urban areas for FY 2004. These areas are identified in Table 4A of section VI. of this Addendum.

3. Updating the Average Standardized Amounts

In accordance with section 1886(d)(3)(A)(iv) of the Act, we are proposing to update the large urban areas' and the other areas' average standardized amounts for FY 2004 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. 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 2004 is 3.5 percent. Thus, for FY 2004, the update to the average standardized amounts equals 3.5 percent for hospitals in all areas.

Although the update factors for FY 2004 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 2004 for both IPPS hospitals and hospitals excluded from the IPPS. Our proposed 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 Amounts

As in the past, we are proposing to adjust the FY 2004 standardized amounts to remove the effects of the FY 2003 geographic reclassifications and outlier payments before applying the FY 2004 updates. We then apply the new offsets to the standardized amounts for outliers and geographic reclassifications for FY 2004.

We do not remove the prior years' budget neutrality adjustment 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. Because the proposed changes to the postacute care transfer policy discussed in section IV.A. of this preamble are not budget neutral, we included the effects of expanding this policy to additional DRGs prior to estimating the payment effects of the DRG and wage data changes.

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.

Section 4410 of Pub. L. 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 Pub. L. 105–33 to be budget neutral. Therefore, we include the effects of this provision in our calculation of the wage update budget neutrality factor.

In addition, we are required to ensure that any add-on payments for new technology under section 1886(d)(5)(K) of the Act are budget neutral. As discussed in section II.E. of this proposed rule, we are proposing to approve one new technology for add-on payments in FY 2004. We estimate that the proposed total add-on payments for this new technology would be $50 million for FY 2004.

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 2002 discharge data to simulate payments and compared aggregate payments using the FY 2003 relative weights, wage index, and new technology add-on payments to aggregate payments using the proposed FY 2004 relative weights and wage index, plus the proposed additional add-on payments for new technology. The same methodology was used for the FY 2003 budget neutrality adjustment.

Based on this comparison, we computed a proposed budget neutrality adjustment factor equal to 1.003133. We also adjust the Puerto Rico-specific standardized amounts for the effect of DRG reclassification and recalibration. We computed a proposed budget neutrality adjustment factor for Puerto Rico-specific standardized amounts equal to 1.000627. These budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the FY 2003 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, 2003. (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 standardized amount or the wage index, or both.

Under section 1886(d)(8)(D) of the Act, the Secretary is required to adjust the standardized amounts so as 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. To calculate this budget neutrality factor, we used FY 2002 discharge data to simulate payments, and compared total IPPS payments prior to any reclassifications to total IPPS payments after reclassifications. Based on these simulations, we are proposing to apply an adjustment factor of 0.991848 to ensure that the effects of reclassification are budget neutral.

The proposed adjustment factor is applied to the standardized amounts after removing the effects of the FY 2003 budget neutrality adjustment factor. We note that the proposed FY 2004 adjustment reflects proposed FY 2004 wage index and standardized amount

reclassifications approved by the MGCRB or the Administrator as of February 28, 2003, and the effects of section 1886(d)(10)(D)(v) of the Act to extend wage index reclassifications for 3 years. The effects of any additional reclassification changes that occur as a result of appeals and reviews of the MGCRB decisions for FY 2004 or from a hospital's request for the withdrawal of a reclassification for FY 2004 will be reflected in the final budget neutrality adjustment required under section 1886(d)(8)(D) of the Act and published in the IPPS final rule for FY 2004.

c. Outliers. Section 1886(d)(5)(A) of the Act provides for payments in addition to the basic prospective payments, for ''outlier'' cases, that is, 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 amounts 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. FY 2004 outlier fixed-loss cost threshold.

In the August 1, 2002 IPPS final rule (67 FR 50124), we established a threshold for FY 2003 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 $33,560. The marginal cost factor (the percent of costs paid after costs for the case exceed the threshold) was 80 percent.

In the March 5, 2003 **Federal Register** (67 FR 10420), we published proposed changes to our outlier policy. We noted recent analyses indicate that some hospitals have taken advantage of our existing outlier payment methodology to maximize their outlier payments. Therefore, we proposed three central changes to our outlier policy in the March 5, 2003 proposed rule.

The first of the proposed changes was that fiscal intermediaries would use more up-to-date data when determining the cost-to-charge ratio for each hospital. Currently, fiscal intermediaries use the hospital's most recent settled cost report. We proposed to revise our regulations to specify that fiscal intermediaries would use either the most recent settled or the most recent tentative settled cost report, whichever is from the latest reporting period.

The second proposed change was to remove the current requirement in our regulations specifying that a fiscal intermediary will assign a hospital the statewide average cost-to-charge ratio when the hospital has a cost-to-charge ratio that falls below established thresholds (3 standard deviations below the national geometric mean cost-to-charge ratio). We proposed that hospitals would receive their actual cost-to-charge ratios no matter how low their ratios actually fall.

The third proposal was to add a provision to our regulations to provide that the outlier payments for some hospitals may become subject to reconciliation when the hospitals' cost reports are settled. In addition, outlier payments would be subject to an adjustment to account for the time value of any outlier overpayments or underpayments that are ultimately reconciled.

However, as of the time this FY 2004 proposed rule was prepared, these proposed changes to the outlier policy had not been finalized. Therefore, the proposed changes have not been factored into the calculation of the proposed FY 2004 fixed-loss threshold. If these changes are made final prior to (or as part of) the publication of the final FY 2004 fixed-loss threshold, they will be reflected in the analysis used to establish the final FY 2004 threshold.

To calculate the proposed FY 2004 outlier thresholds, we simulated payments by applying proposed FY 2004 rates and policies using cases from the FY 2002 MedPAR file. Therefore, in order to determine the appropriate proposed FY 2003 threshold, it was necessary to inflate the charges on the MedPAR claims by 2 years, from FY 2002 to FY 2004.

As discussed in the August 1, 2002 IPPS final rule (67 FR 50124), rather than use the rate-of-cost increase from hospitals' FY 1998 and FY 1999 cost reports to project the rate of increase from FY 2001 to FY 2003, as had been done in prior years, we used a 2-year average annual rate of change in charges per case to calculate the FY 2003 outlier threshold.

We are proposing to continue to use a 2-year average annual rate of change in charges per case to establish the proposed FY 2004 threshold. 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 12.8083 percent annually, or 27.3 percent over 2 years.

Using the methodology above for setting the charge inflation factors for FY 2004, 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 $50,645.

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.

Again, any final rule subsequent to the March 5, 2003 proposed rule that implements changes to the outlier payment methodology is likely to affect how we will calculate the final FY 2004 outlier threshold. Therefore, the final FY 2004 threshold is likely to be different from this proposed threshold, as a result of any changes subsequent to the March 5, 2003 proposed rule. For example, if we were to implement the proposal to no longer apply the statewide average cost-to-charge ratio when hospitals' actual ratios fall below the established threshold (see below), this change would impact our calculation of the threshold.

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 higher percentage of outlier payments for capital-related costs than for operating costs. We project that the proposed thresholds for FY 2004 would result in outlier payments equal to 5.1 percent of operating DRG payments and 5.5 percent of capital payments based on the Federal rate.

In accordance with section 1886(d)(3)(B), we reduced the proposed FY 2004 standardized amounts 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 amounts for FY 2004 are as follows:

	Operating standardized amounts	Capital federal rate
National	0.948981	0.945484
Puerto Rico	0.981549	0.984490

We apply the outlier adjustment factors after removing the effects of the FY 2003 outlier adjustment factors on the standardized amounts.

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.

Once again, although a final rule subsequent to the March 5, 2003 proposed rule on outliers may be published before (or as part of) the FY 2004 IPPS final rule, we are proposing changes for FY 2004 without taking the proposals contained in the March 5, 2003 proposed rule into account at this time.

For those hospitals for which the fiscal intermediary computes operating cost-to-charge ratios lower than 0.194 or greater than 1.223, or capital cost-to-charge ratios lower than 0.012 or greater than 0.163, we are proposing statewide average ratios would be used to calculate costs to determine whether a hospital qualifies for outlier payments.[7] Table 8A in section VI. of this Addendum contains the proposed 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 proposed statewide average ratios would replace the ratios published in the August 1, 2002 IPPS final rule (67 FR 50263). Table 8B in section VI. of this Addendum contains the proposed comparable statewide average capital cost-to-charge ratios. Again, the cost-to-charge ratios in Tables 8A and 8B would be used during FY 2004 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 2002 and FY 2003 outlier payments.

In the August 1, 2002 IPPS final rule (67 FR 50125), we stated that, based on available data, we estimated that actual FY 2002 outlier payments would be approximately 6.9 percent of actual total DRG payments. This estimate was computed based on simulations using the FY 2001 MedPAR file (discharge data for FY 2001 bills). That is, the estimate of actual outlier payments did not reflect actual FY 2002 bills but instead reflected the application of FY 2002 rates and policies to available FY 2001 bills.

Our current estimate, using available FY 2002 bills, is that actual outlier payments for FY 2002 were approximately 7.9 percent of actual total DRG payments. Thus, the data indicate that, for FY 2002, the percentage of actual outlier payments relative to actual total payments is higher than we projected before FY 2002 (and thus exceeds the percentage by which we reduced the standardized amounts for FY 2002). 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 2002 are equal to 5.1 percent of total DRG payments.

We currently estimate that actual outlier payments for FY 2003 will be approximately 5.5 percent of actual total DRG payments, 0.4 percentage points higher than the 5.1 percent we projected in setting outlier policies for FY 2003. This estimate is based on simulations using the FY 2002 MedPAR file (discharge data for FY 2002 bills). We used these data to calculate an estimate of the actual outlier percentage for FY 2003 by applying FY 2003 rates and policies including an outlier threshold of $33,560 to available FY 2002 bills. If changes to the outlier payment methodology are made effective during FY 2003, these may affect the actual percentage of FY 2003 outlier payments.

5. FY 2004 Standardized Amounts

The adjusted standardized amounts are divided into labor and nonlabor portions. Table 1A in section VI. of this Addendum contains the two national standardized amounts that we are proposing will be applicable to all hospitals, except hospitals in Puerto Rico. As described in section II.A.1. of this Addendum, we are not proposing to revise the labor share of the national standardized amount from 71.1 percent.

The following table illustrates the proposed changes from the FY 2003 national average standardized amounts. The first row in the table shows the updated (through FY 2003) average standardized amounts after restoring the FY 2003 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 2003 factor is not removed from the amounts in the table.

	Large urban	Other Areas
FY 2003 Base Rate (after removing reclassification budget neutrality and outlier offset)	Labor $3,212.32 Nonlabor 1,276.01	Labor $3,161.41) Nonlabor 1,285.01
Proposed FY 2004 Update Factor	1.035	1.035
Proposed FY 2004 DRG Recalibrations and Wage Index Budget Neutrality Factor	1.003133	1.003133
Proposed FY 2004 Reclassification Budget Neutrality Factor	0.991848	0.991848
Proposed FY 2004 Outlier Factor	0.948997	0.948997
Proposed Rate for FY 2004 (after multiplying FY 2003 base rate by above factors)	Labor $3,139.26 Nonlabor 1,276.01	Labor $3,089.56 Nonlabor 1,255.81

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 and the national other 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.

B. Adjustments for Area Wage Levels and Cost-of-Living

Tables 1A and 1C, 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 this preamble, we discuss the data and methodology for the proposed FY 2004 wage index. The proposed FY 2004 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 2004, we are proposing to adjust the payments for hospitals in Alaska and Hawaii by multiplying the nonlabor portion of the standardized amounts 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, 2003, we will publish them in the final rule and use them in determining FY 2004 payments.

[7] This range represents 3.0 standard deviations (plus or minus) from the mean of the log distribution of cost-to-charge ratios for all hospitals.

TABLE OF COST-OF-LIVING ADJUSTMENT FACTORS, ALASKA AND HAWAII HOSPITALS

Alaska—All areas	1.25
Hawaii:	
County of Honolulu	1.25
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 2004. These factors have been recalibrated as explained in section II. of the preamble.

D. Calculation of Proposed Prospective Payment Rates for FY 2004

General Formula for Calculation of Proposed Prospective Payment Rates for FY 2004

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 proposed amounts in Table 1A in section VI. of this Addendum.

The proposed prospective payment rate for SCHs equals the higher of the proposed applicable Federal rate from Table 1A 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 50 percent of the Puerto Rico rate plus 50 percent of the proposed national rate from Table 1C in section VI. of this Addendum.

1. Federal Rate

For discharges occurring on or after October 1, 2003 and before October 1, 2004, 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 location of the hospital (large urban or other) (see Table 1A in section VI. of this Addendum).

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 1.003133) 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, 2003.

b. Updating the FY 1982, FY 1987, and FY 1996 Hospital-Specific Rates for FY 2004. We are proposing to increase the hospital-specific rates by 3.5 percent (the hospital market basket percentage) for SCHs and MDHs for FY 2004. 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 2004, 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 2004, is the market basket rate.

3. General Formula for Calculation of Prospective Payment Rates for Hospitals Located in Puerto Rico Beginning On or After October 1, 2003 and Before October 1, 2004

a. Puerto Rico Rate. The Puerto Rico prospective payment rate is determined as follows:

Step 1—Select the appropriate adjusted average standardized amount considering the large urban or other designation of the hospital (see Table 1C of section VI. of the Addendum).

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 50 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—Multiply the labor-related portion of the national average standardized amount (see Table 1C of section VI. of the Addendum) by the appropriate national wage index (see Tables 4A and 4B of section VI. of the Addendum).

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 50 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 2004

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 and during a 10-year transition period extending through FY 2001, acute care hospital inpatient capital-related costs were paid on the basis of an increasing proportion of the capital PPS Federal rate and a decreasing proportion of a hospital's historical costs for capital.

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 2004, which would be effective for discharges occurring on or after October 1, 2003. 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 standard Federal rate, as provided in § 412.308(c)(1), to account for capital input price increases and other factors. Section 412.308(c)(2) provides that the Federal rate is adjusted annually by a factor equal to the estimated proportion of outlier payments under the Federal rate to total capital payments under the Federal rate. In addition, § 412.308(c)(3) requires that the 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 standard Federal rate be adjusted so that 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 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 rate that was made in FY 1994, and § 412.308(b)(3) describes the 0.28 percent reduction to the 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 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)). Since payments are no longer being made under the regular exception policy in FY 2003 and after, 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 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, as a result of 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 compute capital payments to hospitals in Puerto Rico based on a blend of 50 percent of the Puerto Rico rate and 50 percent of the Federal rate.

Section 412.374 provides for the use of this blended payment system for payments to Puerto Rico hospitals under the PPS for acute care hospital inpatient capital-related costs. Accordingly, for capital-related costs, we compute a separate payment rate specific to Puerto Rico hospitals using the same methodology used to compute the national Federal rate for capital.

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, 2002 (67 FR 50127), we established a Federal rate of $407.01 for FY 2003. Section 402(b) of Public Law 108–7 requires that, effective for discharges occurring on or after April 1, 2003, and before October 1, 2003, the Federal rate for operating costs for all IPPS hospitals would be based on the large urban standardized amount. However, for discharges occurring on or after October 1, 2003, the Federal rate will again be calculated based on separate average standardized amounts for hospitals in large urban areas and for hospitals in other areas. In addition, a correction notice to the FY 2003 final IPPS rule issued in the **Federal Register** on April 25, 2003 (68 FR 22272) contains corrections and revisions to the wage index and geographic adjustment factor (GAF). In conjunction with the change to the operating PPS standardized amounts made by Public Law 108–7 and the wage index and GAF corrections, we have established a capital PPS standard Federal rate of $406.93 effective for discharges occurring on or after April 1, 2003 through September 30, 2003. The rates effective for discharges occurring on or after April 1, 2003 through September 30, 2003, were used in determining the proposed FY 2004 rates. As a result of the changes that we are proposing to the factors used to establish the Federal rate that are explained in this Addendum, the proposed FY 2004 capital standard Federal rate is $411.72.

In the discussion that follows, we explain the factors that were used to determine the proposed FY 2004 capital Federal rate. In particular, we explain why the proposed FY 2004 Federal rate has increased 1.18 percent compared to the FY 2003 Federal rate (effective for discharges occurring on or after April 1, 2003 through September 30, 2003). We also estimate aggregate capital payments will increase by 2.5 percent during this same period. This increase is primarily due to the increase in the number of hospital admissions and the increase in case-mix. This increase in capital payments is slightly less than last year (5.81 percent), mostly due to the restoration of the 2.1 percent reduction to the capital Federal rate in FY 2003 (§ 412.308(b)(6)).

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 2004 compared to FY 2003.

1. Proposed Standard Federal Rate Update

a. Description of the Update Framework. Under § 412.308(c)(1), the 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 2004 under that framework is 0.7 percent, based on data available at this time. This 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 2002 DRG reclassification and recalibration, and a forecast error correction of 0.0 percent. We explain the basis for the FY 2004 CIPI projection in section III.C. of this Addendum. Below we describe the 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 2002 DRG reclassification and recalibration as part of our update for FY 2004.) We have adopted this case-mix index adjustment in the capital update framework as well.

For FY 2004, we are projecting a 1.0 percent total increase in the case-mix index. We estimate that real case-mix increase will equal 1.0 percent in FY 2004. Therefore, the net adjustment for case-mix change in FY 2004 is 0.0 percentage points.

We estimate that FY 2002 DRG reclassification and recalibration will 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 2004 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 0.2 percentage points was calculated for the FY 2002 update. That is, current historical data indicate that the forecasted FY 2002 CIPI used in calculating the FY 2002 update factor (0.7 percent) overstated the actual realized price increases (0.5 percent) by 0.2 percentage points. This slight overprediction was mostly due to an underestimation of the interest rate cuts by the Federal Reserve Board in 2002, 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 2004.

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.

As we discussed in the May 9, 2002 proposed rule (67 FR 51514), 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 standard Federal capital 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 2004 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 1998 though 2002. We found that, over this period and in particular the last 3 years of this period (FYs 2000 through 2002), the charge data appear to be skewed. More specifically, we found a dramatic increase in hospital charges for FYs 2000 through 2002 without a corresponding increase in hospital case-mix index. 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.

The timing of this increase in charge growth is consistent with the dramatic increase in charges that we discussed in the March 5, 2003 high-cost outlier proposed rule (68 FR 10420 through 14029). As we discussed in that proposed rule, because hospitals have the ability to increase their outlier payments through dramatic charge increases, we proposed several changes in our high-cost outlier policy at §§ 412.84(i) and (m) in order to prevent hospitals from taking advantage of our current outlier policy.

As discussed above, because our intensity calculation relies heavily upon charge data and we believe that this charge data may be inappropriately skewed, we are proposing a 0.0 percent adjustment for intensity in FY 2004. 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 2004 until we believe that any increase in charges can be tied to intensity rather then 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 2004 as shown in the table below.

CMS'S PROPOSED FY 2004 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 2002 Reclassification and Recalibration	0.0
Forecast Error Correction	0.0

CMS'S PROPOSED FY 2004 UPDATE FACTOR TO THE CAPITAL FEDERAL RATE—Continued

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 2003 Report to Congress, MedPAC did not make an update recommendation for capital PPS payments. However, in that same report, MedPAC made an update recommendation for hospital inpatient and outpatient services (page 4). MedPAC stated that hospital inpatient and outpatient services should be considered together because they are so closely interrelated. Their recommendation is based on an assessment of whether payments are adequate to cover the costs of efficient providers, an estimate of input price inflation (measured by the market basket index), and an adjustment for technological charges, which is offset by reasonable expectations in productivity gains.

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, 2002 IPPS final rule (67 FR 50129), we estimated that outlier payments for capital in FY 2003 would equal 5.31 percent of inpatient capital-related payments based on the FY 2003 Federal rate. Accordingly, we applied an outlier adjustment factor of 0.9469 to the FY 2003 Federal rate. 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 5.45 percent of inpatient capital-related payments based on the Federal rate in FY 2004. Therefore, we are proposing an outlier adjustment factor of 0.9455 to the Federal rate. Thus, the projected percentage of capital outlier payments to total capital standard payments for FY 2004 is higher than the percentage for FY 2003.

The outlier reduction factors are not built permanently into the rates; that is, they are not applied cumulatively in determining the Federal rate. Therefore, the net proposed change in the outlier adjustment to the Federal rate for FY 2004 is 0.9985 (0.9455/0.9469). The outlier adjustment decreases the proposed FY 2004 Federal rate by 0.15 percent compared with the FY 2003 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 Federal rate be adjusted so that aggregate payments for the fiscal year based on the 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 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 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 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 2003 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 2004, we compared (separately for the national rate and the Puerto Rico rate) estimated aggregate Federal rate payments based on the FY 2003 DRG relative weights and the FY 2003 GAF to estimated aggregate Federal rate payments based on the proposed FY 2004 relative weights and the proposed FY 2004 GAF. In the August 1, 2002 IPPS final rule (67 FR 50129) for FY 2003, the budget neutrality adjustment factors were 0.9885 for the national rate and 0.9963 for the Puerto Rico rate. As a result of the revisions to the GAF effective for discharges occurring on or after April 1, 2003 through September 30, 2003, the budget neutrality adjustment factor is 0.9983 for the national rate for discharges occurring on or before April 1, 2003 through September 30, 2003. The budget neutrality adjustment factor for the Puerto Rico rate remained unchanged (0.9963). As we noted above, the rates effective for discharges occurring on or after April 1, 2003 through September 30, 2003 were used in determining the proposed FY 2004 rates. 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 1.0034 for FY 2004 to the previous cumulative FY 2003 adjustment (0.9883), yielding a proposed cumulative adjustment of 0.9929 through FY 2004. For the Puerto Rico GAF, we are proposing to apply an incremental budget neutrality adjustment of 1.0002 for FY 2004 to the previous cumulative FY 2003 adjustment (0.9963), yielding a proposed cumulative adjustment of 0.9964 through FY 2004. (This is the rounded result of a calculation performed on unrounded numbers.)

We then compared estimated aggregate Federal rate payments based on the FY 2003 DRG relative weights and the FY 2003 GAF to estimated aggregate Federal rate payments based on the proposed FY 2004 DRG relative weights and the proposed FY 2004 GAF. The proposed incremental adjustment for DRG classifications and changes in relative weights is 1.0004 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 2004 are 0.9920 nationally and 0.9968 for Puerto Rico (this is the rounded result of a calculation performed with unrounded numbers). The following table summarizes the adjustment factors for each fiscal year:

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]	[3]0.99771	[3]1.00009	[3]0.99780	0.99922	[3]1.00365	[3]1.00009	[3]1.00374	1.00508
2002	[4]0.99666	[4]0.99668	[4]0.99335	0.99268	[4]0.98991	[4]0.99668	[4]0.99662	0.99164
2003[5]	0.99915	0.99662	0.99577	0.98848	1.00809	0.99662	1.00468	0.99628
2003[6]	[7]0.99896	[7]0.99662	[7]0.99558	0.98830	[7]1.00809	[7]0.99662	[7]1.00468	0.99628
2004	[8]1.00341	[8]1.00036	[8]1.00376	0.99202	[8]1.00015	[8]1.00036	[8]1.00051	0.99679

[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] Incremental factors are applied to the cumulative factors for the second half of FY 2003.

The methodology used to determine the proposed recalibration and geographic (DRG/GAF) budget neutrality adjustment factor for FY 2004 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 rate and the Puerto Rico 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, 2002 IPPS final rule (67 FR 50129), we calculated a GAF/DRG budget neutrality factor of 0.9957 for FY 2003. As we noted above, as a result of the revisions to the GAF effective for discharges occurring on or after April 1, 2003 through September 30, 2003, we calculated a GAF/DRG budget neutrality factor of 0.9956 for discharges occurring on or after April 1, 2003 through September 30, 2003. Furthermore, the rates effective for discharges occurring on or after April 1, 2003 through September 30, 2003 were used in determining the proposed FY 2004 rates. For FY 2004, we are proposing a GAF/DRG budget neutrality factor of 1.00038. The GAF/DRG budget neutrality factors are built permanently into the rates; that is, they are applied cumulatively in determining the 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 2003 to FY 2004 is 1.00038. The proposed cumulative change in the rate due to this adjustment is 0.9920 (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, and the proposed incremental factor for FY 2004: $0.9980 \times 1.0053\ 0.9998 \times 0.9994 \times 0.9987 \times 0.9989 \times 1.0028 \times 0.9985 \times 0.9979 \times 0.9934 \times 0.9956 \times 1.00038 = 0.9920$).

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 2004 geographic reclassification decisions made by the MGCRB compared to FY 2003 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 standard capital 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 rates.

An adjustment for regular exception payments is no longer necessary in determining the FY 2004 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 2003 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 proposed FY 2004 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).

As we explained in the August 1, 2001 IPPS final rule (66 FR 39912 through 39914), in order to determine the estimated proportion of special exceptions payments to total capital payments, we attempted to identify the universe of eligible hospitals that may potentially qualify for special exceptions payments. First, we identified hospitals that met the eligibility requirements at § 412.348(g)(1). Then we determined each hospital's average fixed asset age in the earliest available cost report starting in FY 1992 and subsequent fiscal years. For each of those hospitals, we calculated the average fixed asset age by dividing the accumulated depreciation by the current year's depreciation. In accordance with § 412.348(g)(3), a hospital must have an average age of buildings and fixed assets above the 75th percentile of all hospitals in the first year of the capital PPS. In the September 1, 1994 final rule (59 FR 45385), we stated that, based on the June 1994 update of the cost report files in HCRIS, the 75th percentile for buildings and fixed assets for FY 1992 was 16.4 years. However, we noted that we would make a final determination of that value on the basis of more complete cost report information at a later date. In the August 29, 1997 final rule (62 FR 46012), based on the December 1996 update of HCRIS and the removal of outliers, we finalized the 75th percentile for buildings and fixed assets for FY 1992 as 15.4 years. Thus, we eliminated any hospitals from the potential universe of hospitals that may qualify for special exception payments if its average age of fixed assets did not exceed 15.4 years.

For the hospitals remaining in the potential universe, we estimated project-size by using the fixed capital acquisitions shown on Worksheet A7 from the following HCRIS cost reports updated through December 2002.

PPS year	Cost reporting periods beginning in . . .
IX	FY 1992.
X	FY 1993.
XI	FY 1994.
XII	FY 1995.
XIII	FY 1996.
XIV	FY 1997.
XV	FY 1998.
XVI	FY 1999.
XVII	FY 2000.
XVIII	FY 2001.

Because the project phase-in may overlap 2 cost reporting years, we added together the fixed acquisitions from sequential pairs of cost reports to determine project size. Under § 412.348(g)(5), the hospital's project cost must be at least $200 million or 100 percent of its operating cost during the first 12-month cost reporting period beginning on or after October 1, 1991. We calculated the operating costs from the earliest available cost report starting in FY 1992 and later by subtracting inpatient capital costs from inpatient costs (for all payers). We did not subtract the direct medical education costs as those costs are not available on every update of the HCRIS minimum data set. If the hospital met the project size requirement, we assumed that it also met the project need requirements at § 412.348(g)(2) and the excess capacity test for urban hospitals at § 412.348(g)(4).

Because we estimate that so few hospitals will qualify for special exceptions, projecting costs, payments, and margins would result in high statistical variance. Consequently, we decided to model the effects of special exceptions using historical data based on hospitals' actual cost experiences. If we determined that a hospital may qualify for special exceptions, we modeled special exceptions payments from the project start date through the last available cost report (FY 2000). (Although some FY 2001 cost reports are available in HCRIS, only a few hospitals have submitted FY 2001 costs. Consequently, too few cost reports are available to reliably model FY 2001 special exceptions payments.) For purposes of modeling, we used the cost and payment data on the cost reports from HCRIS assuming that special exceptions would begin at the start of the qualifying project. In other words, when modeling costs and payment data, we ignored any regular exception payments that these hospitals may otherwise have received as if there had not been regular exception provision during the transition period. In projecting an eligible hospital's special exception payment, we applied the 70-percent minimum payment level, the cumulative comparison of current year capital PPS payments and costs, and the cumulative operating margin offset (excluding 75 percent of operating DSH payments).

Our modeling of special exception payments for FY 2004 produced the following results:

Cost report	Number of hospitals eligible for special exceptions	Special exceptions as a fraction of capital payments to all hospitals
PPS IX	.....	.....
PPS X	.....	.....
PPS XI	1	.....
PPS XII	4	.....
PPS XIII	5	.....
PPS XIV	11	.....
PPS XV	15	.....
PPS XVI	24	0.0002
PPS XVII	27	0.0005
PPS XVIII	N/A	N/A

We note that hospitals still have one more cost reporting period (PPS XVIII) to complete their projects in order to be eligible for special exceptions payments, and, therefore, we estimate that about 30 hospitals could qualify for special exceptions payments. Thus, we project that special exception payments as a fraction of capital payments to all hospitals to be approximately 0.0005.

Because special exceptions are budget neutral, we are proposing to offset the Federal capital rate by 0.05 percent for special exceptions payments for FY 2004. Therefore, the proposed exceptions adjustment factor would equal 0.9995 (1 − 0.0005) to account for special exceptions payments in FY 2004. Furthermore, we are proposing to estimate the exceptions payment adjustment factor for special exceptions payments in FY 2004 in the final rule based on updated data.

In the August 1, 2002 IPPS final rule (67 FR 50131) for FY 2003, we estimated that total (special) exceptions payments would equal 0.30 percent of aggregate payments based on the Federal rate. Therefore, we applied an exceptions reduction factor of 0.9970 (1 − 0.0030) in determining the FY 2003 Federal rate. As we stated, we estimate that exceptions payments in FY 2004 would equal 0.05 percent of aggregate payments based on the proposed FY 2004 Federal rate. Therefore, we are proposing to apply an exceptions payment adjustment factor of 0.9995 (1 − 0.0005) to the proposed Federal rate for FY 2004. The proposed exceptions adjustment factor for FY 2004 is 0.25 percent higher than the factor for FY 2003 published in the August 1, 2002 IPPS final rule (67 FR 50131). This increase is primarily due to a refined analysis of more recent data.

The exceptions reduction factors are not built permanently into the rates; that is, the factors are not applied cumulatively in determining the Federal rate. Therefore, the proposed net change in the exceptions adjustment factor used in determining the proposed FY 2004 Federal rate is 0.9995/0.9970, or 1.0025.

5. Proposed Standard Capital Federal Rate for FY 2004

In the August 1, 2002 IPPS final rule (67 FR 50131) we established a capital Federal rate of $407.01 for FY 2003. As we noted above, as a result of the revisions to the GAF effective for discharges occurring on or after April 1, 2003 through September 30, 2003, we have established a capital Federal rate of $406.93 for discharges occurring on or after April 1, 2003 through September 30, 2003. The rates effective for discharges occurring on or after April 1, 2003 through September 30, 2003, were used in determining the proposed FY 2004 rates. In this proposed rule, we are proposing a capital Federal rate of $411.72 for FY 2004. The proposed Federal rate for FY 2004 was calculated as follows:

- The proposed FY 2004 update factor is 1.0070; that is, the update is 0.70 percent.
- The proposed FY 2004 budget neutrality adjustment factor that is applied to the standard Federal payment rate for changes in the DRG relative weights and in the GAF is 1.0038.
- The proposed FY 2004 outlier adjustment factor is 0.9455.
- The proposed FY 2004 (special) exceptions payment adjustment factor is 0.9995.

Since the proposed 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 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 2004 affected the computation of the proposed FY 2004 Federal rate in comparison to the FY 2003 Federal rate. The proposed FY 2004 update factor has the effect of increasing the Federal rate by 0.70 percent compared to the FY 2003 Federal rate, while the proposed GAF/DRG budget neutrality factor has the effect of increasing the Federal rate by 0.38 percent. The proposed FY 2004 outlier adjustment factor has the effect of decreasing the Federal rate by 0.15 percent compared to the FY 2003 Federal rate. The proposed FY 2004 exceptions payment adjustment factor has the effect of increasing the Federal rate by 0.25 percent compared to the exceptions payment adjustment factor for FY 2003. The combined effect of all the proposed changes is to increase the Federal rate by 1.18 percent compared to the FY 2003 Federal rate.

COMPARISON OF FACTORS AND ADJUSTMENTS: FY 2003 FEDERAL RATE AND PROPOSED FY 2004 FEDERAL RATE

	FY 2003	Proposed FY 2004	Change	Percent change
Update factor [1]	1.0110	1.0070	1.0070	0.70
GAF/DRG Adjustment Factor [1]	0.9957	1.0038	1.0038	0.38
Outlier Adjustment Factor [2]	0.9469	0.9455	0.9985	−0.15
Exceptions Adjustment Factor [2]	0.9970	0.9995	1.0025	0.25
Federal Rate	$406.93	$411.72	1.0118	1.18

[1] The update factor and the GAF/DRG budget neutrality factors are built permanently into the rates. Thus, for example, the incremental change from FY 2003 to FY 2004 resulting from the application of the proposed 1.0038 GAF/DRG budget neutrality factor for FY 2004 is 1.0038.

[2] The outlier reduction factor and the exceptions adjustment factor are not built permanently into the rates; that is, these factors are not applied cumulatively in determining the rates. Thus, for example, the net change resulting from the application of the proposed FY 2004 outlier adjustment factor is 0.9455/0.9469, or 0.9985.

6. Special Rate for Puerto Rico Hospitals

As explained at the beginning of section II.D. of this Addendum, hospitals in Puerto Rico are paid based on 50 percent of the Puerto Rico rate and 50 percent of the Federal rate. The Puerto Rico rate is derived from the costs of Puerto Rico hospitals only, while the Federal rate is derived from the costs of all acute care hospitals participating in the PPS (including Puerto Rico). To adjust hospitals' capital payments for geographic variations in capital costs, we apply a GAF to both portions of the blended 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 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 in section III.A.4. of this Addendum, for Puerto Rico the proposed GAF budget neutrality factor is 1.0002, while the proposed DRG adjustment is 1.0004, for a proposed combined cumulative adjustment of 0.9968.

In computing the payment for a particular Puerto Rico hospital, the Puerto Rico portion of the rate (50 percent) is multiplied by the Puerto Rico-specific GAF for the MSA in which the hospital is located, and the national portion of the rate (50 percent) 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 rate as a result of Public Law 105–33. In FY 2003, a small part of that reduction was restored.

For FY 2003, before application of the GAF, the special rate for Puerto Rico hospitals was $198.29. With the changes we are proposing to the factors used to determine the rate, the proposed FY 2004 special rate for Puerto Rico is $201.26.

B. Calculation of Inpatient Capital-Related Prospective Payments for FY 2004

With the end of the capital PPS transition period 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 Federal rate in FY 2004. The applicable Federal rate was determined by making adjustments as follows:

- For outliers, by dividing the standard Federal rate by the outlier reduction factor for that fiscal year; and
- For the payment adjustments applicable to the hospital, by multiplying the hospital's GAF, disproportionate share adjustment factor, and IME adjustment factor, when appropriate.

For purposes of calculating payments for each discharge during FY 2004, the 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 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 2004 are in section II.A.4.c. of this Addendum. For FY 2004, 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 $50,645.

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 are 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 was 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.B. 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 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 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 2004

We are forecasting the proposed CIPI to increase 0.7 percent for FY 2004. This reflects a projected 1.2 percent increase in vintage-weighted depreciation prices (building and fixed equipment, and movable equipment) and a 3.4 percent increase in other capital expense prices in FY 2004, partially offset by a 2.0 percent decline in vintage-weighted interest rates in FY 2004. The weighted average of these three factors produces the 0.7 percent increase for the CIPI as a whole.

IV. Proposed Changes to Payment Rates for Excluded Hospitals and Hospital Units: Rate-of-Increase Percentages

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 no longer paid on a reasonable cost basis but are paid under the IRF PPS. 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 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, subject to the blend methodology, may elect to be paid based on a 100 percent of the Federal prospective rate.

In accordance with existing § 413.40(c)(4)(ii) and (d)(1)(i) and (ii), where applicable, excluded hospitals and units that continue to be paid on a reasonable cost basis will have payments based on their Medicare inpatient operating costs, not to exceed the ceiling (as defined in § 413.40(a)(3)).

Section 1886(b)(7) of the Act had established a payment limitation for new hospitals and units excluded from the IPPS. While both rehabilitation hospitals and units and LTCHs are now paid under a PPS, psychiatric hospitals and units continue to be subject to the payment limitation. 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 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 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 proposed amounts included in the following table reflect the updated 110 percent of the national median target amounts of new excluded psychiatric hospitals and units for cost reporting periods beginning during FY 2004. These figures are updated with the most recent data available to reflect the projected market basket increase percentage of 3.5 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's 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	FY 2004 proposed labor-related share	FY 2004 proposed nonlabor-related share
Psychiatric	$7,301	$2,902

Effective for cost reporting periods beginning on or after October 1, 2002, this payment limitation is no longer applicable to new LTCHs since they will be paid 100 percent of the Federal rate. A new LTCH is a provider of inpatient hospital services that meets the qualifying criteria for LTCHs specified under § 412.23(e)(1) and (e)(2) and whose first cost reporting period as a LTCH begins on or after October 1, 2002 (§ 412.23(e)(4)). Under the LTCH PPS, new LTCHs are paid 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. 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). 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

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. For purposes of this proposed rule, and to avoid confusion, we have retained the designations of Tables 1 through 5 that were first used in the September 1, 1983 initial prospective payment final rule (48 FR 39844). Tables 1A, 1C, 1D, 2, 3A, 3B, 4A, 4B, 4C, 4F, 4G, 4H, 5, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H, 7A, 7B, 8A, 8B, 9, 10, and 11 are presented below. The tables presented below are as follows:

Table 1A—National Adjusted Operating Standardized Amounts, Labor/Nonlabor
Table 1C—Adjusted Operating Standardized Amounts for Puerto Rico, Labor/Nonlabor
Table 1D—Capital Standard Federal Payment Rate
Table 2—Hospital Average Hourly Wage for Federal Fiscal Years 2002 (1998 Wage Data), 2003 (1999 Wage Data), and 2004 (2000 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 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 2002 MedPAR Update December 2002 GROUPER V20.0
Table 7B—Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 2002 MedPAR Update December 2002 GROUPER V21.0
Table 8A—Statewide Average Operating Cost-to-Charge Ratios for Urban and Rural Hospitals (Case Weighted) March 2003
Table 8B—Statewide Average Capital Cost-to-Charge Ratios (Case Weighted) March 2003
Table 9—Hospital Reclassifications and Redesignations by Individual Hospital—FY 2004
Table 10—Mean and Standard Deviations by Diagnosis-Related Groups (DRGs)—FY 2004
Table 11—Proposed LTC–DRGs Relative Weights and Geometric and Five-Sixths of the Average Length of Stay-FY 2004

TABLE 1A.—NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR

Large urban areas		Other areas	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$3,139.26	$1,276.01	$3,089.56	$1,255.81

TABLE 1C.—ADJUSTED OPERATING STANDARDIZED AMOUNTS FOR PUERTO RICO, LABOR/NONLABOR

	Large urban areas		Other areas	
	Labor	Nonlabor	Labor	Nonlabor
National	$3,112.84	$1,265.27	$3,112.84	$1,267.03
Puerto Rico	1,516.86	610.57	1,492.84	600.90

TABLE 1D.—CAPITAL STANDARD FEDERAL PAYMENT RATE

	Rate
National	$411.72
Puerto Rico	$201.26

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
010001	17.4467	17.9841	19.3989	18.2929
010004	19.0010	20.1613	19.9457	19.7003
010005	18.6554	19.9733	18.3970	19.0198
010006	17.6115	18.3931	19.0976	18.4162
010007	15.6788	16.0781	17.5462	16.4299
010008	17.4728	19.0182	19.6573	18.7416
010009	18.4979	19.7272	20.3130	19.5087
010010	16.4664	17.7348	18.5730	17.5867
010011	22.4292	24.8922	25.6737	24.2683
010012	15.8686	20.3376	20.0896	18.5710
010015	19.1178	19.8205	18.8890	19.2826
010016	20.2198	20.3175	21.7918	20.8284
010018	18.9388	19.5519	19.2071	19.2353
010019	17.0856	17.6414	18.6539	17.7694
010021	15.1241	25.3335	17.7595	18.4456
010022	17.6435	22.1250	22.2266	20.3667
010023	16.3209	18.4567	20.0397	18.1965
010024	15.9034	17.3746	18.5108	17.2202
010025	15.1548	17.4702	18.9839	17.1956
010027	16.8595	16.5157	14.0974	15.7259
010029	18.3605	19.3393	20.9608	19.6182
010031	18.6402	19.2612	21.0176	19.6504
010032	15.3590	16.3967	16.4712	16.0937
010033	21.2986	21.9828	24.5088	22.5487
010034	15.3639	14.9379	14.5106	14.9494
010035	15.9439	20.7808	21.6182	19.2869
010036	17.7166	18.7158	17.7766	18.0775
010038	19.6098	19.6887	18.5873	19.2586
010039	20.3406	21.3550	22.9241	21.5758
010040	20.0983	20.4486	20.7536	20.4392
010043	18.6640	17.3567	19.9012	18.6528
010044	24.0265	23.4575	25.8561	24.4502
010045	17.0417	18.7569	21.1167	18.8731
010046	18.9737	18.8741	19.7870	19.2388
010047	15.4190	13.4130	16.1695	14.9341
010049	15.5246	16.3349	16.2841	16.0555
010050	17.9830	20.3028	20.7398	19.6262
010051	11.8108	12.3280	14.2767	12.7951
010052	18.0653	19.8289	11.9019	15.6329
010053	15.5649	15.4156	17.3238	16.1023
010054	19.4955	20.9656	20.6203	20.3735
010055	18.8590	19.5667	19.8170	19.4298
010056	19.6577	20.5645	21.1104	20.4208
010058	16.9715	16.1265	17.7800	16.9302
010059	18.8020	19.1270	20.5534	19.4928
010061	14.5003	18.5320	16.9028	16.6415
010062	12.3259	16.9721	17.1786	15.3820
010064	19.5256	20.5650	21.7162	20.5136
010065	16.8752	17.0557	17.2698	17.0733
010066	13.1559	14.8904	14.8696	14.3351
010068	18.6925	23.4322	18.2092	20.2305
010069	14.7211	15.4497	16.9839	15.7052
010072	16.2339	16.5652	18.8807	17.1920
010073	14.1273	13.5594	14.9826	14.2068
010078	18.1363	18.5127	20.1447	18.9315
010079	17.0648	17.1612	20.7401	18.2252
010081	17.2996	*	*	17.2996
010083	18.0312	18.4282	19.8525	18.7454
010084	18.7769	19.8773	21.6522	20.1274
010085	19.9023	21.5860	22.5282	21.3942
010086	16.5711	16.8886	18.0122	17.1417
010087	18.0567	18.7915	18.7253	18.4944
010089	17.7800	19.5241	19.5783	18.9652
010090	18.9445	19.5635	20.0287	19.5086
010091	17.0799	17.1775	17.4672	17.2432

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
010092	17.8144	18.5478	19.9289	18.7707
010095	12.2597	12.3064	12.5243	12.3676
010097	12.7286	14.2675	15.1593	14.0568
010098	14.0300	15.5763	15.1629	14.9158
010099	15.5619	15.9232	16.3307	15.9423
010100	17.9430	18.3755	19.8146	18.7658
010101	14.4625	18.9525	19.0718	17.2612
010102	13.8136	15.7777	16.4636	15.3148
010103	17.7242	22.0802	22.5709	20.6405
010104	16.8457	21.9457	20.9391	19.7211
010108	19.4617	19.1596	20.6337	19.7473
010109	14.6752	15.9627	18.2235	16.2157
010110	15.8283	15.5817	16.0015	15.8256
010112	16.8271	15.6041	17.9243	16.7545
010113	16.8936	18.2774	19.1978	18.1229
010114	17.0760	19.3772	20.1763	18.8237
010115	14.2261	15.3510	15.7873	15.0923
010118	17.0834	17.4620	19.4280	17.9013
010119	19.3942	19.5163	20.1990	19.7084
010120	18.2567	18.9975	19.4369	18.8719
010121	14.5262	15.2345	17.1640	15.7079
010123	19.2140	*	*	19.2141
010124	16.7465	*	*	16.7465
010125	16.0136	16.5117	16.8622	16.4618
010126	19.1065	19.5933	19.9845	19.5804
010127	18.2786	*	*	18.2786
010128	14.4322	16.6899	14.7646	15.2637
010129	16.1733	16.7609	16.4904	16.4644
010130	19.5573	17.4614	18.7190	18.5367
010131	20.1883	19.0492	22.3132	20.5855
010134	19.9856	18.5179	16.8181	18.4871
010137	20.5828	21.3573	28.7410	23.1563
010138	14.5254	14.1369	14.2024	14.2898
010139	20.4331	20.5708	22.8390	21.2553
010143	17.6212	18.9084	20.6578	19.0594
010144	18.2040	18.8272	19.1497	18.7345
010145	20.5895	20.8157	21.7700	21.0799
010146	19.1415	18.3666	21.3384	19.6056
010148	15.8349	18.4591	17.6830	17.3825
010149	18.0156	19.0199	20.8645	19.3169
010150	18.9359	19.4819	21.1878	19.8964
010152	18.7677	19.8990	21.1438	19.9058
010155	15.0689	13.6136	*	14.4394
010157	*	17.7372	19.6977	18.7304
010158	18.3957	18.6052	18.5464	18.5206
010159	*	19.3950	*	19.3950
020001	28.0394	28.6530	30.1452	28.9867
020002	25.1987	28.2759	30.4165	27.8092
020004	25.4679	29.2351	27.3516	27.2833
020005	29.2378	35.0860	32.7936	32.3866
020006	28.1417	33.0843	31.2673	30.7745
020007	32.3852	27.7269	27.5708	28.8969
020008	30.8691	31.8878	33.4543	32.1364
020009	18.4660	18.5594	24.9415	20.3403
020010	22.7559	23.7275	20.7928	22.3051
020011	28.0658	27.5062	29.6249	28.3773
020012	25.5320	26.7586	27.9955	26.7886
020013	28.1557	29.5646	30.6424	29.4993
020014	24.5875	27.7870	29.6806	27.4656
020017	28.0572	28.8752	30.3017	29.1234
020024	25.3205	25.5933	28.0930	26.3977
020025	20.2583	29.4375	32.8655	26.7102
030001	21.7869	22.8996	25.7513	23.3305

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
030002	21.8375	23.1450	25.6038	23.5516
030003	22.6804	23.9849	22.1436	22.9249
030004	15.5478	13.8452	15.7742	15.0275
030006	20.0273	20.5019	23.0216	21.0706
030007	21.5169	22.2473	26.1551	23.4298
030008	22.2190	*	*	22.2190
030009	18.7557	19.1258	19.9131	19.2261
030010	19.5123	19.8496	20.7204	20.0003
030011	19.4310	19.8141	21.0028	20.0690
030012	20.6585	21.1099	24.2366	22.1509
030013	20.0535	19.9517	21.9766	20.7166
030014	19.7966	20.3017	21.5382	20.5679
030016	19.4785	22.2526	24.3380	22.1886
030017	21.7938	23.1702	21.8792	22.2509
030018	20.8980	21.8067	24.9216	22.5811
030019	21.2540	22.0341	23.2973	22.2278
030022	19.5794	22.3351	24.9941	22.3479
030023	24.1678	25.4626	28.6628	26.2700
030024	23.6009	23.7663	26.7641	24.7020
030025	11.9894	20.2690	18.7967	16.8149
030027	17.6555	18.5500	19.4583	18.5927
030030	21.6932	23.1280	25.2425	23.1970
030033	20.2820	20.3034	26.4812	22.3008
030034	20.8689	19.5578	17.7772	19.3850
030035	20.0226	20.5339	*	20.2741
030036	21.6371	22.2690	24.9432	23.0233
030037	23.7615	23.7325	23.0542	23.5162
030038	22.9822	23.4477	25.2632	23.9087
030040	19.7636	19.3706	21.2717	20.1331
030041	18.8717	18.4750	18.6985	18.6886
030043	20.5598	20.5653	20.8619	20.6748
030044	17.6575	18.6781	21.9503	19.2464
030047	21.4412	22.7385	23.8939	22.7605
030049	19.3580	19.7315	*	19.5288
030054	15.0657	15.7973	16.8863	15.9671
030055	20.2991	20.8373	22.8612	21.3919
030059	22.6279	27.3929	*	24.8227
030060	18.6313	19.5021	21.7685	19.9508
030061	19.9047	21.1013	22.9706	21.3676
030062	18.7172	19.2670	21.1639	19.7478
030064	20.3837	21.6435	22.8009	21.6120
030065	20.7838	22.2846	24.6064	22.6068
030067	17.2778	17.6414	18.4004	17.7581
030068	17.7208	18.9718	19.7097	18.8803
030069	21.0936	23.4902	24.5432	23.0752
030080	20.6581	21.2299	22.7867	21.6244
030083	23.5229	23.5049	24.3273	23.8162
030085	20.8690	21.6542	21.8196	21.4875
030087	21.9465	23.1339	25.6344	23.5331
030088	20.5340	21.4491	23.5761	21.9185
030089	20.9516	22.0850	24.5055	22.5911
030092	21.8308	19.6625	20.6577	20.5622
030093	20.4314	21.7195	23.2485	21.9062
030094	22.8123	21.8049	24.5992	23.0301
030095	13.7664	20.5222	*	16.1313
030099	18.2263	19.8092	20.3310	19.5882
030100	23.7609	23.5868	*	23.6643
030101	19.2547	21.1029	23.8414	21.3423
030102	18.2413	21.5405	*	19.8425
030103	*	28.9308	40.8755	33.8153
030104	*	32.8668	34.6026	33.8315
040001	16.9178	16.3882	16.2652	16.4883
040002	15.1107	16.1353	18.0776	16.4361

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
040003	15.5740	15.5186	16.3918	15.8349
040004	17.9034	19.0105	19.8567	18.9476
040005	11.1318	16.5465	*	13.6054
040007	18.6998	22.5319	23.3992	21.2518
040008	14.7985	20.2121	*	17.4031
040010	19.4913	19.8251	20.4612	19.9398
040011	16.0995	17.1337	18.8346	17.5256
040014	18.1434	19.3996	22.4970	19.9652
040015	15.5207	17.9602	18.8513	17.4824
040016	20.2321	19.8087	21.2198	20.4114
040017	15.4736	16.5648	17.7545	16.6023
040018	18.7463	18.8203	22.2459	19.8242
040019	23.4163	21.0465	21.1711	21.7572
040020	18.9844	17.6056	18.0130	18.1484
040021	19.6835	21.3321	23.3840	21.5035
040022	20.8281	19.2393	20.5951	20.1448
040024	17.6607	17.1507	17.5750	17.4623
040025	13.4705	14.8071	17.6791	15.1660
040026	19.7924	21.0143	22.6617	21.1612
040027	17.4431	17.7161	19.3388	18.1973
040028	13.9946	15.2850	13.9975	14.4367
040029	21.1370	22.5094	22.1882	21.9489
040030	11.2402	16.5488	*	13.2353
040032	13.2872	13.8013	16.2781	14.3506
040035	10.9569	11.0611	11.8237	11.2698
040036	20.2012	21.1066	21.6742	21.0202
040037	14.0941	15.4984	*	14.7246
040039	14.7177	15.2811	15.9673	15.3471
040040	19.1984	19.6704	*	19.4380
040041	16.4624	17.7783	20.4646	18.2091
040042	15.2057	16.6875	16.2285	16.0552
040044	13.3501	17.1869	18.4270	16.2509
040045	16.2469	16.6648	19.5573	17.3603
040047	17.5336	18.6295	20.4173	18.8431
040050	14.0036	14.2087	15.1428	14.4627
040051	16.6039	18.2152	17.6964	17.5006
040053	15.0219	14.1508	19.2586	15.8377
040054	14.2577	16.5217	16.5573	15.7676
040055	18.0414	17.4236	17.1669	17.5528
040058	16.4278	19.3124	*	17.6419
040060	17.9805	15.4220	19.0007	17.4501
040062	17.8902	19.4255	20.6917	19.3314
040064	11.5029	13.3479	18.6107	14.1151
040066	19.7144	19.5619	21.7766	20.3116
040067	14.4741	15.0081	16.0516	15.1736
040069	17.0026	18.9754	20.5968	18.8667
040070	16.9700	18.6066	20.5214	18.8036
040071	17.6144	18.4956	18.7641	18.2815
040072	17.4960	21.3320	18.4032	18.9950
040074	18.7542	20.8465	22.0800	20.5126
040075	14.0975	14.6681	15.7875	14.8313
040076	20.5840	21.8010	23.5948	21.9901
040077	13.9114	14.7230	16.7832	15.1038
040078	18.5821	19.6363	21.4854	19.9519
040080	19.3707	22.8153	18.3431	19.9751
040081	11.1332	12.4796	13.2797	12.2892
040082	15.1331	16.4840	18.1636	16.5196
040084	17.7295	18.3410	20.1163	18.7753
040085	16.5216	14.1782	15.5811	15.3778
040088	17.1624	18.3159	19.8286	18.3979
040090	19.0824	16.6619	*	17.8591
040091	20.1378	20.2904	20.6688	20.3813
040093	13.9741	14.7132	*	14.3380

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
040100	15.6833	17.0271	17.8889	16.9700
040105	14.3896	14.8936	15.4697	14.9508
040106	18.1341	19.0936	19.1726	18.8593
040107	17.8628	20.6852	17.6695	18.7676
040109	16.6278	16.2496	17.1706	16.6926
040114	21.1231	21.3826	21.3532	21.2885
040118	18.2123	19.6248	21.8065	19.9138
040119	16.9407	18.6028	19.9013	18.5380
040124	19.2889	*	*	19.2889
040126	11.6517	16.3391	13.3832	13.6732
040132	10.3875	24.6941	29.2337	17.5163
040134	19.0185	22.1291	*	20.6229
040135	23.0084	*	*	23.0082
040136	*	21.4139	*	21.4138
040137	*	*	24.7813	24.7813
040138	*	*	21.0859	21.0859
050002	36.9630	30.2629	30.9729	32.2632
050006	18.2061	22.4890	25.4618	22.0352
050007	30.8676	31.6270	34.1406	32.1656
050008	26.3682	28.2021	32.4067	28.7024
050009	28.4734	28.3021	30.2740	29.0378
050013	28.0569	27.2552	30.1682	28.4525
050014	23.6745	25.1664	27.7646	25.5586
050015	27.7731	28.2204	27.5652	27.8552
050016	21.2045	22.7014	25.1232	23.0550
050017	25.6178	25.7403	28.4165	26.5820
050018	15.2903	16.5909	17.9621	16.7254
050022	24.5254	26.2574	28.1312	26.3930
050024	22.4274	21.5230	25.1016	22.9531
050025	24.8245	26.0161	29.8262	26.8932
050026	23.1904	23.4651	23.8785	23.5278
050028	17.6138	17.9421	18.7866	18.1131
050029	24.6839	26.6783	30.2538	27.1782
050030	21.5621	21.8639	21.9251	21.7896
050032	24.3598	24.4176	24.6284	24.4685
050033	32.0179	31.1768	*	31.6954
050036	21.8239	24.8017	25.3885	24.0459
050038	29.9698	32.1757	36.1619	32.5954
050039	22.8288	23.8478	26.8993	24.5711
050040	30.2607	30.1153	30.7426	30.3810
050042	24.5260	25.4903	27.6765	25.9508
050043	33.8255	38.8988	37.3217	36.6008
050045	21.1474	21.0356	22.1691	21.4359
050046	25.2005	25.3067	25.5490	25.3505
050047	29.9580	31.6959	34.4427	32.0849
050051	18.7809	17.9266	*	18.3161
050054	22.0982	19.2395	21.3495	20.8463
050055	29.2730	32.0923	36.1182	32.3322
050056	23.8396	24.7994	27.1458	25.3250
050057	20.7420	22.2584	24.2758	22.4840
050058	23.3009	24.8366	23.2205	23.7636
050060	20.5450	21.9971	22.9491	22.0213
050061	24.5488	23.9906	25.3042	24.6040
050063	25.7593	25.5798	28.6093	26.6450
050065	24.6290	27.6677	28.8369	27.0472
050066	16.1649	26.3920	*	19.8363
050067	25.8857	22.1250	27.8867	24.8006
050068	19.3615	19.2325	21.9031	19.5920
050069	24.6153	25.8560	27.2744	25.8994
050070	34.0721	36.4136	39.5178	36.7625
050071	34.4367	36.4834	40.1344	37.0182
050072	39.7321	36.1146	39.2188	38.3181
050073	32.8555	36.1054	38.6763	35.9238

* Denotes wage data not available for the provider for that year.
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TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
050075	33.7160	37.8104	40.2265	37.4233
050076	33.9752	37.0415	40.8075	37.1398
050077	24.1404	25.3481	27.1234	25.5664
050078	24.3150	23.0613	23.2913	23.5117
050079	30.0167	36.5455	39.6651	35.3854
050082	23.7617	23.7718	23.9154	23.8161
050084	25.4517	25.1155	25.9728	25.5331
050088	24.9641	25.2282	27.1103	25.7384
050089	22.8450	23.4120	24.7857	23.6599
050090	24.6070	25.4545	27.4193	25.8348
050091	23.7713	26.6463	29.2522	26.4442
050092	17.1211	17.1883	18.1132	17.4867
050093	25.6647	27.2048	29.2642	27.4393
050095	30.4847	29.2226	*	29.7245
050096	22.7394	22.5034	23.0526	22.7555
050097	22.5991	24.2548	24.4129	23.7724
050099	25.3722	26.2363	27.1308	26.2772
050100	25.2031	23.9877	25.3258	24.8411
050101	31.8957	33.1232	32.3802	32.4675
050102	24.0014	22.6741	25.5763	24.0204
050103	25.4133	23.5946	25.0854	24.6669
050104	26.9726	27.3260	26.1592	26.8000
050107	22.2019	22.2746	22.6900	22.4227
050108	25.1758	25.6983	28.5244	26.4357
050110	19.9589	21.3399	21.9296	21.1132
050111	20.7897	21.0813	23.7715	21.9292
050112	26.8182	29.1268	31.9797	29.3043
050113	28.5224	32.4493	32.6932	31.3678
050114	26.6757	27.6486	28.1909	27.5327
050115	23.0182	24.3748	24.1481	23.8529
050116	24.9196	27.0331	28.2924	26.6320
050117	22.2123	23.0697	24.7555	23.3917
050118	23.7129	24.9094	28.9358	25.8815
050121	18.7272	18.8430	24.6584	20.3903
050122	26.9546	26.9048	29.1534	27.6723
050124	24.5069	23.9379	23.0843	23.8087
050125	32.0230	33.3290	35.6572	33.6339
050126	24.6752	26.9718	27.7126	26.4996
050127	20.9027	20.5928	21.8559	21.1158
050128	26.6132	26.2519	28.7668	27.1805
050129	24.0108	23.7432	25.2780	24.3452
050131	32.5462	33.0980	37.7844	34.4656
050132	24.0173	24.1583	28.0265	25.4346
050133	23.2093	23.9479	25.1948	24.1576
050135	24.7157	23.2750	12.5413	18.0625
050136	24.7280	28.0754	31.1484	27.7833
050137	32.9192	33.7489	35.0503	33.8818
050138	38.1584	40.8912	43.0858	40.6538
050139	31.4984	35.1492	33.8749	33.3407
050140	32.7609	36.7096	36.1708	35.1295
050144	27.4069	29.8983	30.3678	29.2851
050145	34.5185	37.5003	37.5722	36.5610
050148	20.0971	21.1622	17.3908	19.5271
050149	26.8674	25.8880	28.0501	26.8823
050150	24.6596	25.9494	26.7728	25.8255
050152	33.3305	34.5096	34.5694	34.1486
050153	32.3389	33.3333	34.5870	33.4428
050155	25.3354	23.2118	21.2069	23.1002
050158	28.6071	28.9764	30.6598	29.4328
050159	22.5313	26.6139	21.3422	23.0637
050167	21.8796	21.9596	23.1879	22.3467
050168	25.1937	27.1971	26.4047	26.2183
050169	24.8407	24.7737	25.6896	25.1108

* Denotes wage data not available for the provider for that year.
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TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
050170	24.3654	27.7693	29.4075	26.9505
050172	19.6120	22.0400	24.5849	22.0737
050173	24.8694	*	27.7070	26.3141
050174	30.2775	31.6888	33.5204	31.9008
050175	24.7548	26.0146	26.9627	25.9076
050177	21.1396	22.5039	23.1575	22.2317
050179	23.8868	22.8941	23.0583	23.2574
050180	33.3257	34.0900	36.9905	34.8613
050186	23.6288	25.0791	27.6638	25.5202
050188	28.2364	30.6007	34.1503	31.0517
050189	27.4071	28.3295	32.3514	29.2097
050191	25.3516	29.4162	28.1689	27.6587
050192	14.1996	19.0400	19.5157	17.3616
050193	24.9444	25.5294	24.6307	25.0325
050194	29.5678	28.5389	28.0291	28.6722
050195	36.9068	39.1617	42.1735	39.4471
050196	18.2411	19.4304	19.8203	19.1752
050197	32.4030	34.6878	25.9224	30.7008
050204	22.7099	23.0192	24.9458	23.5600
050205	24.1691	24.1275	25.2841	24.5169
050207	22.9941	23.7774	25.1863	23.9991
050211	31.7280	33.2481	34.3396	33.0898
050213	21.4951	*	*	21.4951
050214	24.0276	21.1480	22.2431	22.4178
050215	35.0459	31.6895	34.4745	33.7035
050217	20.2042	21.3026	22.2055	21.2565
050219	21.2458	21.7637	21.8649	21.6598
050222	23.3563	23.0670	24.6959	23.7403
050224	23.5101	24.8431	25.1943	24.5595
050225	21.6820	22.0981	24.5601	22.7516
050226	24.4443	26.1959	26.0826	25.7144
050228	34.2596	36.0632	38.6751	36.2629
050230	26.6291	26.7963	30.0380	27.8217
050231	26.7321	27.4697	27.0320	27.0798
050232	24.5245	25.8640	25.3439	25.2423
050234	24.6126	25.0104	23.2830	24.1727
050235	27.0922	26.0323	27.2838	26.7962
050236	25.9458	27.7406	26.9290	26.8640
050238	24.5823	25.1796	26.0312	25.2541
050239	23.2711	24.9469	27.0911	25.1055
050240	26.7620	28.8910	32.8542	29.7204
050241	29.8345	*	*	29.8345
050242	32.0829	33.5646	34.4412	33.3749
050243	26.4627	26.0256	28.5626	27.0708
050245	23.2716	24.6092	25.7585	24.5579
050248	27.6457	28.4413	29.1192	28.4523
050251	23.6360	27.9531	24.4552	25.2214
050253	16.7540	21.0399	23.9247	20.2377
050254	20.1176	22.3414	23.3358	21.9420
050256	23.4835	25.1104	26.8618	25.3035
050257	17.2596	15.6379	17.4909	16.8191
050260	27.4234	30.1623	24.9073	27.2549
050261	20.1040	19.4649	21.4693	20.3613
050262	29.5550	30.8866	33.0425	31.0973
050264	36.0331	33.2270	37.5425	35.5478
050267	26.0401	27.8393	26.6558	26.7955
050270	25.3757	26.4092	27.9871	26.6878
050272	23.0587	23.3443	24.0921	23.5076
050276	33.3302	34.0633	34.4832	33.9454
050277	26.0822	23.6065	35.6323	28.8604
050278	23.9289	24.9699	26.0331	24.9976
050279	21.8949	22.2776	23.5145	22.5756
050280	25.6651	26.3392	28.4969	26.8343

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.