hospitals in accordance with sections 1886(d)(8)(B) and 1886(d)(10) of the Act when calculating the wage index. 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. This adjustment is discussed in section II.4.b. of the Addendum to this final rule.

Section 1886(d)(3)(E) of the Act also provides for the collection of data every 3 years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program, in order to construct an occupational mix adjustment to the wage index. The initial collection of these data must be completed by September 30, 2003, for application beginning October 1, 2004 (the FY 2005 wage index). In the April 4, 2003 **Federal Register** (68 FR 16516), we published a notice of intent to collect calendar year 2002 data from hospitals.

Many commenters on the April 4, 2003 notice requested that CMS publish a more detailed proposed methodology, illustrating how the occupational mix index will be calculated and how it will be used to adjust the overall wage index. Other comments on the April 4, 2003 notice included: CMS should develop or expand more categories to include all hospital employees; CMS should develop and publish a more reasonable timeframe for the hospitals to complete the survey, and a more reasonable timeframe for fiscal intermediaries to audit the occupational mix survey; CMS should clarify the relationship between the current annual cost report wage index schedule and the proposed occupational mix survey.

We plan to publish a final notice of intent in the **Federal Register**, with a 30-day comment period. The notice will include any revisions to the survey published on April 4, 2003 based on the comments we received, a detailed timetable, and all audit guidelines. Subsequent to that, we plan to send the surveys to all IPPS hospitals (and hospitals in Maryland that are under a waiver from the IPPS) through the fiscal intermediaries, with the intent to collect these data to be incorporated in the FY 2005 wage index.

Comment: In response to the May 19, 2003 IPPS proposed rule, commenters requested that we publish a detailed proposed methodology, for comment, illustrating how the occupational mix index will be calculated and how it will be used to adjust the overall wage index.

Response: Although our approach will not be finalized until publication of the FY 2005 rule, one possible approach to computing an occupational mix adjusted index is to first calculate, based on the hours collected for each occupational category from all hospitals nationally, a national average percentage attributable to each occupational category. Next, for each hospital, the total dollars and hours for each category would be summed, and an average hourly wage would be determined for each category by dividing dollars by hours. Each hospital's occupational mix adjusted average hourly wage would be calculated by multiplying each category's average hourly wage by the applicable weighting factors and then summing the results across all categories. Similar calculations would then be performed at the labor market level and the national level to construct an index.

We intend to analyze the impacts of implementing an occupational mix adjusted index in the proposed rule for FY 2005. Based on the estimated impacts, we will also evaluate at that time the possibilities for blending such an index with the FY 2005 wage index calculated using our current methodology based on data from the Worksheet S–3, Part II of the Medicare cost report.

B. FY 2004 Wage Index Update

The FY 2004 wage index values (effective for hospital discharges occurring on or after October 1, 2003 and before October 1, 2004) in section VI. of the Addendum to this final rule are based on the data collected from the Medicare cost reports submitted by hospitals for cost reporting periods beginning in FY 2000 (the FY 2003 wage index was based on FY 1999 wage data).

The data for the FY 2004 wage index were obtained from Worksheet S–3, Parts II and III of the FY 2000 Medicare cost reports. Instructions for completing the Worksheet S–3, Parts II and III are in the Provider Reimbursement Manual, Part I, sections 3605.2 and 3605.3. The FY 2004 wage index includes the following categories of data associated with costs paid under the IPPS (as well as outpatient costs), which were also included in the FY 2003 wage index:

- Salaries and hours from short-term, acute care hospitals.
- Home office costs and hours.
- Certain contract labor costs and hours (includes direct patient care, certain top management, pharmacy, laboratory, and nonteaching physician Part A services).
- Wage-related costs (The September 1, 1994 **Federal Register** included a list of core wage-related costs that are included in the wage index, and discussed criteria for including other wage-related costs (59 FR 45356)).

Consistent with the wage index methodology for FY 2003, the wage index for FY 2004 also excludes the direct and overhead salaries and hours for services not subject to IPPS payment, such as skilled nursing facility (SNF) services, home health services, costs related to GME (teaching physicians and residents) and certified registered nurse anesthetists (CRNAs), and other subprovider components that are not paid under the IPPS.

These wage data are also currently used to calculate wage indexes applicable to other providers, such as SNFs, home health agencies, and hospices. They are also used for prospective payments to rehabilitation and long-term care hospitals, and for hospital outpatient services.

C. FY 2004 IPPS Wage Index

1. Elimination of Wage Costs Associated With Rural Health Clinics and Federally Qualified Health Centers

In the FY 2001 IPPS final rule, we discussed removing from the wage index the salaries, hours, and wage-related costs of hospital-based rural health clinics (RHCs) and Federally qualified health centers (FQHCs) because Medicare pays for these costs outside of the IPPS (65 FR 47074). We noted that because RHC and FQHC costs were not previously separately reported on Worksheet S–3 of the Medicare cost report, we could not exclude these costs from the prior wage indexes. We further noted that we would evaluate the exclusion of RHC and FQHC wage data in developing the FY 2004 wage index.

We revised the FY 2000 Worksheet S–3 so that it now allows for the separate reporting of RHC and FQHC wage costs and hours. In the May 19, 2003 proposed rule, we proposed to exclude the wage and hours data for RHCs and FQHCs from the hospital wage index calculation beginning with the FY 2004 wage index.

We received several comments, all supporting this proposal. Therefore, beginning with the FY 2004 wage index, we are excluding the salaries, hours and wage-related costs associated with RHCs and FQHCs. This change is consistent with others we have implemented in our continuous effort to limit the wage index as much as possible to costs for which hospitals receive payment under

IPPS. An analysis of the effects of this change is included in the Appendix A of this final rule.

2. Paid Hours

It has been the longstanding policy of CMS to calculate the wage index using paid hours rather than hours worked (*see* the September 1, 1993 **Federal Register**, 58 FR 46299). This policy reflects our belief that paid hours more appropriately reflect a hospital's total wage costs, which include amounts paid for actual time worked and for covered leave periods (for example, annual, sick, and holiday leave). Therefore, the inclusion of paid lunch hours in the wage index is consistent with our inclusion of other paid nonworking hours.

Several hospitals have requested that we exclude paid lunch or meal break hours from the wage index calculation. At these hospitals, the typical workday is 7½ working hours, plus a ½ hour paid meal break, for a total of 8 paid hours. These hospitals, some of which are municipal-owned and required by their overarching union contracts to provide paid lunch hours, believe they are disadvantaged by a wage index policy that requires paid lunch hours to be included in calculating the wage index.

The hospitals argue that their practice of paying employees for meal breaks is not substantially different, in practice, from other hospitals whose employees do not receive paid lunch hours but who are on call during their lunch periods. These hospitals further argue that this policy causes them, in some cases due to union contracts beyond their control, to be the only hospitals with this category of nonproductive hours included in their wage index.

In the May 19, 2003 proposed rule, we solicited comments on our policy that paid lunch hours should be excluded from the wage index. Specifically, we were interested in a broader understanding of the issue of whether some hospitals may, in fact, be truly disadvantaged by this policy through no fault of their own. We indicated that any change in our policy would not be implemented until, at the earliest, the FY 2005 wage index.

Some hospitals and associations have also recommended that we exclude the paid hours associated with military and jury duty leave from the wage index calculation. They state that, unlike other paid leave categories for which workers are usually paid at their full hourly rates (for example, annual, sick, and holiday), hospitals typically pay employees on military or jury duty only a fraction of their normal pay. The amount that the hospital pays is intended to only supplement the earnings that the employee receives from the government so that, while performing military or civic duties, the employee can continue to be paid the same salary level, as if he or she were still working at the hospital.

The hospitals and associations believe that including lower pay rates associated with employees' military and jury duty leave unfairly decreases a hospital's average hourly wage and, therefore, its wage index value. Therefore, we proposed to exclude from the wage index the paid hours associated with military and jury duty leave, beginning with the FY 2005 wage index. We also proposed that the associated salaries would continue to be reported on Worksheet S–3, Part II, Line 1 of the Medicare cost report.

Comment: A few commenters agreed that paid lunch hours and hours associated with military and jury duty leave should be removed from the wage index. Many more commenters, including some national and state hospital associations and Medicare fiscal intermediaries, opposed or expressed concern about whether excluding paid lunch hours and hours associated with military and jury duty leave would result in a more accurate wage index.

Those commenters who opposed the proposal to exclude paid lunch hours and hours associated with military and jury duty leave expressed concern that these changes would further complicate the wage index and that the additional data collection effort for providers might outweigh any benefits achieved through these changes. Further, the commenters believed that paid lunch hours, military, and jury leave affect all providers in the same way, so the changes would likely be immaterial. One commenter also expressed concern that excluding paid hours could cause hospitals to rewrite existing contracts to raise their wage index. In addition, some commenters cautioned that excluding these paid hours would be difficult for intermediaries to apply consistently; excluding these hours would require estimations because most payroll systems do not capture this data. Many commenters indicated that CMS had not published data to provide support that these changes are warranted.

One commenter suggested that, if CMS excludes paid lunch hours, CMS should set a standard for hospitals to qualify for excluding the hours, such as the Fair Labor Standards Act requirements for payment. Another suggested that the determination of excluding paid lunch hours should be based on whether lunch is included for the purpose of computing the hourly wage rate used to pay for overtime. If paid lunch hours are included in the overtime payment computation, and excluding them would result in an hourly rate that is higher than what is usually used for overtime, the paid lunch hours should be excluded. If the paid lunch hours are not included in computing the hourly wage for overtime, and excluding them would result in the correct hourly wage rate that should be used for overtime, the lunch hours should be excluded. Two commenters recommended that the wage index should also exclude time associated with paid breaks from the wage index, but acknowledged that paid breaks are not usually tracked in payroll systems. One commenter recommended that CMS allow all hospitals in an area to include paid hours on a standard basis in order to eliminate differences that are more a matter of how hours are reported rather than actual difference in wages.

Those commenters who opposed the exclusion of paid lunch hours were generally concerned that hospitals do not currently track paid lunch hours. They indicated that it would be a major burden for hospitals to change their systems to accommodate reporting the hours and the benefits are likely to be minimum.

A few commenters suggested that, if a hospital pays its employees at the full rate for military and jury duty leave, the full associated hours should be included. However, they added that if a hospital pays its employees at a reduced rate for these leave categories, the hospital should exclude hours based on the fraction of the salary that is not paid. If the hospital does not pay for any military or jury duty leave, all of the associated hours should be excluded. The commenters believed that this treatment would be consistent with our longstanding policy to include hours associated with paid time off, while a hospital's average hourly rate would not be negatively impacted by the reduced rates that some hospitals pay for military and jury duty leave. One commenter recommended that CMS permit hospitals to exclude the hours, but not require such reporting.

Several commenters opposed excluding paid hours associated with military and jury duty because they believe that military and jury duty leave affect all providers in the same way. Therefore, they believed that any changes in the wage index would likely be immaterial. Two commenters expressed concern that, if paid hours are excluded and wages are not, the wage index would be overstated. The

commenters recommended that, if CMS excludes paid hours associated with military and jury duty leave, for consistency, CMS should also exclude the related wages. Alternatively, the commenters recommended that CMS collect data on the wages and hours associated with military and jury duty first, so that the impact of excluding the hours can be determined before the policy is implemented. One commenter believed that CMS should only include in the wage index, hours associated with regular hours, overtime, and sick leave, because these paid leave or paid time off categories are consistently offered among hospitals. The commenter also believed other paid leave or paid time off categories such as vacation hours, maternity leave, bereavement leave, and vacation hours should be excluded because they are not consistently offered among hospitals. In addition, the commenter believed that when hospitals are competing for employees in the labor market, if offered, these paid leave or paid time off hours could vary from hospital to hospital. For example, hospital A will only pay 2 weeks for paid vacation leave, while hospital B will pay 4 weeks for paid vacation leave. Therefore, the commenter believed these other paid leave or paid time off leave hours should be excluded from the wage index.

Response: As we stated above and in the proposed rule, it has been our longstanding policy to include paid hours in the calculation of the wage index because they more appropriately reflect a hospital's total wage costs. We solicited comments on the possible exclusion of paid lunch hours and proposed to exclude the paid hours associated with military and jury duty hours because of our concern that there were significant issues with the consistent treatment of these issues across hospitals that may impact the validity of the wage index. However, the comments indicate to us there is substantial disagreement with respect to whether either category of paid hours should be excluded from the wage index calculation. Therefore, we are not proceeding with either change at this time. We intend to explore a more comprehensive assessment of the use of paid hours in a future rule. For the FY 2005 final wage index, we are including paid lunch hours, and hours associated with military leave and jury duty.

D. Verification of Wage Data From the Medicare Cost Reports

The data file used to construct the wage index includes FY 2000 data submitted to us as of June 27, 2003. As in past years, we performed an intensive review of the wage data, mostly through the use of edits designed to identify aberrant data.

We constructed the proposed FY 2004 wage index based on the wage data for facilities that were IPPS hospitals in FY 2000, even for those facilities that have terminated their participation in the program as hospitals or have since been designated as a critical access hospital (CAH), as long as those data do not fail any of our edits for reasonableness. We stated that including the wage data for these hospitals is, in general, appropriate to reflect the economic conditions in the various labor market areas during the relevant past period.

Prior to the proposed rule, we had received correspondence suggesting that the wage data for hospitals that have subsequently been redesignated as CAHs should be removed from the wage index calculation because CAHs are a separate provider type and are unique compared to other short-term, acute care hospitals. CAHs are limited to only 15 acute care beds. An additional 10 beds may be designated as swing-beds, but only 15 beds can be used at one time to serve acute care patients. CAHs tend to be located in isolated, rural areas. In the May 19, 2003 proposed rule, we solicited comments on whether we should exclude wage data from such hospitals from the wage index calculation. However, we included the data for current CAHs in the proposed FY 2004 wage index if the CAH was paid under the IPPS during FY 2000 as an acute care hospital.

Comment: Commenters, including national hospital associations, generally supported the removal of CAH wage data from the wage index. One commenter agreed that CAHs are dissimilar to IPPS hospitals and described a situation in which including a CAH has a negative impact on the other hospitals' wage index. One commenter agreed that CMS should exclude the costs, but expressed concern about the immediate financial impact that excluding CAHs might have on all hospitals in FY 2004. The commenter recommended that CMS examine the impact of removing CAH wage data from the wage index and make this analysis available for public comment. Another commenter recommended that CMS establish a date prior to the release of the wage index public use file that the facility must be certified as a CAH to be excluded from the wage index calculation.

Several commenters opposed excluding CAH data from the wage index. Some commenters indicated that CMS does not exclude hospitals that converted to CAH status subsequent to the year used to derive DRG weights. Another commenter opposed excluding CAHs from the wage index because the commenter believed that the wage index should reflect conditions of a labor market at a specific point in time. The commenter believed that other conditions, such as closures, mergers, or expansions, are analogous circumstances and warned that excluding these hospitals would also distort the wage index. Another commenter recommended that CMS apply a hold-harmless policy.

Response: CAHs represent a substantial number of hospitals with significantly different labor costs in many labor market areas where they exist. Using data collected for the proposed FY 2004 wage index, we found that, in 89 percent of all labor market areas with hospitals that converted to CAH status some time after FY 2000, the average hourly wage for CAHs is lower than the average hourly wage for other short-term hospitals in the area. In 79 percent of the labor market areas with CAHs, the average hourly wage for CAHs is lower than the average hourly wage for other short-term hospitals by 5 percent or greater. These results suggest that the wage data for CAHs, in general, are significantly different from other short-term hospitals.

Further, we found that removing CAHs from the wage index would have a minimal redistributive effect on Medicare payments to hospitals. The majority of the labor market areas would decrease by only 0.30 percent in their wage index value. The actual payment impact would be even smaller because the wage index is applied to only the labor-related portion of the average standardized amount. Only 10 areas would experience a decrease in their wage index values greater than 0.30 percent. The greatest negative impact is 9.57 percent. Meanwhile, positive impacts occur in 48 areas, 30 of which are in rural areas. Overall, removing CAHs from the wage index would have a minimal redistributive effect on Medicare payments to hospitals.

We believe that removing CAHs from the wage index is prudent policy, given the substantial negative impact these hospitals have on the wage indexes in the areas where they are located and the minimal impact they have on the wage indexes of other areas. We note that we would continue to include the wage data for other terminating or converting hospitals for the period preceding their change in Medicare provider status, as long as those data do not fail any of our edits for reasonableness. This is because

we continue to believe that the wage data for these hospitals, unlike CAHs, are not necessarily unique compared to other short-term hospitals, and these terminating or converting hospitals provide an accurate reflection of the labor market area during the relevant past period.

Therefore, beginning with the FY 2004 wage index, we are excluding from the wage index the wages and hours for all hospitals that are currently designated as a CAH, even if the hospital was paid under the IPPS during the cost reporting period used in calculating the wage index. We believe that this change improves the overall equity of the wage index. Therefore, it is important to proceed with this change for FY 2004. Consistent with our general approach to wage index changes, we are not holding other hospitals' payments harmless for this change.

As recommended, any hospital that is designated as a CAH by 7 days prior to the publication of the preliminary wage index public use file are excluded from the calculation of the wage index. Hospitals receiving designation after this date will remain in the wage index calculation.

We asked our fiscal intermediaries to revise or verify data elements that resulted in specific edit failures. The unresolved data elements that were included in the calculation of the proposed FY 2004 wage index have been resolved and are reflected in the calculation of the final FY 2004 wage index. For the final FY 2004 wage index in this final rule, we removed data for 23 hospitals that failed edits. For 9 of these hospitals, we were unable to obtain sufficient documentation to verify or revise the data because the hospitals are no longer participating in the Medicare program, are under new ownership, or are in bankruptcy status, and supporting documentation is no longer available. We identified 14 hospitals with incomplete or inaccurate data resulting in zero or negative, or otherwise aberrant, average hourly wages. Therefore, these hospitals were removed from the calculation. As a result, the final FY 2004 wage index is calculated based on FY 2000 wage data for 4,087 hospitals.

E. Computation of the FY 2004 Wage Index

The method used to compute the FY 2004 wage index follows:

Step 1—As noted above, we based the FY 2004 wage index on wage data reported on the FY 2000 Medicare cost reports. We gathered data from each of the non-Federal, short-term, acute care hospitals for which data were reported on the Worksheet S–3, Parts II and III of the Medicare cost report for the hospital's cost reporting period beginning on or after October 1, 1999 and before October 1, 2000. In addition, we included data from some hospitals that had cost reporting periods beginning before October 1999 and reported a cost reporting period covering all of FY 2000. These data were included because no other data from these hospitals are available for the cost reporting period described above, and because particular labor market areas might be affected due to the omission of these hospitals. However, we generally describe these wage data as FY 2000 data. We note that, if a hospital had more than one cost reporting period beginning during FY 2000 (for example, a hospital had two short cost reporting periods beginning on or after October 1, 1999 and before October 1, 2000), we included wage data from only one of the cost reporting periods, the longer, in the wage index calculation. If there was more than one cost reporting period and the periods were equal in length, we included the wage data from the later period in the wage index calculation.

Step 2—Salaries—The method used to compute a hospital's average hourly wage excludes certain costs that are not paid under the IPPS. In calculating a hospital's average salaries plus wage-related costs, we subtracted from Line 1 (total salaries) the GME and CRNA costs reported on lines 2, 4.01, and 6, the Part B salaries reported on Lines 3, 5 and 5.01, home office salaries reported on Line 7, and excluded salaries reported on Lines 8 and 8.01 (that is, direct salaries attributable to SNF services, home health services, and other subprovider components not subject to the IPPS). We also subtracted from Line 1 the salaries for which no hours were reported. To determine total salaries plus wage-related costs, we added to the net hospital salaries the costs of contract labor for direct patient care, certain top management, pharmacy, laboratory, and nonteaching physician Part A services (Lines 9, 9.01, 9.02, and 10), home office salaries and wage-related costs reported by the hospital on Lines 11 and 12, and nonexcluded area wage-related costs (Lines 13, 14, and 18).

We note that contract labor and home office salaries for which no corresponding hours are reported were not included. In addition, wage-related costs for nonteaching physician Part A employees (Line 18) are excluded if no corresponding salaries are reported for those employees on Line 4.

Step 3—Hours—With the exception of wage-related costs, for which there are no associated hours, we computed total hours using the same methods as described for salaries in Step 2.

Step 4—For each hospital reporting both total overhead salaries and total overhead hours greater than zero, we then allocated overhead costs to areas of the hospital excluded from the wage index calculation. First, we determined the ratio of excluded area hours (sum of Lines 8 and 8.01 of Worksheet S–3, Part II) to revised total hours (Line 1 minus the sum of Part II, Lines 2, 3, 4.01, 5, 5.01, 6, 7, and Part III, Line 13 of Worksheet S–3). We then computed the amounts of overhead salaries and hours to be allocated to excluded areas by multiplying the above ratio by the total overhead salaries and hours reported on Line 13 of Worksheet S–3, Part III. Next, we computed the amounts of overhead wage-related costs to be allocated to excluded areas using three steps: (1) we determined the ratio of overhead hours (Part III, Line 13) to revised hours (Line 1 minus the sum of Lines 2, 3, 4.01, 5, 5.01, 6, and 7); (2) we computed overhead wage-related costs by multiplying the overhead hours ratio by wage-related costs reported on Part II, Lines 13, 14, and 18; and (3) we multiplied the computed overhead wage-related costs by the above excluded area hours ratio. Finally, we subtracted the computed overhead salaries, wage-related costs, and hours associated with excluded areas from the total salaries (plus wage-related costs) and hours derived in Steps 2 and 3.

Step 5—For each hospital, we adjusted the total salaries plus wage-related costs to a common period to determine total adjusted salaries plus wage-related costs. To make the wage adjustment, we estimated the percentage change in the employment cost index (ECI) for compensation for each 30-day increment from October 14, 1999 through April 15, 2001 for private industry hospital workers from the Bureau of Labor Statistics' *Compensation and Working Conditions.* We use the ECI because it reflects the price increase associated with total compensation (salaries plus fringes) rather than just the increase in salaries. In addition, the ECI includes managers as well as other hospital workers. This methodology to compute the monthly update factors uses actual quarterly ECI data and assures that the update factors match the actual quarterly and annual percent changes. The factors used to adjust the hospital's data were based on the midpoint of the cost reporting period, as indicated below.

MIDPOINT OF COST REPORTING PERIOD

After	Before	Adjustment factor
10/14/1999	11/15/1999	1.06794
11/14/1999	12/15/1999	1.06447
12/14/1999	01/15/2000	1.06083
01/14/2000	02/15/2000	1.05713
02/14/2000	03/15/2000	1.05335
03/14/2000	04/15/2000	1.04954
04/14/2000	05/15/2000	1.04571
05/14/2000	06/15/2000	1.04186
06/14/2000	07/15/2000	1.03786
07/14/2000	08/15/2000	1.03356
08/14/2000	09/15/2000	1.02898
09/14/2000	10/15/2000	1.02425
10/14/2000	11/15/2000	1.01953
11/14/2000	12/15/2000	1.01482
12/14/2000	01/15/2001	1.01004
01/14/2001	02/15/2001	1.00509
02/14/2001	03/15/2001	1.00000
03/14/2001	04/15/2001	0.99491

For example, the midpoint of a cost reporting period beginning January 1, 2000 and ending December 31, 2000 is June 30, 2000. An adjustment factor of 1.03786 would be applied to the wages of a hospital with such a cost reporting period. In addition, for the data for any cost reporting period that began in FY 2000 and covered a period of less than 360 days or more than 370 days, we annualized the data to reflect a 1-year cost report. Annualization is accomplished by dividing the data by the number of days in the cost report and then multiplying the results by 365.

Step 6—Each hospital was assigned to its appropriate urban or rural labor market area before any reclassifications under section 1886(d)(8)(B) or section 1886(d)(10) of the Act. Within each urban or rural labor market area, we added the total adjusted salaries plus wage-related costs obtained in Step 5 for all hospitals in that area to determine the total adjusted salaries plus wage-related costs for the labor market area.

Step 7—We divided the total adjusted salaries plus wage-related costs obtained under both methods in Step 6 by the sum of the corresponding total hours (from Step 4) for all hospitals in each labor market area to determine an average hourly wage for the area.

Step 8—We added the total adjusted salaries plus wage-related costs obtained in Step 5 for all hospitals in the nation and then divided the sum by the national sum of total hours from Step 4 to arrive at a national average hourly wage. Using the data as described above, the national average hourly wage is $24.8076.

Step 9—For each urban or rural labor market area, we calculated the hospital wage index value by dividing the area average hourly wage obtained in Step 7 by the national average hourly wage computed in Step 8.

Step 10—Following the process set forth above, we developed a separate Puerto Rico-specific wage index for purposes of adjusting the Puerto Rico standardized amounts. (The national Puerto Rico standardized amount is adjusted by a wage index calculated for all Puerto Rico labor market areas based on the national average hourly wage as described above.) We added the total adjusted salaries plus wage-related costs (as calculated in Step 5) for all hospitals in Puerto Rico and divided the sum by the total hours for Puerto Rico (as calculated in Step 4) to arrive at an overall average hourly wage of $11.5905 for Puerto Rico. For each labor market area in Puerto Rico, we calculated the Puerto Rico-specific wage index value by dividing the area average hourly wage (as calculated in Step 7) by the overall Puerto Rico average hourly wage.

Step 11—Section 4410 of Public Law 105–33 provides that, for discharges on or after October 1, 1997, the area wage index applicable to any hospital that is located in an urban area of a State may not be less than the area wage index applicable to hospitals located in rural areas in that State. Furthermore, this wage index floor is to be implemented in such a manner as to ensure that aggregate IPPS payments are not greater or less than those that would have been made in the year if this section did not apply. For FY 2004, this change affects 150 hospitals in 49 MSAs. The MSAs affected by this provision are identified by a footnote in Table 4A in the Addendum of this final rule.

Comment: One commenter indicated that there are serious deficiencies in the payment rates to Iowa hospitals under IPPS because of the development and application of the wage index, and, accordingly, CMS must make revisions to the wage index in this final rule. The comment suggested that CMS should: reduce the labor-related portion of the standardized amount to which the wage index is applied; adjust the wage index upward to account for low Medicare payments; or utilize a wage index floor or compress the wage index.

Response: We appreciate the concerns expressed by this commenter about the impact of the wage index upon Iowa's hospitals. We strive each year to ensure the wage index accurately reflects the relative wage differences across labor market areas. Further, the methodology we use to compute the wage index values is the same for all urban and rural hospitals. Therefore, the wage index values we include in the proposed and final rules for Iowa hospitals reflect the actual wage costs that are reported by these hospitals relative to those reported by hospitals across the nation.

With respect to the commenter's specific recommendations, we address comments related to the labor-related portion of the standardized amounts in section VII. of the preamble of this final rule. With respect to the other recommendations raised, these were not proposed and, therefore, we do not wish to implement them in this final rule. We are willing to explore these and other options in the future and to work with the commenter to address the concerns expressed.

Comment: One commenter indicated that we failed to address the problem associated with the exclusion of indirect patient care contract labor in the proposed rule. The commenter indicated that we recognized this problem in the FY 2002 final rule (67 FR 50022), but failed to carry out our commitment to address it.

Response: We indicated last year it would be necessary to revise the cost report form and instructions in order to collect the data necessary to separately identify the costs and hours associated with the following contracted overhead services: administrative and general; housekeeping; and dietary. In Transmittal Number 10 of the Medicare cost report, we revised Worksheet S–3, Part II to collect contract labor costs associated with these services, effective with cost reporting periods beginning on or after October 1, 2003.

We also indicated our final decision on whether to include contract indirect patient care labor costs in our calculation of the wage index will depend on the outcome of our analyses of the data collected and public comments.

F. Revisions to the Wage Index Based on Hospital Redesignation

1. General

Under section 1886(d)(10) of the Act, the Medicare Geographic Classification Review Board (MGCRB) considers applications by hospitals for geographic reclassification for purposes of payment under the IPPS. Hospitals can elect to reclassify for the wage index or the standardized amount, or both, and as individual hospitals or as rural groups. Generally, hospitals must be proximate to the labor market area to which they are seeking reclassification and must demonstrate characteristics similar to hospitals located in that area. Hospitals must apply for reclassification to the MGCRB. The MGCRB issues its decisions by the end of February for

reclassification to become effective for the following fiscal year (beginning October 1). The regulations applicable to reclassifications by the MGCRB are located in §§ 412.230 through 412.280.

Section 1886(d)(10)(D)(v) of the Act provides that, beginning with FY 2001, a MGCRB decision on a hospital reclassification for purposes of the wage index is effective for 3 fiscal years, unless the hospital elects to terminate the reclassification. Section 1886(d)(10)(D)(vi) of the Act provides that the MGCRB must use the 3 most recent years' average hourly wage data in evaluating a hospital's reclassification application for FY 2003 and any succeeding fiscal year.

Section 304(b) of Pub. L. 106–554 provides that the Secretary must establish a mechanism under which a statewide entity may apply to have all of the geographic areas in the State treated as a single geographic area for purposes of computing and applying a single wage index, for reclassifications beginning in FY 2003. The implementing regulations for this provision are located at § 412.235.

Section 1886(d)(8)(B) of the Act permits a hospital located in a rural county adjacent to one or more urban areas to be designated as being located in the MSA to which the greatest number of workers in the county commute (1) if the rural county would otherwise be considered part of an urban area under the standards published in the **Federal Register** for designating MSAs (and for designating NECMAs), and (2) if the commuting rates used in determining outlying counties (or, for New England, similar recognized area) were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or counties of all contiguous MSAs (or NECMAs). Hospitals that meet these criteria are deemed urban for purposes of the standardized amounts and for purposes of assigning the wage index.

Revised MSA standards were published in the December 27, 2000 **Federal Register** (65 FR 82228). We are working with the Census Bureau to compile a list of hospitals that meet the new standards based on the 2000 census data; however, that work was not yet complete at the time of publication of the proposed rule.

As noted above, OMB announced the new Metropolitan and Micropolitan Statistical Area designations and definitions on June 6, 2003. These new designations have extensively revised the construct of many of the existing Metropolitan Areas and created many new designated areas. In order to implement these changes, we need to carefully evaluate the implications of these changes for each county and hospital nationwide. As a result, we are unable to incorporate these new standards for redesignating hospitals and, therefore, we are not implementing the new standards for purposes of redesignation for FY 2004 under section 1886(d)(8)(B) of the Act. As a result, to qualify for redesignation under this section in FY 2004, hospitals must be located in counties that meet the 1990 standards.

2. Effects of Reclassification

The methodology for determining the wage index values for redesignated hospitals is applied jointly to the hospitals located in those rural counties that were deemed urban under section 1886(d)(8)(B) of the Act and those hospitals that were reclassified as a result of the MGCRB decisions under section 1886(d)(10) of the Act. Section 1886(d)(8)(C) of the Act provides that the application of the wage index to redesignated hospitals is dependent on the hypothetical impact that the wage data from these hospitals would have on the wage index value for the area to which they have been redesignated. Therefore, as provided in section 1886(d)(8)(C) of the Act,[5] the wage index values were determined by considering the following:

- If including the wage data for the redesignated hospitals would reduce the age index value for the area to which the hospitals are redesignated by 1 percentage point or less, the area wage index value determined exclusive of the wage data for the redesignated hospitals applies to the redesignated hospitals.
- If including the wage data for the redesignated hospitals reduces the wage index value for the area to which the hospitals are redesignated by more than 1 percentage point, the area wage index determined inclusive of the wage data for the redesignated hospitals (the combined wage index value) applies to the redesignated hospitals.
- If including the wage data for the redesignated hospitals increases the wage index value for the urban area to which the hospitals are redesignated, both the area and the redesignated hospitals receive the combined wage index value. Otherwise, the hospitals located in the urban area receive a wage index excluding the wage data of hospitals redesignated into the area.
- The wage data for a reclassified urban hospital is included in both the wage index calculation of the area to which the hospital is reclassified (subject to the rules described above) and the wage index calculation of the urban area where the hospital is physically located.
- Rural areas whose wage index values would be reduced by excluding the wage data for hospitals that have been redesignated to another area continue to have their wage index values calculated as if no redesignation had occurred (otherwise, redesignated rural hospitals are excluded from the calculation of the rural wage index).
- The wage index value for a redesignated rural hospital cannot be reduced below the wage index value for the rural areas of the State in which the hospital is located.

The wage index values for FY 2004 are shown in Tables 4A, 4B, 4C, and 4F in the Addendum to this final rule. Hospitals that are redesignated must use the wage index values shown in Table 4C. Areas in Table 4C may have more than one wage index value because the wage index value for a redesignated urban or rural hospital cannot be reduced below the wage index value for the rural areas of the State in which the hospital is located. Therefore, those areas with more than one wage index shown have hospitals from more than one State reclassified into them, and the rural wage index for a State in which at least one hospital is physically located is higher than the wage index for the area to which the hospital is reclassified.

Tables 3A and 3B in the Addendum of this final rule list the 3-year average hourly wage for each labor market area before the redesignation of hospitals, based on FYs 1998, 1999, and 2000 cost reporting periods. Table 3A lists these data for urban areas and Table 3B lists these data for rural areas. In addition, Table 2 in the Addendum to this final rule includes the adjusted average hourly wage for each hospital from the FY 1998 and FY 1999 cost reporting periods, as well as the FY 2000 period used to calculate the final FY 2004 wage index. The 3-year averages are calculated by dividing the sum of the dollars (adjusted to a common reporting

[5] Although section 1886(d)(8)(C)(iv)(I) of the Act also provides that the wage index for an urban area may not decrease as a result of redesignated hospitals if the urban area wage index is below the wage index for rural areas in the State in which the urban area is located, this was effectively made moot by section 4410 of Public Law 105–33, which provides that the area wage index applicable to any hospital that is located in an urban areas of a State may not be less than the area wage index applicable to hospitals located in rural areas in that State.

Also, section 1886(d)(8)(C)(iv)(II) of the Act provides that an urban area's wage index may not decrease as a result of redesignated hospitals if the urban area is located in a State that is composed of a single urban area.

period using the method described previously) across all 3 years, by the sum of the hours. If a hospital is missing data for any of the previous years, its average hourly wage for the 3-year period is calculated based on the data available during that period.

Table 9 in the Addendum of this final rule shows hospitals that have been reclassified under either section 1886(d)(8) or section 1886(d)(10)(D) of the Act. This table includes hospitals reclassified for FY 2004 by the MGCRB (68 for wage index, 31 for the standardized amount, and 34 for both the wage index and the standardized amount), as well as hospitals that were reclassified for the wage index in either FY 2002 (451) or FY 2003 (55) and are, therefore, in either the second or third year of their 3-year reclassification. In addition, it includes rural hospitals redesignated to an urban area under section 1886(d)(8)(B) of the Act for purposes of the standardized amount and the wage index (42). Since publication of the May 19 proposed rule, the number of reclassifications has changed because some MGCRB decisions were still under review by the Administrator and because some hospitals decided to withdraw their requests for reclassification.

Changes to the wage index that result from withdrawals of requests for reclassification, wage index corrections, appeals, and the Administrator's review process have been incorporated into the wage index values published in this final rule. The changes may affect not only the wage index value for specific geographic areas, but also the wage index value redesignated hospitals receive; that is, whether they receive the wage index value that includes the data for both the hospitals already in the area and the redesignated hospitals. Further, the wage index value for the area from which the hospitals are redesignated may be affected.

Applications for FY 2005 reclassifications are due to the MCGRB by September 2, 2003. We note that this is also the deadline for canceling a previous wage index reclassification withdrawal or termination under § 412.273(d). Applications and other information about MCGRB reclassifications may be obtained via the CMS Internet Web site at *http://cms.hhs.gov/providers/prrb/mgcinfo.asp*, or by calling the MCGRB at (410) 786–1174. The mailing address of the MGCRB is: 2520 Lord Baltimore Drive, Suite L, Baltimore, MD 21244–2670.

As noted previously, OMB announced its new Metropolitan and Micropolitan Statistical Area definitions on June 6, 2003. However, as noted previously as well as in the proposed rule, in order to implement these changes for the IPPS, it is necessary to identify the new area designations for each county and hospital in the country. This is not possible by the September 2, 2003 deadline for reclassification by the MCGRB for FY 2005. Therefore, hospitals submitting applications for reclassification by the MCGRB for FY 2005 should base those applications on the current MSAs. We plan to move deliberately in determining the implications the new definitions will have on hospitals' reclassification requests, and we are considering addressing these implications in the FY 2005 proposed rule.

G. Requests for Wage Data Corrections

In the May 19, 2003 proposed rule, we described the process for hospitals to review and revise their FY 2000 wage data. The preliminary wage data file was made available on January 10, 2003 (and subsequently on February 4, 2003), through the Internet on CMS's Web site at: *http://www.cms.hhs.gov/providers/hipps/default.asp.* At that time, we also made available, at the same Internet address, a file showing each MSA's and rural areas's FY 2004 average hourly wage based on data then available compared to its FY 2003 average hourly wage. In a memorandum dated December 31, 2002, we instructed all Medicare fiscal intermediaries to inform the IPPS hospitals they service of the availability of the wage data file and the process and timeframe for requesting revisions (including the specific deadlines listed below). We also instructed the fiscal intermediaries to advise hospitals that these data are made available directly through their representative hospital organizations.

If a hospital wished to request a change to its data as shown in that wage data file, the hospital was to submit corrections along with complete, detailed supporting documentation to its intermediary by February 17, 2003 (this deadline was initially announced as February 10, 2003, but was changed due to the need to repost some of the data). Hospitals were notified of this deadline and of all other possible deadlines and requirements, including the requirement to review and verify their data as posted on the preliminary wage data file on the Internet, through the December 31, 2002 memorandum referenced above.

After reviewing requested changes submitted by hospitals, fiscal intermediaries transmitted any revised cost reports to CMS and forwarded a copy of the revised Worksheet S–3, Parts II and III to the hospitals by April 4, 2003. In addition, fiscal intermediaries were to notify hospitals of the changes or the reasons that changes were not accepted. These deadlines were necessary to allow sufficient time to review and process the data so that the final wage index calculation could be completed for the development of the final FY 2004 prospective payment rates to be published by August 1, 2003.

If a hospital disagreed with the fiscal intermediary's resolution of a policy issue (for example, whether a general category of cost is allowable in the wage data), the hospital could have contacted CMS in an effort to resolve the issue. We note that the April 4, 2003 deadline also applied to these requests. Requests were required to be sent to CMS at the address below (with a copy to the hospital's fiscal intermediary). The request must have fully documented all attempts by the hospital to resolve the dispute through the process described above, including copies of relevant correspondence between the hospital and the fiscal intermediary. During review, we do not consider issues such as the adequacy of a hospital's supporting documentation, as we believe that fiscal intermediaries are generally in the best position to make evaluations regarding the appropriateness of these types of issues (which should have been resolved earlier in the process).

The final wage data public use file was released in May 2003. Hospitals had an opportunity to examine both Table 2 of the proposed rule and the May 2003 final public use wage data file (which reflected revisions to the data used to calculate the values in Table 2) to verify the data CMS used to calculate the wage index.

As with the file made available in January 2003, we made the final wage data released in May 2003 available to hospital associations and the public on the internet. However, the May 2003 public use file was made available solely for the limited purpose of identifying any potential errors made by CMS or the fiscal intermediary in the entry of the final wage data that result from the correction process described above (with the February 2003 deadline). Hospitals were encouraged to review their hospital wage data promptly after the release of the May 2003 file. Data presented at that time could not be used by hospitals to initiate new wage data correction requests.

If, after reviewing the May 2003 final file, a hospital believed that its wage data were incorrect due to a fiscal

intermediary or CMS error in the entry or tabulation of the final wage data, it was provided an opportunity to send a letter to both its fiscal intermediary and CMS that outlined why the hospital believed an error existed and provided all supporting information, including relevant dates (for example, when it first became aware of the error). These requests had to be received by CMS and the fiscal intermediaries no later than June 6, 2003.

Changes to the hospital wage data were only made in those very limited situations involving an error by the intermediary or CMS that the hospital could not have known about before its review of the final wage data file. Specifically, at this stage of the process, neither the intermediary nor CMS accepted the following types of requests:

- Requests for wage data corrections that were submitted too late to be included in the data transmitted to CMS by fiscal intermediaries on or before April 4, 2003.
- Requests for correction of errors that were not, but could have been, identified during the hospital's review of the January 2003 wage data file.
- Requests to revisit factual determinations or policy interpretations made by the intermediary or CMS during the wage data correction process.

Verified corrections to the wage index received timely (that is, by June 6, 2003) are incorporated into the final wage index in the final rule to be published by August 1, 2003, and to be effective October 1, 2003.

We have created the process described above to resolve all substantive wage data correction disputes before we finalize the wage data for the FY 2004 payment rates. Accordingly, hospitals that did not meet the procedural deadlines set forth above will not be afforded a later opportunity to submit wage data corrections or to dispute the intermediary's decision with respect to requested changes. Specifically, our policy is that hospitals that do not meet the procedural deadlines set forth above will not be permitted to challenge later, before the Provider Reimbursement Review Board, the failure of CMS to make a requested data revision (*See W. A. Foote Memorial Hospital v. Shalala,* No. 99–CV–75202–DT (E.D. Mich. 2001), also *Palisades General Hospital* v. *Thompson,* No. 99–1230 (D.D.C. 2003)).

Again, we believe the wage data correction process described above provides hospitals with sufficient opportunity to bring errors in their wage data to the fiscal intermediaries' attention. Moreover, because hospitals had access to the final wage data by early May 2003, they had the opportunity to detect any data entry or tabulation errors made by the fiscal intermediary or CMS before the development and publication of the FY 2004 wage index in this final rule, and the implementation of the FY 2004 wage index on October 1, 2003. If hospitals avail themselves of this opportunity, the wage index implemented on October 1 should be accurate. Nevertheless, in the event that errors are identified after publication in the final rule, we retain the right to make midyear changes to the wage index under very limited circumstances.

Specifically, in accordance with § 412.63(x)(2) of our existing regulations, we make midyear corrections to the wage index only in those limited circumstances in which a requesting hospital can show: (1) that the intermediary or CMS made an error in tabulating its data; and (2) that the requesting hospital could not have known about the error or did not have an opportunity to correct the error, before the beginning of FY 2004 (that is, by the June 6, 2003 deadline.) This provision is not available to a hospital seeking to revise another hospital's data that may be affecting the requesting hospital's wage index. As indicated earlier, since a hospital had the opportunity to verify its data, and the fiscal intermediary notified the hospital of any changes, we do not expect that midyear corrections would be necessary. However, if the correction of a data error changes the wage index value for an area, the revised wage index value will be effective prospectively from the date the correction is approved.

Comment: One commenter requested that CMS release all of the assumptions used in developing the MSA average hourly wage file posted on the Internet, including the midpoint of cost reporting period adjustment factors. The commenter also requested that CMS release a file with the average hourly wage by hospital prior to the proposed rule. The commenter believed that this information would facilitate a hospital's review of its wage data.

Response: We agree that providing all of the assumptions used in calculating the wage index would be useful for hospitals and other interested parties. This year, we added to our Web site a spreadsheet that can be used to calculate a hospital's average hourly wage. Beginning with the release of the FY 2005 wage index, we will also publish on our Web site the midpoint of cost reporting period adjustment factors and a file that includes the average hourly wage for each hospital.

Comment: One commenter recommended that CMS establish a wage index list server similar to those available for the various open door forums. The list server would allow CMS to e-mail interested parties when items, such as the wage index PUF and program memoranda, are released.

Response: We currently notify all hospitals, through the fiscal intermediaries, regarding all public use files and program memorandum releases pertaining to the wage index. We also post this information on the IPPS Web site (*http://cms.hhs.gov/providers/hipps/ippswage.asp*). In addition, we make announcements regarding the wage index at the hospital open door forums. To supplement these efforts, we will also begin announcing the availability of wage index files and new program memoranda on the hospital open door forum Web site, at *http://www.cms.hhs.gov/opendoor/.* Those registered with the hospital open door forum list server will be automatically notified when there are announcements at this site pertaining to the wage index. Information on registering with the hospital open door forum list server is located at the open door forum Web site.

Comment: One commenter expressed concern regarding the average hourly wage calculator available on the Internet, stating that they were unable to replicate the average hourly wage published in the proposed rule for its area hospitals using the May public use file data and the online calculator.

Response: The average hourly wage values printed in the proposed rule, published on May 19, 2003 in the **Federal Register**, reflect the data saved in our database as of February 17, 2003. Alternatively, the May public use file was updated based on data collected through May 5, 2003. Therefore, calculating an average hourly wage using the May data could yield discrepancies between the value published in the proposed rule and the number generated by the online calculator.

H. Modification of the Process and Timetable for Updating the Wage Index

In the May 19, 2003 proposed rule, we stated that although the wage data correction process described in section III.G. of the preamble of this final rule has proven successful in the past for ensuring that the wage data used each year to calculate the wage indexes are generally reliable and accurate, we continue to be concerned about the growing volume of wage data revisions initiated by hospitals after the release of the first public use file in February. This issue has been discussed previously in

the FY 1998 IPPS proposed rule (62 FR 29918) and in the FY 2002 IPPS proposed rule (66 FR 22682). In each discussion, we described the increasing number of revisions to wage data between the proposed rule and the final rule.

Currently, the fiscal intermediaries are required to conduct initial desk reviews on or before November 15 in advance of the preparation of the preliminary wage data public use file in early January (see Program Memorandum A–02–94, October 4, 2002). Furthermore, fiscal intermediaries are required to explain and attempt to resolve items that fall outside the established thresholds. This may involve further review of the supplementary documentation or contacting the hospital for additional documentation. In addition, fiscal intermediaries are required to notify State hospital associations regarding hospitals that fail to respond to issues raised during the desk review. These actions are to be completed in advance of sending the data to CMS to prepare the preliminary wage data public use file in early January. However, as we have indicated in prior **Federal Register**s, nearly 30 percent of hospitals subsequently request revisions to their data after the preliminary wage data file is made available.

This high volume of revisions results in an additional workload for the fiscal intermediaries. In particular, much of a fiscal intermediary's efforts prior to submitting the data to prepare the preliminary public use file may be in vain if the hospital subsequently revises all of its data prior to the early February deadline (which is the hospital's right at that point). Therefore, in the May 19 proposed rule, we proposed to modify the process to release the preliminary wage data file prior to requiring the fiscal intermediaries to conduct their initial desk reviews on the data. We proposed that this unaudited data would be available on the Internet by early October rather than early January. Hospitals would review this file to ensure it contains their correct data as submitted on their cost reports and request any changes by early November. At that time, the fiscal intermediaries would review the revised requests and conduct desk reviews of the data including all approved changes.

Under the proposed revised timetable, the fiscal intermediaries would notify the hospitals in early February of any changes to the wage data as a result of the desk reviews and the resolution of the hospitals' early November change requests. The fiscal intermediaries would also submit the revisions to CMS in early February. Hospitals would then have until early March to submit requests to the fiscal intermediaries for reconsideration of adjustments made by the fiscal intermediaries as a result of the desk review. Other than requesting reconsideration of desk review adjustments, hospitals would not be able to submit new requests for additional changes that were not submitted by early November. By early April, the fiscal intermediaries would notify all hospitals of their decisions regarding the hospitals' requests to reconsider desk review adjustments and submit all of the revised wage data to CMS. From this point (early April) until the publication of the final rule, the process would be identical to the current timetable. Similar to the current timetable, hospitals would also have the opportunity in early April to request CMS consideration of policy disputes.

Therefore, we proposed to revise the schedule to improve the quality of the wage index by initiating hospitals' review of their data sooner and allowing the fiscal intermediaries to focus their reviews on the final data submitted by hospitals to be included in the wage index. In addition, we would receive the revised data in time to incorporate them into the wage indexes published in the proposed rule, resulting in fewer changes from the proposed rule to the final rule. This will improve the ability of hospitals to assess whether they should request a withdrawal from a MGCRB reclassification. Because the decision of whether to withdraw a wage index reclassification must be made prior to publication of the final rule, the proposed schedule should decrease the likelihood that the final wage index will be dramatically different from the proposed wage index.

Comment: Commenters stated their appreciation of the desire to expedite the process and reduce the workload of its fiscal intermediaries, but some were concerned about the additional workload these timeframes would place on hospitals.

Some commenters were concerned about the 30-day review period for the hospitals, stating it would not be enough time to conduct a thorough and complete review of the detailed data, adding that a 45-day comment period should be the minimum review time for providers. Commenters also stated their concerns about adjusting to a new timetable while also collecting and submitting occupational mix data, and the possible adoption of the new MSA definitions for the FY 2005 wage index. They believe any changes to the timeline should be postponed until the FY 2006 wage index.

Other commenters were concerned about the additional workloads for hospitals whose fiscal year ends on June 30. These hospitals would most likely be preparing cost reports for the fiscal year just ended and this would be an additional burden. Another commenter expressed concern that the proposed rule did not mention the State hospital association notification for hospitals failing desk review edits and that the new deadlines would not afford hospitals any recourse to ensure accurate data. One commenter cited the major role its fiscal intermediary played in the delay of revisions to its wage index.

Several other commenters generally supported the proposal to modify the wage index timetable, but with some modification. The commenters asked that hospitals have 75 days from the proposed October release of the public use file to submit revised data to the fiscal intermediaries and that CMS finalize the timetable in June rather than waiting until the final rule is published. The commenters believed this would allow virtually all hospitals the time they need to do a thorough and complete review to determine the accuracy of the detail data needed to compute an accurate wage index. Commenters also believed this would give fiscal intermediaries time to respond to hospital issues raised during the desk review period.

Finally, other commenters expressed support for the timetable changes. These commenters believed the hospitals will have more time to review their wage data and there will be less of an administrative burden on fiscal intermediaries. Another commenter believed auditors' and hospitals' resources will be better utilized and this could help eliminate the problem of reauditing wage index data after revisions are submitted. Another commenter added that hospitals would be able to better determine how they compare to other hospitals and whether a reclassification would be appropriate using much more accurate data. Also, aberrant data would become more apparent earlier in the process.

Response: Although hospitals will be required to review the data sooner, they are not being asked to perform any more reviews or work than currently. Therefore, we do not believe this change will be burdensome to hospitals. Hospitals will still have sufficient time to complete a thorough review of the data, because the data for the FY 2005 wage index values will be taken from cost reporting periods beginning during FY 2001. These cost reports should have already been thoroughly reviewed

before being submitted to their fiscal intermediary and sent to CMS earlier this year.

Further, since the ultimate goal is improvement of the wage index, we believe this will be achieved with a more streamlined process in which fiscal intermediary work is not duplicated and is instead focused on the final data submitted by hospitals instead of preliminary data, of which nearly 40 percent ends up being revised under the current timetable. As noted above, these revisions under the current process often nullify the desk reviews performed by the fiscal intermediary.

We recognize the commenters' concern with respect to the interaction of this process with the collection of occupational mix data and the potential adoption of OMB's new MSA definitions. As we proceed with developing the details of the occupational mix data collection for the FY 2005 wage index, we intend to schedule that collection effort in a way that accommodates this revised timetable. The details of that schedule will be forthcoming shortly.

Finally, as previously discussed, the ability of hospitals to assess whether they should request a withdrawal from a MGCRB reclassification will also be improved, thereby decreasing the likelihood that the final wage index will be dramatically different from the proposed wage index. For these reasons, we are adopting as final the proposed revisions to the wage data development timeline and will use the revised timeline for the development of the FY 2005 wage index.

However, in order to address commenter concerns about the 30-day review period being too short, we are modifying the timetable to have the preliminary public use file on the CMS Web site in mid-September, thereby giving hospitals approximately 45 days instead of 30 days to review the preliminary wage data. Further instructions and a detailed timeline will be released in the form of a Program Memorandum.

The following table illustrates the timetable that will be applicable for the development of the FY 2005 wage index:

Timeframe	Steps in wage index development process
Mid-September	Preliminary and unaudited wage data file published as a public use file (PUF) on CMS Web site.
Mid-November	Deadline for hospitals to send requests for revisions to their fiscal intermediaries.
Early February	Fiscal intermediaries review revisions and desk review wage data; notify hospitals of changes and resolution of revision requests; and submit preliminary revised data to CMS.
Early March	Deadline for hospitals to request wage data reconsideration of desk review adjustments and provide adequate documentation to support the request.
Early April	Deadline for the fiscal intermediaries to submit additional revisions resulting from the hospitals' reconsideration requests. This is also the deadline for hospitals to request CMS intervention in cases where the hospital disagrees with the fiscal intermediary's policy interpretations.
Early May*	Release of final wage data PUF on CMS Web site.
Early June*	Deadline for hospitals to submit correction requests, to both CMS and their fiscal intermediary, for errors due to the mishandling of the final wage data by CMS or the fiscal intermediary.
August 1*	Publication of the final rule.
October 1*	Effective date of updated wage index.

*Indicates no change from prior years.

IV. Other Decisions and Changes to the IPPS for Operating Costs and GME Costs

A. Transfer Payment Policy (§ 412.4)

Existing regulations at § 412.4(a) define discharges under the IPPS as situations in which a patient is formally released from an acute care hospital or dies in the hospital. Section 412.4(b) defines transfers from one acute care hospital to another, and § 412.4(c) defines transfers to certain postacute care providers. Our policy provides that, in transfer situations, full payment is made to the final discharging hospital and each transferring hospital is paid a per diem rate for each day of the stay, not to exceed the full DRG payment that would have been made if the patient had been discharged without being transferred.

The per diem rate paid to a transferring hospital is calculated by dividing the full DRG payment by the geometric mean length of stay for the DRG. Based on an analysis that showed that the first day of hospitalization is the most expensive (60 FR 45804), our policy provides for payment that is double the per diem amount for the first day (§ 412.4(f)(1)). Transfer cases are also eligible for outlier payments. The outlier threshold for transfer cases is equal to the fixed-loss outlier threshold for nontransfer cases, divided by the geometric mean length of stay for the DRG, multiplied by the length of stay for the case, plus one day.

1. Transfers to Another Acute Care Hospital (§ 412.4(b))

Medicare adopted its IPPS transfer policy because, if we were to pay the full DRG payment regardless of whether a patient is transferred or discharged, there would be a strong incentive for hospitals to transfer patients to another IPPS hospital early in their stay in order to minimize costs while still receiving the full DRG payment. The transfer policy adjusts the payments to approximate the reduced costs of transfer cases.

Currently, when a patient chooses to depart from a hospital against the medical opinion of treating physicians, the case is treated as a left against medical advice (LAMA) discharge and coded as discharge status ''07-Left Against Medical Advice (LAMA)'' on the inpatient billing claim form. Because, by definition, LAMA discharges are assumed not to involve the active participation of the hospital administration, our policy has been to treat LAMA cases as discharges. This policy applies even if the patient is admitted to another hospital on the date of the LAMA discharge. Consequently, we currently make a full DRG payment for any discharge coded as a LAMA case.

However, we are concerned that some hospitals may be incorrectly coding transfers as LAMA cases. The Office of Inspector General (OIG) issued a report in March 2002 (A–06–99–00045), asserting that of the approximately 60,000 LAMA discharges annually, 1,500 patients were subsequently admitted to another IPPS hospital the same day. The OIG performed a detailed review of the medical records at selected hospitals and found evidence that the hospitals actively participated in transferring the patients to a different IPPS hospital, yet the hospital coded the claim as a LAMA. OIG cited several examples of these cases:

''In the first example, the transferring hospital did not have an inpatient room available for the patient, who had been in the emergency room for 24 hours. The medical record showed that the treating physician contacted another PPS hospital to determine whether the hospital could accept the patient. Specifically, the medical record stated: 'Upon request of the patient, [hospital name] was contacted since there is a good possibility of transferring patient to [name of hospital]. At present, he has been in emergency room for 24 hours waiting for a bed.' ''

In this example, despite the overt participation of the physician in securing the admission to the other IPPS hospital and the fact that the transferring hospital did not have an inpatient room available for the patient, the claim was submitted as a LAMA discharge, rather than as a transfer to another IPPS hospital.

''In the second example, the patient was brought to the first hospital by ambulance. Subsequently, the patient's family indicated that they wanted a neurologist at another hospital to render the treatment needed by the patient. The attending physician contacted the neurologist in order to determine if the neurologist would accept, admit, and treat the patient. The medical record contained ample evidence of knowledge and participation of the transferring hospital, and the discharge should have been reported as a PPS transfer. Specifically, the medical record stated: 'Patient's family wanted to sign the patient out against medical advice and take her to [name of hospital]. The physician spoke with the neurologist at [name of hospital], who agreed to accept the patient. The patient's family signed the patient discharged against medical advice. All the risks of self-discharge were explained.' ''

In this case, although the medical record indicated the patient wanted to leave against medical advice, there is also evidence that the patient's attending physician at the hospital participated in the transfer to another IPPS hospital. While we do not wish to discourage such participation and cooperation in cases where a transfer occurs, this situation would seem almost indistinguishable from other transfer situations. For instance, we have long recognized situations where patients are transferred from a rural hospital to an urban hospital for a surgical procedure, then back to the rural hospital to complete the recuperative care, as appropriate transfer situations as long as the transfers are medically appropriate. In such a case, the rural hospital would receive a payment under the transfer policy for the first portion of the stay, the urban hospital would also receive payment under the transfer policy for the care it provided, and the rural hospital would receive a full DRG payment as the discharging hospital for the recuperative care it provided upon the patient's return from the urban hospital. In such situations, each portion of the stay may be assigned a different DRG.

Therefore, in the May 19, 2003 proposed rule, we proposed to expand our definition of a transfer under § 412.4(b) to include all patients who are admitted to another IPPS hospital on the same day that the patient is discharged from an IPPS hospital, unless the first (transferring) hospital can demonstrate that the patient's treatment was completed at the time of discharge from that hospital. In other words, unless the same-day readmission is to treat a condition that is unrelated to the condition treated during the original admission (for example, the beneficiary is in a car accident later that day), any situation where the beneficiary is admitted to another IPPS hospital on the same date that he or she is discharged from an IPPS hospital would be considered a transfer, even if the patient left against medical advice from the first hospital.

Although we considered proposing a policy that would be based on whether the hospital actively participated in the transfer, and exempting from the transfer definition cases where the hospital had absolutely no knowledge that the patient intended to go to another hospital, we did not propose such a policy for two reasons. First, it would be difficult to administer equitably a policy that required a determination as to whether the hospital or the physician had knowledge of the patient's intentions. Such a policy would require fiscal intermediaries to make a difficult judgment call in many cases. Second, if we were to base the determination of whether a case is a transfer on the level of involvement of the hospital and the physician caring for the patient, we would be creating a financial disincentive to hospitals for ensuring an efficient and cooperative transfer once a decision has been made by the patient or the patient's family to leave the hospital.

We recognize that, in some cases, a hospital cannot know the patient will go to another hospital. However, we note the claims processing system can identify cases coded as discharges where the date of discharge matches the admission date at another hospital. In these cases, the fiscal intermediary will notify the hospital of the need to submit an adjustment claim. However, if the hospital can present documentation showing that the patient's care associated with the admission to the hospital was completed before discharge, consistent with our current policy, the transfer policy will not be applied.

Comment: Commenters opposed the proposed expansion of the transfer policy to include all patients who are admitted to another IPPS hospital on the same day that the patient is discharged from an IPPS hospital. They argued that situations in which a limited number of hospitals are abusing the payment rules should be handled by review of those hospitals' claims, and not through a policy change that will place additional burdens on all hospitals.

Response: We disagree that this policy expansion would create an additional burden on all hospitals. We note that it is our current policy to consider patients discharged from one IPPS hospital and admitted to another IPPS hospital on the same day as a transfer in all situations except LAMA situations, unless the original discharging hospital can document that the discharge was appropriate and unrelated to the subsequent same-day admission. We understand from the OIG that these situations are extremely rare, and in the vast majority of cases, same-day readmissions to another hospital are, in fact, transfers.

Our proposal would merely extend this current policy to LAMA situations. As is the case under our present policy, we believe it will be exceedingly rare that a patient leaves one hospital in LAMA status, and is readmitted to a second hospital on the same day for an unrelated purpose. Because the need for a hospital to supply documentation would only arise in these rare situations, we do not believe this policy change creates an additional burden for hospitals.

In relation to the appropriateness of a general policy expansion as opposed to a review and adjustment of individual hospital's claims, we believe a general policy expansion is necessary in this circumstance. As described in the proposed rule and above in this final rule, we considered proposing a policy that would be based on whether the hospital actively participated in the transfer and that would exempt from the transfer definition cases in which the hospital had absolutely no knowledge that the patient intended to go to another hospital. However, we did not propose such a policy because it would require a determination as to whether the hospital or the physician had

knowledge of the patient's intentions. We believed that if we adopted such a policy, we would be creating a financial disincentive to hospitals for ensuring an efficient and cooperative transfer once a decision has been made by the patient or the patient's family to leave the hospital.

Comment: Several commenters wrote that CMS was overreacting to anecdotal examples and that the proposed policy was ''not sustainable under any application of reasonableness.'' They suggested that, rather than put the burden on all hospitals due to the abuse from these isolated incidents, hospitals should be evaluated from the frequency of LAMA discharges. Those that fall outside of the ''norm'' could be investigated, similar to the outlier studies.

Response: We agree that the problems uncovered in the OIG's report on transfers reported as LAMAs are relatively small within the overall scope of the IPPS. In fact, we made the point to OIG in our comments on a draft of its report that their findings equated with one inappropriate LAMA discharge per hospital per year. However, the OIG found this problem was not spread equally across all hospitals, but occurred disproportionately in a small number of hospitals.

We believe we are establishing clear and unequivocal policies for handling those situations that do occur and that this policy change will have a minimal impact on the majority of hospitals nationwide. Consequently, we are finalizing the change to our regulations to expand our definition of a transfer under § 412.4(b) to include all patients who are admitted to another IPPS hospital on the same day that the patient is discharged from an IPPS hospital, unless the first (transferring) hospital can demonstrate that the patient's treatment was completed at the time of discharge from that hospital, effective for discharges occurring on or after October 1, 2003.

Comment: Commenters stated that the proposed expanded definition of a transfer provides no guidance to hospitals as to what would be acceptable documentation that the patient's treatment was completed at the time of discharge. Some commenters asked whether an exact match of the principal diagnoses codes for the two admissions would be used to determine that the same-day readmission was related to the prior discharge. One commenter suggested that it would be more appropriate for the fiscal intermediary to request medical documentation from both hospitals involved in the transfer in order to determine whether a transfer payment should be made to the transferring hospital, rather than solely requesting documentation from the transferring hospital.

Another commenter asserted that CMS is placing the burden of correcting this situation on all hospitals rather than directing fiscal intermediaries to develop screens to identify these cases. In addition, they noted possible conflicts of sharing information between hospitals regarding patient care due to new HIPAA requirements.

Response: We anticipate the documentation necessary to establish that the readmission was unrelated to the prior, same-day discharge would be similar to the type of documentation relied upon by fiscal intermediaries and Quality Improvement Organizations (QIOs) to evaluate whether patients were discharged prematurely. (For example, section 4135 of the Peer Review Manual discusses discharge review.) That is, there are existing practices for determining that patients were medically unstable at discharge or the discharge was inconsistent with the patient's need for continued acute inpatient hospitalization. Therefore, there should be no breach in HIPAA disclosure requirements.

We are developing claims processing systems edits to more accurately identify transfers that are inappropriately coded as discharges. These edits identify claims that are entered with inappropriate discharge codes and will prevent payment to the second hospital if there is already a discharge from another hospital in the system for the same beneficiary on the same day. If this situation occurs, the claim from the first hospital is sent back to the hospital for correction, and the second claim is paid. We expect a similar edit that identifies same-day readmissions following a LAMA discharge would be added to the claims processing system edits.

Comment: One commenter requested clarification as to the appropriate discharge destination code in those situations when a patient left the first hospital against medical advice and the fiscal intermediary notifies this hospital of a subsequent same-day admission to another hospital.

Response: This situation is similar to those situations in which a hospital believes and intends to discharge a patient to home, but is subsequently notified that the discharge qualifies under the postacute care transfer policy because the patient received qualifying postacute care. The hospital would submit an amended bill coded to reflect the fact that the hospital now has information that the patient received subsequent care.

2. Technical Correction

Section 412.4(b)(2) defines a discharge from one inpatient area of the hospital to another area of the hospital as a transfer. Although this situation may be viewed as an intrahospital transfer, it does not implicate the transfer policy under the IPPS. In the May 19, 2003 proposed rule, to avoid confusion and to be consistent with the changes to § 412.4(b) described at section IV.A.3. of this preamble, we proposed to delete existing § 412.4(b)(2) from the definition of a transfer. We did not receive any comments on this proposal. Therefore, we are deleting existing § 412.4(b)(2) from the definition of a transfer.

3. Expanding the Postacute Care Transfer Policy to Additional DRGs (§§ 412.4(c) and (d))

Under section 1886(d)(5)(J) of the Act, a ''qualified discharge'' from one of 10 DRGs selected by the Secretary, to a postacute care provider is treated as a transfer case beginning with discharges on or after October 1, 1998. This section requires the Secretary to define and pay as transfers all cases assigned to one of 10 DRGs selected by the Secretary, if the individuals are discharged to one of the following postacute care settings:

- A hospital or hospital unit that is not a subsection 1886(d) hospital. (Section 1886(d)(1)(B) of the Act identifies the hospitals and hospital units that are excluded from the term ''subsection (d) hospital'' as psychiatric hospitals and units, rehabilitation hospitals and units, children's hospitals, long-term care hospitals, and cancer hospitals.)
- A SNF (as defined at section 1819(a) of the Act).
- Home health services provided by a home health agency, if the services relate to the condition or diagnosis for which the individual received inpatient hospital services, and if the home health services are provided within an appropriate period (as determined by the Secretary).

In the July 31, 1998 IPPS final rule (63 FR 40975 through 40976), we specified the appropriate time period during which we would consider a discharge to postacute home health services to constitute a transfer as within 3 days after the date of discharge. Also, in the July 31, 1998 final rule, we did not include in the definition of postacute care transfer cases patients transferred to a swing-bed for skilled nursing care (63 FR 40977).

Section 1886(d)(5)(J) of the Act directed the Secretary to select 10 DRGs based upon a high volume of discharges to postacute care and a disproportionate use of postacute care services. As discussed in the July 31, 1998 final rule, these 10 DRGs were selected in 1998 based on the MedPAR data from FY 1996. Using that information, we identified and selected the first 20 DRGs that had the largest proportion of discharges to postacute care (and at least 14,000 such transfer cases). In order to select 10 DRGs from the 20 DRGs on our list, we considered the volume and percentage of discharges to postacute care that occurred before the mean length of stay and whether the discharges occurring early in the stay were more likely to receive postacute care. We identified the following DRGs to be subject to the special 10 DRG transfer rule:

- DRG 14 (Intracranial Hemorrhage and Stroke with Infarction (formerly ''Specific Cerebrovascular Disorders Except Transient Ischemic Attack''));
- DRG 113 (Amputation for Circulatory System Disorders Except Upper Limb and Toe);
- DRG 209 (Major Joint Limb Reattachment Procedures of Lower Extremity);
- DRG 210 (Hip and Femur Procedures Except Major Joint Procedures Age ≤17 With CC);
- DRG 211 (Hip and Femur Procedures Except Major Joint Procedures Age ≤17 Without CC);
- DRG 236 (Fractures of Hip and Pelvis);
- DRG 263 (Skin Graft and/or Debridement for Skin Ulcer or Cellulitis With CC);
- DRG 264 (Skin Graft and/or Debridement for Skin Ulcer or Cellulitis Without CC);
- DRG 429 (Organic Disturbances and Mental Retardation); and
- DRG 483 (Tracheostomy With Mechanical Ventiliation 96 + Hours or Principal Diagnosis Except Face, Mouth, and Neck Diagnoses (formerly ''Tracheostomy Except for Face, Mouth, and Neck Diagnoses'')).

Similar to the policy for transfers between two acute care hospitals, the transferring hospital in a postacute care transfer for 7 of the 10 DRGs receives twice the per diem rate the first day and the per diem rate for each following day of the stay before the transfer, up to the full DRG payment. However, 3 of the 10 DRGs exhibit a disproportionate share of costs very early in the hospital stay in postacute care transfer situations. For these 3 DRGs, hospitals receive 50 percent of the full DRG payment plus the single per diem (rather than double the per diem) for the first day of the stay and 50 percent of the per diem for the remaining days of the stay, up to the full DRG payment. This is consistent with section 1886(d)(5)(J)(i) of the Act, which recognizes that in some cases ''a substantial portion of the costs of care are incurred in the early days of the inpatient stay.''

Section 1886(d)(5)(J)(iv) of the Act authorizes the Secretary to expand the postacute care transfer policy beyond 10 DRGs. In the May 9, 2002 IPPS proposed rule, we discussed the possibility of expanding this policy to either all DRGs or a subset of additional DRGs (we identified 13 additional DRGs in that proposed rule) (67 FR 31455). However, as discussed further in the August 1, 2002 final rule (65 FR 50048), we did not expand the postacute care transfer provision to additional DRGs for FY 2003. The commenters on the options in the May 9, 2002 proposed rule raised many issues regarding the impact of expanding this policy that we needed to consider further before proceeding. In particular, due to the limited time between the close of the comment period and the required publication date of August 1, we were unable to completely analyze and respond to all of the points that were raised. We indicated that we would continue to conduct research to assess whether further expansion of this policy may be warranted and, if so, how to design any such refinements.

Many commenters on the May 9, 2002 proposed rule argued that, in a system based on averages, expansion of the postacute care transfer policy negatively influences, and in fact penalizes, hospitals for efficient care. They claimed that this policy indiscriminately penalizes hospitals for efficient treatment and for ensuring that patients receive the right care at the right time in the right place. They believed that the postacute care transfer provision creates an inappropriate incentive for hospitals to keep patients longer.

Commenters also expressed concern that the expansion of the transfer provision violates the fundamental principle of the IPPS. The DRG system is based on payments that will, on average, be adequate. These commenters argued that expansion of the postacute care transfer policy would give the IPPS a per-diem focus and would mean that hospitals would be paid less for shorter than average lengths of stay, although they would not be paid more for the cases that are longer than average (except for outlier cases).

We agree that the transfer policy should not hamper the provision of effective patient care. We also agree that any future expansion must consider both the need to reduce payments to reflect cost-shifting out of the acute care setting due to reductions in length of stay attributable to early transfers to postacute care and the need to ensure that payments, on average, remain adequate to ensure effective patient care. Therefore, we have assessed the extent to which the current postacute care transfer policy balances these objectives.

The table below displays the results of our analysis. We first examined whether the 10 DRGs included in the policy continue to exhibit a relatively high percentage of cases transferred to postacute care settings, particularly among cases with lengths of stay shorter than the geometric mean for the DRG (these cases would be affected by the reduced payments for transfers). The table shows that these DRGs continue to contain high percentages of cases transferred to postacute care settings similar to those we reported in the FY 1999 final rule (63 FR 40975). These results would appear to demonstrate that the postacute care transfer policy has not greatly altered hospitals' treatment patterns for these cases.

This similarity in treatment patterns is further evidenced by the fact that, for 6 of the 10 DRGs, the geometric mean length of stay has continued to decline in the 5 years since the policy was implemented. Accordingly, hospitals have continued to transfer many patients in these DRGs before the mean length of stay, despite the transfer policy. As we stated in the July 31, 1998 final rule, the transfer provision adjusts payments to hospitals to reflect the reduced lengths of stay arising from the shift of patient care from the acute care setting to the postacute care setting (63 FR 40977). This policy does not require a change in physician clinical decisionmaking nor in the manner in which physicians and hospitals practice medicine: It simply addresses the appropriate level of payments once those decisions have been made.

With respect to whether this policy alters the fundamental averaging principles of the IPPS, we believe the current policy, which targets specific DRGs where evidence shows hospitals have aggressively moved care to postacute care settings, does not alter the averaging principles of the system. In fact, it could be said to enhance those principles because a transfer case is counted as only a fraction of a case toward DRG recalibration based on the ratio of its transfer payment to the full DRG payment for nontransfer cases. This methodology ensures the DRG

weight calculation is consistent with the payment policy for transfer cases. The last column of the table below indicates that all but three of these DRGs have experienced increases in DRG weights since the policy was implemented. By reducing the contribution of transfer cases to the calculation of the DRG average charge, the relative weights (the result of dividing the DRG average charge by the national average charge per case) are higher than they would otherwise be. This is because transfers, particularly short-stay transfers, have lower total charges, on average.

DRG	DRG title	All transfer cases	Percent of all cases transferred to postacute care setting	Percent of all cases transferred prior to mean length of stay	Percent change in mean length of stay FYs 1992–1998	Percent change in mean length of stay FYs 1998–2003	Percent change in DRG relative weight FYs 1998–2003
14	Intracranial Hemorrhage and Stroke with Infarction.	143,649	48.88	11.74	−29.17	−5.88	8.53
113	Amputation for Circulatory System Disorders Except Upper Limb and Toe.	24,470	66.57	30.12	−32.17	7.22	9.21
209	Major Joint and Limb Reattachment Procedures of Lower Extremity.	244,969	66.66	19.76	−47.52	−15.09	−8.09
210	Hip and Femur Procedures Except Major Joint Age >17 With CC.	87,253	76.26	35.67	−42.98	−6.15	0.1
211	Hip and Femur Procedures Except Major Joint Age >17 Without CC.	20,239	72.38	15.89	−44.44	−8.00	1.39
236	Fractures of Hip and Pelvis	26,583	69.86	11.20	−34.85	−6.98	−1.43
263	Skin Graft and/or Debridement for Skin Ulcer or Cellulitis with CC.	13,158	62.00	31.35	−41.45	4.49	9.36
264	Skin Graft and/or Debridement for Skin Ulcer or Cellulitis Without CC.	1,759	49.97	18.81	−37.21	1.85	5.36
429	Organic Disturbances and Mental Retardation.	30,349	53.25	15.22	−28.95	−12.96	−5.27
483	Tracheostomy With Mechanical Ventilation 96 + Hours or Principal Diagnosis Except Face, Mouth, and Neck Diagnoses.	21,818	52.93	27.34	−15.29	2.37	1.38

We indicated in the proposed rule that we believe the current 10 DRG postacute care transfer policy appears to be appropriately balancing the objectives to reduce payments to reflect cost-shifting due to reductions in length of stay attributable to early postacute care transfers and to ensure that payments, on average, remain adequate to ensure effective patient care. Therefore, we once again undertook the analysis to identify additional DRGs to which the policy might be expanded.

However, we did not propose to expand the policy to all DRGs. Although we indicated that expanding the postacute care transfer policy to all DRGs might be the most equitable approach because a policy that is limited to certain DRGs may result in disparate payment treatment across hospitals, at this time, we believe an incremental expansion is appropriate. That is, we believe further analysis is necessary to assess whether it would be appropriate to apply a reduced payment for postacute care transfers across all DRGs. In particular, it is important to attempt to distinguish between DRGs where the care is increasingly being shifted to postacute care sites versus DRGs where some patients have always been discharged to postacute care early in the stay. It may not be appropriate to reduce payment for these latter DRGs if the base payment already reflects a similar postacute care utilization rate (for example, in these cases there would be no cost shifting).

As described below, we proposed an additional 19 DRGs, based on declining mean lengths of stay and high percentages of postacute transfers, for which an expansion of the current policy appeared warranted.

We also noted that MedPAC has conducted analysis on the current postacute care transfer policy. Most recently, in its March 2003 Report to Congress, MedPAC recommended adding 13 additional DRGs to the 10 DRGs covered under the current policy (page 46). The 13 DRGs were the same DRGs included in one of our proposals to expand the postacute care transfer policy in last year's IPPS proposed rule. MedPAC did not recommend expanding the policy to include all DRGs at this time, noting that this expansion might reduce payments to some hospitals by as much as 4 percent. Rather, it suggested evaluating the impact of a limited expansion before extending the policy to more DRGs.

MedPAC's report cites several reasons for expanding the postacute care transfer policy beyond the current 10 DRGs. First, it notes the continuing shifts in services from the acute care setting to the postacute care setting. Second, the report points to different postacute care utilization for different hospitals, particularly based on geographic location. Third, the report states: ''the expanded transfer policy provides a better set of incentives to protect beneficiaries from potential premature discharge to postacute care.'' Fourth, MedPAC notes that the policy improves payment equity across hospitals by: reducing payments to hospitals that transfer patients to postacute care while making full payments to hospitals that provide all of the acute inpatient services in an acute care setting; and maintaining more accurate DRG weights that reflect the

true resource utilization required to provide the full course of acute inpatient care, as distinguished from the partial services provided to patients who are transferred to postacute care.

Since the publication of last year's rule, we have conducted an extensive analysis to identify the best method by which to expand the postacute care transfer policy. Similar to the analysis used to identify the current 10 DRGs, in the May 19, 2003 proposed rule, we proposed to identify DRGs with high postacute care transfer rates and at least 14,000 transfer cases. However, rather than ranking DRGs on the basis of the percentage of all postacute care transfers, we proposed to rank DRGs on the basis of the percentage of postacute care transfers occurring before the DRG geometric mean length of stay. This is because only transfers that occur before the geometric mean length of stay, minus one day due to the policy that hospitals receive double the per diem for the first day, are impacted by the transfer policy. In order to focus on those DRGs where this policy would have the most impact, we proposed to include only DRGs where at least 10 percent of all cases were transferred to postacute care before the geometric mean length of stay. (We note that preceding sentence was stated incorrectly in the proposed rule. The criterion should have read ''at least 10 percent of all cases that were transferred to postacute care were transferred before the geometric mean length of stay.'') The next proposed criterion is to identify DRGs with at least a 7-percent decline in length of stay over the past 5 years (from FY 1998 to FY 2003). This criterion would focus on those DRGs for which hospitals have been most aggressively discharging patients sooner into postacute care settings. Finally, we proposed to include only DRGs with a geometric mean length of stay of at least 3 days because the full payment is reached on the second day for a DRG with a 3-day length of stay.

Using these criteria, we proposed 19 additional DRGs to include in the postacute care transfer policy. However, some of the 13 DRGs proposed last year (and included in MedPAC's proposed expansion) were not included in the May 19, 2003 proposed rule. For example, DRGs 79 and 80 (Respiratory Infections and Inflammations Age >17 With and Without CC, respectively) were included in last year's proposed expansion but were not included in the proposed rule for FY 2004. DRGs 79 and 80 were excluded from the proposed rule because they did not exhibit a decline in length of stay of at least 7 percent over the past 5 years.

We noted that 7 of the proposed 19 DRGs are paired DRGs (that is, they contain a CC and no-CC split). Because these DRGs are paired DRGs (that is, the only difference in the cases assigned to DRG 130, for example, as opposed to DRG 131 is that the patient has a complicating or comorbid condition), we proposed to include both DRGs under this expanded policy. If we were to include only DRG 130 in the transfer policy, we believed there would be an incentive for hospitals not to include any code that would identify a complicating or comorbid condition, so that a transfer case would be assigned to DRG 131 instead of DRG 130.

Using the selection criteria described above, we proposed the following 19 DRGs to include under the postacute care transfer policy (in addition to the 10 DRGs already subject to the policy).

DRG	DRG title	All transfer cases	Percent of all cases transferred to postacute care setting	Percent of all cases transferred prior to mean length of stay	Percent change in mean length of stay FYs 1992–1998	Percent change in mean length of stay FYs 1998–2003
12	Degenerative Nervous System Disorders	39,034	54.13	13.10	−21.74	−12.00
24	Seizure and Headache Age >17 With CC	19,239	35.67	11.63	−20.75	−7.69
25	Seizure and Headache Age >17 Without CC	4,738	19.15	2.15	−14.29	−10.71
89	Simple Pneumonia and Pleurisy Age > 17 With CC.	175,441	34.86	11.37	−18.31	−11.11
90	Simple Pneumonia and Pleurisy Age >17 Without CC.	9,544	20.86	2.82	−20.37	−15.00
121	Circulatory Disorders With AMI and Major Complication, Discharged Alive.	79,242	52.52	20.46	−21.95	−11.67
122	Circulatory Disorders With AMI Without Major Complications Discharged Alive.	33,028	48.91	24.09	−26.67	−23.08
130	Peripheral Vascular Disorders With CC	31,106	37.78	14.27	−13.11	−11.76
131	Peripheral Vascular Disorders Without CC	5,723	23.08	5.42	−4.44	−19.51
239	Pathological Fractures and Musculoskeletal and Connective Tissue Malignancy.	23,188	53.54	21.96	−22.67	−7.55
243	Medical Back Problems	36,772	41.49	13.61	−14.00	−7.50
277	Cellulitis Age >17 With CC	35,015	37.77	14.03	−21.43	−7.84
278	Cellulitis Age >17 Without CC	6,526	22.05	3.11	−18.87	−10.00
296	Nutritional and Miscellaneous Metabolic Disorders Age >17 With CC.	104,216	40.05	11.88	−21.67	−9.30
297	Nutritional and Miscellaneous Metabolic Disorders Age >17 Without CC.	12,649	28.03	2.17	−17.50	−10.00
320	Kidney and Urinary Tract Infectious Age >17 With CC.	77,669	44.64	12.40	−23.88	−8.51
321	Kidney and Urinary Tract Infections Age >17 Without CC.	8,610	29.90	5.67	−20.41	−13.89
462	Rehabilitation	147,211	56.59	22.69	−22.54	−11.43
468	Extensive O.R. Procedure Unrelated to Principal Diagnosis.	24,783	44.51	18.53	−20.30	−7.07

We proposed to revise § 412.4(d) to incorporate these additional 19 DRGs as qualifying DRGs for transfer payments and to make a conforming change to § 412.4(c).

We also examined whether any of these DRGs would qualify for the alternative payment methodology of 50

percent of the full DRG payment plus the per diem for the first day of the stay, and 50 percent of the per diem for the remaining days of the stay, up to the full DRG payment specified in existing regulations under § 412.4(f). To identify the DRGs that might qualify, we compared the average charges for all cases with a length of stay of 1 day to the average charges of all cases in a particular DRG. To qualify for the alternative methodology, we indicated that the average charges of 1-day discharge cases must be at least 50 percent of the average charges for all cases in the DRG.

Based on this analysis, we determined that 5 out of the proposed 19 DRGs would qualify for this payment method (DRGs 25, 122, 131, 297, and 321). However, the fact that the average charges of 1-day stays equal at least 50 percent of the average charges for all cases in these DRGs is due to the very short lengths of stay for these DRGs. Therefore, we did not propose to include them in the alternative payment methodology. For example, for a DRG with a 3-day geometric mean length of stay, full DRG payment will be made on the second day of the stay, regardless of which payment methodology is used. Therefore, in the May 19, 2003 proposed rule, we proposed that none of the 19 additional DRGs that we were proposing to add to the postacute care transfer policy would be paid under the alternative payment methodology.

We also analyzed the 10 DRGs that are currently subject to the postacute care transfer policy. Of the three DRGs that are receiving payments under the special payment (transfers after 1 day incur charges equal to at least 50 percent of the average charges for all cases). Unlike the five DRGs that would otherwise meet this criterion, the geometric mean length of stay of both DRG 209 and 211 is over 4 days. In addition, DRG 210 is currently paid under the special payment methodology, but our current analysis indicates average charges for 1-day stays are less than 50 percent of the average charges for all cases in the DRG. Nonetheless, DRG 210 is paired with DRG 211, which meets the criteria. Therefore, we proposed that DRG 210 would continue to be paid under the special payment methodology. Similar to our rationale for including both paired DRGs when one qualifies for inclusion in the postacute care transfer policy, we proposed to include both DRGs in this pair under the special payment methodology. Accordingly, we proposed that only DRGs 209, 210, and 211 that are currently paid under the alternative transfer payment methodology would continue to be paid under this methodology.

Finally, we noted that the OIG has prepared several reports that examined hospitals' compliance with proper coding of patients' discharge status as transferred under our guidelines, and has found substantial noncompliance leading to excessive payments.[6] Specifically, the OIG found hospitals submitting claims indicating the patient had been discharged when, in fact, the patient was transferred to a postacute care setting. As we indicated in the May 8, 1998 **Federal Register** (63 FR 25593), hospitals found to be intentionally engaging in such practices may be investigated for fraudulent or abusive billing practices. We intend to work with the OIG to develop the most appropriate response to ensure all hospitals are compliant with our guidelines.

Comment: Many commenters argued that any expansion of the postacute care transfer policy, and even the policy itself, undermines clinical decisionmaking and penalizes hospitals for providing the right care at the right time and in the right setting. Commenters further argued that the policy itself violates the original premise of the IPPS, because it makes it difficult or impossible for hospitals to break-even on patients who receive postacute care after discharge. One commenter argued that hospitals lose if patients are discharged prior to the mean length of stay, and they lose if patients are discharged after the mean length of stay.

Commenters also argued the postacute care transfer policy is not good policy because it may create a perverse incentive for hospitals to increase patients' lengths of stay. One commenter expressed concern that longer lengths of stay would result from a shift in focus from per-case cost control to per-day cost control. The commenter suggested that this policy sends a conflicting message to hospital administrators who have taken steps recently to reduce their hospitals' average lengths of stay.

Some commenters pointed out that the postacute care transfer policy fails to acknowledge or recognize that, for many patients, postacute care is already reflected in the IPPS base payment rate for many DRGs. In particular, hospitals in certain regions of the country have historically had lower average lengths of stay, and therefore, these hospitals are disproportionately impacted by this policy.

Other commenters suggested the DRG relative weights are self-adjusting, and as patients spend less time in the acute care setting and costs decrease, the DRG relative weights will begin to fall. Therefore, there is no need for a postacute care transfer policy.

Commenters also noted the increasing costs of dealing with these higher cost cases, and that transfer payments do not adequately cover the costs of the newer and better treatment that is resulting in shorter lengths of stay. Commenters objected to the expansion of the policy due to the current financial pressure that many hospitals are currently under because of nursing shortages, inadequate Medicare payment for services they provide, and increasing costs associated with malpractice and insurance costs and increasing costs of pharmaceuticals and equipment. They also noted the financial burden in preparing to treat the aging ''baby boomer'' generation and costs associated with emergency management preparation.

Commenters argued that many hospitals are suffering as a result of not receiving the full market basket update (accounting for inflation each year), and further expansion of the postacute care transfer policy will further limit their resources. In addition, they argued, Congress already addresses the issues of shorter lengths of stay when it determines the market basket update each year. In effect, they claimed, hospitals whose lengths of stay decline significantly are not praised, but penalized—twice—for their efforts to provide better care. One commenter wrote to ''respectfully submit that to deal with fraudulent providers in this sweeping manner is inconsistent and inappropriate.''

Response: We disagree that the postacute care transfer policy is contrary to the fundamental theory of the IPPS. Concern that hospitals would shift a portion of the acute care services to other providers in response to the incentives of the IPPS has been an ongoing concern. In fact, in response to a comment during the first year of the IPPS on the hospital-to-hospital transfer policy, we stated that ''(t)he rationale for per diem payments as part of our transfer policy is that the transferring hospital generally provides only a limited amount of treatment. Therefore, payment of the full prospective payment rate would be unwarranted'' (49 FR 244). We also note that in its earliest update recommendations, the Prospective Payment Assessment Commission (a predecessor to MedPAC)

[6] The OIG report identification numbers are: A–04–00–02162, A–04–00–01210, A–04–0122, and A–04–02–07005.

included what it called a site-of-service substitution adjustment to account for the shifting of portions of inpatient care to other settings.

We disagree that the postacute care transfer policy creates a perverse incentive to keep patients in the hospital longer than necessary. Our view is the policy simply responds to changing medical practice and addresses the appropriate level of payment once clinical decisions about the most appropriate care in the most appropriate setting have been made. The validity of this position is substantiated by the finding that the geometric mean length of stay for 6 of the 10 DRGs currently included in the policy have continued to fall since the policy was implemented.

In regard to the comment that the policy fails to recognize that the DRG base payments reflect some degree of postacute care, we note that the policy is intended to recognize that, since the implementation of the IPPS, the use of postacute care has generally increased. For many DRGs, the use of postacute care continues to increase at a high rate. However, an increase in the frequency of the use of postacute care does not, by itself, necessitate a policy response. If patients continue to receive the full course of acute care in the IPPS setting prior to transfer, a full DRG payment is warranted. However, if patients begin to be transferred to postacute care settings to receive care that, during the IPPS base period, was provided in the IPPS setting, paying a full DRG would not be appropriate because some of the care on which the full DRG payment is based is now being provided in the postacute care setting.

This shift in the setting where care is provided is not accounted for through DRG recalibration. During recalibration, reductions in the relative weights of certain DRGs result in increases in the weights of other DRGs. Therefore, there is no net reduction in the IPPS payments to hospitals, even though some of the care that used to be provided in the acute inpatient setting is now provided elsewhere.

Comment: Commenters took issue with our evaluation of the impact of the postacute care transfer policy on the averaging aspects of the IPPS if the policy were expanded. Pointing to our statement in the August 1, 2002 **Federal Register** that we intended to undertake a more comprehensive analysis of this issue, some commenters stated that we did not provide such a comprehensive analysis or include a discussion of the topic in the proposed rule.

However, other commenters expressed appreciation for our analysis of the impacts of the existing policy in the proposed rule. One commenter noted that we had made some interesting and potentially valid points that an expanded transfer policy would eliminate or reduce some of the problems caused by making national average payments to all hospitals, regardless of treatment patterns and patient-mix within specific DRGs (although this commenter suggested that we address the payment inequities caused by expensive short-stay cases, or ''inliers'').

Several commenters noted that the recalculation of weights in the affected DRGs is unfair because, in the system of averages, transfers are accounted for as only partial cases but the remaining cases are not adjusted upward. The commenter wrote: ''[i]f a DRG's length of stay is declining, doesn't that suggest recalibration of the relative weight?'' The commenter believed inclusion of reduction in length of stay criteria ''begs the question of what is the true average length of stay for these particular DRGs. If these DRGs are experiencing a large percentage of cases transferred prior to the average length of stay, it logically follows that the average length of stay would be less.''

Response: We regret that commenters perceived that we neglected to address this important issue. Our point in evaluating the DRG relative weights for the 10 DRGs that are currently included in the policy was to make the point that reducing the contribution of transfer cases in the DRG relative weight recalibration enhances the averaging mechanism for these DRGs. By treating transfer cases as less than a full discharge (reducing the denominator), we effectively inflate the charges (the numerator) to reflect the higher charges that would have occurred if the patient had been transferred. This increases, rather than decreases, the average charges (and thus the relative weights) for the affected DRGs.

For example, the DRG weights for each of these 10 DRGs declined over the 5-year period (FYs 1993 through 1998) immediately preceding the implementation of this policy. However, as shown in the table above, the DRG weights for all but three of these DRGs have increased during the 5-years since implementation of this policy. Payments for all cases in these DRGs were declining as the number of cases being transferred to postacute care increased and the average length of the inpatient acute stay decreased. However, since implementation of the policy, payments for the cases that are not implicated under this policy are rising in most of the 10 DRGs. In those DRGs where the relative weight has declined in over the 5-year period since implementation of this policy, the geometric mean length of stay has continued to decline.

As discussed above, the premise of the postacute care transfer policy is that hospitals have shifted some of the acute care formerly provided in the hospital into the postacute care setting. This distorts the averaging principle of the IPPS because the average case is now less expensive without a corresponding adjustment to the base rate. However, a high percentage of postacute care utilization by cases in a particular DRG does not, by itself, create a distortion, if the high postacute care utilization was also reflected in the calculation of the base rate.

Therefore, to ensure that any proposed expansion of the postacute care transfer policy did not improperly distort the averaging principles of the IPPS, we evaluated the change in the mean lengths of stay for the DRGs we proposed to add to the policy to identify those in which the high postacute care utilization is resulting in shorter lengths of stay and lower costs. These shorter stays represent a shift in the site (and costs) of care relative to the base period, and, thus, a distortion in the averaging principle of the IPPS.

Comment: Several commenters argued that the postacute care transfer policy is no longer necessary, as lengths of stay have stabilized and Medicare spending on postacute care has slowed. In particular, commenters pointed to the transition of postacute care provider types to prospective payment systems, which reduces the incentives for postacute care providers to agree to admit very sick patients from an acute care hospital. One commenter argued that the concept of duplicate payment for the same care is a misconception when both the acute and the postacute care providers are paid under a prospective payment system.

Commenters claimed the policy puts an undue burden on them to be required to track patients after they are discharged to another setting. They claimed this creates an ''unworkable'' situation for them by making hospitals track patients and requiring frequent payment and claim readjustments. They noted the relatively small payment impact for all hospitals (only 0.2 percent) compared to the administrative burden hospitals will incur to administer the expansion of the policy.

Response: We agree that postacute care providers are likely to be less willing to admit very sick patients under prospective payment systems than they were under cost reimbursement payment methodologies.

However, the incentives for acute care hospitals to reduce costs by transferring patients to a postacute care setting remain as strong as ever. Furthermore, duplicate payments would still exist if the acute care hospital is shifting costs for which it is paid under the IPPS to a postacute care provider; that is, receiving payment for the care under a prospective payment system (potentially at a rate even higher than its costs). Therefore, we believe there is still a need for the postacute care transfer policy, despite the adoption of prospective payment systems for most postacute care providers under Medicare. Similarly, it is appropriate to evaluate the need to expand the policy.

Comment: Commenters suggested that, under our proposed criterion for selecting additional DRGs to cover under the policy, we should apply the same criteria to the existing postacute care transfer DRGs as to the new proposed DRGs. These commenters pointed out that 7 of the 10 DRGs would not qualify under these criteria, and should no longer be included in the policy.

One commenter argued that DRG 209 should be removed from the current list of DRGs subject to the postacute care transfer policy because the rate of decline in the average length of stay for this DRG had fallen dramatically since its inclusion in the postacute care transfer policy.

In addition, one commenter applied the proposed criteria to more recent data and determined some of the DRGs proposed to be included in the policy no longer met all the criteria. Specifically, the commenter found that 11 of the 19 DRGs proposed to be included in the transfer policy fail to meet the criterion that at least 10 percent of the postacute care transfer cases occur prior to the geometric mean length of stay.

Several commenters also noted that it appears our analysis identifying the 19 DRGs that were proposed to be added to the list included transfers from IPPS-exempt units. The commenters added that these units are not subject to the postacute care transfer policy and should not have been included in the analysis. The commenters pointed out that DRG 462 (Rehabilitation) only qualifies as a result of the inclusion of transfers from IPPS-exempt units in the analysis.

Response: We do not believe it is necessary to evaluate whether the lengths of stay for the DRGs currently included in the policy are declining. One would expect that, to the extent patients were being transferred early in the episode of care to a postacute care setting in order to minimize costs to the acute care hospital (as opposed to a general shift in the clinical care for particular cases, which is more likely to result in a continued drop in the length of stay despite the inclusion of the DRG in the transfer policy), inclusion of a particular DRG in the postacute care transfer policy would be likely to stabilize the mean length of stay for the DRG. Therefore, we did not evaluate the current DRGs included in the policy to the 7-percent decline in the length of stay criterion.

We also note that included in the commenter's list of 11 DRGs that it claim did not meet the new criteria, 6 of these DRGs are paired DRGs and were not selected based on meeting the criteria, but rather were included due to the paired nature of the DRG.

We have analyzed the remaining 5 DRGs the commenter identified as having not met the criteria that at least 10 percent of all postacute care transfer cases occur before the geometric mean length of stay. However, it appears the commenter divided the total number of transfer cases by the total number of cases in the DRG, rather than dividing by the number of postacute care transfer cases. Using the data the commenter provided to us, we found that all but l DRG met the 10 percent short-stay transfer definition we had proposed, with one DRG being a pair to another DRG that does meet the criterion.

However, we do agree with the notion that, to be included in the postacute care transfer policy, DRGs currently included in the policy should continue to meet all of the other applicable criteria. In addition, concerns from the commenters encouraged us evaluate whether the variation from year to year might also needs to be accounted for in our new criteria. Therefore, in order to improve the year-to-year stability of all the DRGs included in the policy, in this final rule, we are adding the requirement that the criteria must be met during both of the 2 most recent years for which data are available. That is, to be included in the policy, a DRG must have, for both of the 2 most recent years for which data are available:

- At least 14,000 cases postacute care transfer cases;
- At least 10 percent of its postacute care transfers occurring before the geometric mean length of stay;
- A geometric mean length of stay of at least 3 days; and
- If a DRG is not already included in the policy, a decline in its geometric mean length of stay during the most recent 5 year period of at least 7 percent.

Applying these criteria, we determined that DRG 263 no longer qualifies (there were only 13,588 postacute care transfer cases in this DRG during FY 2002). In addition, this is a paired DRG with DRG 264. Therefore, for FY 2004, we are no longer including DRGs 263 and 264 in the postacute care transfer policy.

We also corrected the programming error noted by the commenters that allowed IPPS-exempt units to be included in the analysis. Removing these units from the analysis resulted in the exclusion of some DRGs that were proposed to be included in the policy, and the inclusion of some new DRGs. The table below displays all the DRGs that met the criteria during both of the 2 most recent years available (FYs 2001 and 2002), as well as their paired-DRG if one of the DRGs meeting the criteria includes a CC/no-CC split.

DRG	DRG title	DRG title care transfer cases	Percent of all cases transferred prior to mean length of stay	Percent change in mean length of stay FYs 1998–2003
12	Degenerative Nervous System Disorders	28,103	31.42	−12.00
14	Intracranial Hemorrhage and Stroke with Infarction	138,636	22.84	−5.88
24	Seizure and Headache Age >17 With CC	19,306	15.85	−7.69
25	Seizure and Headache Age >17 Without CC	4,695	10.46	−10.71
88	Chronic Obstructive Pulmonary Disease	95,249	24.88	−10.87
89	Simple Pneumonia nad Pleurisy Age >17 With CC	175,526	31.83	−11.11
90	Simple Pneumonia and Pleurisy Age >17 Without CC	47,987	12.51	−15.00
113	Amputation for Circulatory System Disorders Except Upper Limb and Toe ..	24,810	45.31	7.22
121	Circulatory Disorders With AMI and Major Complication, Discharged Alive ..	55,629	22.42	−11.67
122	Circulatory Disorders With AMI Without Major Complications Discharged Alive.	71,838	10.53	−23.08

DRG	DRG title	DRG title care transfer cases	Percent of all cases transferred prior to mean length of stay	Percent change in mean length of stay FYs 1998–2003
127	Heart Failure & Shock	196,581	24.18	−8.89
130	Peripheral Vascular Disorders With CC	29,859	21.92	−11.76
131	Peripheral Vascular Disorders Without CC	26,455	20.16	−19.51
209	Major Joint and Limb Reattachment Procedures of Lower Extremity	247,513	29.20	−15.09
210	Hip and Femur Procedures Except Major Joint Age >17 With CC	89,612	46.77	−6.15
211	Hip and Femur Procedures Except Major Joint Age >17 Without CC	20,584	21.89	−8.00
236	Fractures of Hip and Pelvis	24,633	11.26	−6.98
239	Pathological Fractures and Musculoskeletal and Connective Tissue Malignancy.	23,184	40.44	−7.55
277	Cellulitis Age >17 With CC	35,873	36.56	−7.84
278	Cellulitis Age >17 Without CC	31,857	13.24	−10.00
294	Diabetes Age >35	29,608	17.65	−15.00
296	Nutritional and Miscellaneous Metabolic Disorders Age >17 With CC	106,923	29.26	−9.30
297	Nutritional and Miscellaneous Metabolic Disorders Age >17 Without CC	48,116	7.25	−10.00
320	Kidney and Urinary Tract Infections Age >17 With CC	80,717	27.38	−8.51
321	Kidney and Urinary Tract Infections Age >17 Without CC	30,934	18.34	−13.89
395	Red Blood Cell Disorders Age >17	23,053	25.27	−11.11
429	Organic Disturbances and Mental Retardation	14,731	46.30	−12.96
468	Extensive O.R. Procedure Unrelated to Principal Diagnosis	25,114	41.26	7.07
483	Tracheotomy With Mechanical Ventilation 96 + Hours or Principal Diagnosis Except Face, Mouth, and Neck Diagnoses.	20,034	49.56	2.37

Transfers to postacute care from the DRGs listed in the above table will be included under this policy, effective for discharges occurring on or after October 1, 2003. As a result of our analysis in which we applied the new qualifying criteria, we removed DRG 263 and DRG 264 from the current list of 10 DRGs, and we removed DRG 243 and DRG 462 from the proposed list of additional 19 DRGs. However, we added four new DRGs (that were not included in our proposal) to the policy based on this analysis: DRG 88 (Chronic Obstructive Pulmonary Disease); DRG 127 (Heart Failure and Shock); DRG 294 (Diabetes Age >35); and DRG 395 (Red Blood Cell Disorders, Age >17). We will review and update this list periodically to assess whether additional DRGs should be added or existing DRGs should be removed.

Comment: One commenter contested the automatic inclusion of both DRGs in a paired-DRG combination. The commenter believed any incentive for hospitals not to include a code that would identify a complicating or comorbid condition would be very limited and would have negligible effect on hospital behavior. However, the commenter asserted that if CMS is going to include both DRGs in a paired-DRG combination, CMS must combine the data for the two DRGs when applying the selection criteria.

Response: We include both DRGs from a paired-DRG combination because if we were to include only the ''with CC'' DRG from a ''with/without CC'' DRG combination in the transfer policy, there would be an incentive for hospitals not to include any code that would identify a complicating or comorbid condition. We believe our approach of identifying either DRG from a paired-DRG combination individually for inclusion in the policy is appropriate.

Comment: One commenter argued that DRG 468 should not be included in the policy because of the variation in the types of cases included in this DRG. The commenter pointed out that the cases in the DRG are, by definition, atypical, and the average lengths of stay for procedures included in this DRG vary widely. The commenter noted that ''every year CMS makes changes to the list of procedures that are assigned to this DRG. Therefore, a comparison of length of stay over time is not valid because the types of cases in the DRG change every year. The criterion that length of stay must have decreased by 7 percent compared to 1998 cannot be applied to DRG 468.'' The commenter added that application of a per diem payment based on a mean length of stay to a DRG that contains such a wide variety of different types of cases will result in extreme inequities.

One commenter argued for the exclusion of DRG 483 from the policy. The commenter argued that due to the large variation of lengths of stay for treatments in this DRG, the transfer policy has a very significant impact on payment for these cases that is unrelated to the use of postacute care.

Response: We disagree that DRG 468 should be excluded from the policy because of the variation in the types of cases within this DRG. Over 40 percent of transfers to postacute care within this DRG occurred before the geometric mean length of stay. Although it is true the nature of this DRG makes it difficult to assess whether there is a trend to shift care out of the acute care setting into the postacute care setting or there is just a different mix of cases being assigned to this DRG, we believe it is equitable to adjust payments for short-stay cases transferred to postacute care within this DRG. As noted above, application of this policy in the DRG recalibration process results in an overall increase in the payments for other cases in the DRG. Given the heterogeneous nature of this DRG, we believe this is appropriate.

We have addressed similar concerns in the past with respect to the inclusion of DRG 483 in this policy.

Comment: One comment noted that DRGs 121 and 122 should be included in the special payment provision due to the fact that ''these cases receive the most resource intensive services within the first day of the stay due to the acute nature of a myocardial infarction * * * [including care in] intensive care units, costly IV drug infusions, and multiple tests and monitoring.''

Response: Based on the revised list of DRGs that meet the criteria as described above, we analyzed which of these DRGs qualified for the special payment methodology. The only DRGs that had charges for short-stay transfer cases on the first day of stay that were greater than 50 percent of the average charges of all cases across the DRG were DRGs 209 and 211 (71 percent and 57 percent, respectively). Because DRG 211 is paired with DRG 210, we included DRG 210 in the payment policy as well (our analysis showed that short-stay transfer cases had 40 percent of costs on the first

day of the stay compared to costs for all cases across the DRG). However, DRGs 121 and 122 did not meet the 50 percent threshold.

Comment: Commenters again noted their objection to the expansion of the policy to all DRGs, even though we did not propose to expand the policy to all DRGs at this time. They refer to the language in section 1886(d)(J) of the Act that states that only those DRGs that have a ''high volume of discharges'' and ''disproportionate use of post discharge services'' could be included in an expanded postacute care transfer policy. Since this language would not apply to many DRGs, it makes this possibility ''implausible.''

Commenters also argue that, since we admit we need to do further analysis before expanding the policy to all DRGs, it is unclear why we do not need to conduct further analysis to make an incremental expansion.

Response: As noted previously, we did not propose to expand this policy to all DRGs because, for some DRGs, it may not be appropriate to reduce payment for these DRGs if the base payment already reflects a similar postacute care utilization rate. For the 29 DRGs included in the policy effective October 1, 2003, we have determined the data indicate there is substantial utilization of postacute care early in the stay, leading to decreasing lengths of stay.

Comment: Other commenters noted that, if we were focusing our efforts on analyzing lengths of stay in this manner, we should redirect our focus instead on a more thorough analysis of length of stay in particular regions to determine if changes are being adequately reflected in the yearly updates.

Response: We recognize that lengths of stay have tended to vary by region, and that regions with shorter lengths of stay tend to also have lower average costs due to the fewer number of days that patient spend in the hospitals. One of the reasons for the variation is the greater reliance on postacute care earlier in the stay in those areas with lower average lengths of stay.

We do not believe it would be appropriate to base the transfer payment methodology on regional average lengths of stay. The national standardized amounts, which apply across all regions, reflect costs and lengths of stay across all regions. To the extent hospitals in one area of the country are transferring patients early in the course of their treatment while hospitals in another part of the country are providing the entire treatment in the acute care hospital, adjusting payments for those hospitals transferring patients early in the stay and reflecting this in the process of recalibration maintains full DRG payments for hospitals in areas of the country providing the full course of treatment in the acute care hospital.

B. Rural Referral Centers (§ 412.96)

Under the authority of section 1886(d)(5)(C)(i) of the Act, the regulations at § 412.96 set forth the criteria that a hospital must meet in order to qualify under the IPPS as a rural referral center. For discharges occurring before October 1, 1994, rural referral centers received the benefit of payment based on the other urban amount rather than the rural standardized amount. Although the other urban and rural standardized amounts are the same for discharges beginning with that date, rural referral centers continue to receive special treatment under both the DSH payment adjustment and the criteria for geographic reclassification.

Rural referral centers with a disproportionate share percentage of at least 30 percent are not subject to the 5.25 percent cap on DSH payments that is applicable to other rural hospitals (with the exception of rural hospitals with 500 or more beds). Rural referral centers are not subject to the proximity criteria when applying for geographic reclassification, and they do not have to meet the requirement that a hospital's average hourly wage must exceed 106 percent of the average hourly wage of the labor market area where the hospital is located.

As discussed in **Federal Register** documents at 62 FR 45999 and 63 FR 26325, under section 4202 of Pub. L. 105–33, a hospital that was classified as a rural referral center for FY 1991 is to be considered as a rural referral center for FY 1998 and later years so long as that hospital continues to be located in a rural area and does not voluntarily terminate its rural referral center status. Effective October 1, 2000, if a hospital located in what is now an urban area was ever a rural referral center, it is reinstated to rural referral center status (65 FR 47089). Otherwise, a hospital seeking rural referral center status must satisfy the applicable criteria.

One of the criteria under which a hospital may qualify as a rural referral center is to have 275 or more beds available for use (§ 412.96(b)(1)(ii)). A rural hospital that does not meet the bed size requirement can qualify as a rural referral center if the hospital meets two mandatory prerequisites (a minimum case-mix index and a minimum number of discharges) and at least one of three optional criteria (relating to specialty composition of medical staff, source of inpatients, or referral volume) (§ 412.96(c)(1) through (c)(5)). (See also the September 30, 1988 **Federal Register** (53 FR 38513).) With respect to the two mandatory prerequisites, a hospital may be classified as a rural referral center if—

- The hospital's case-mix index is at least equal to the lower of the median case-mix index for urban hospitals in its census region, excluding hospitals with approved teaching programs, or the median case-mix index for all urban hospitals nationally; and
- The hospital's number of discharges is at least 5,000 per year, or, if fewer, the median number of discharges for urban hospitals in the census region in which the hospital is located. (The number of discharges criterion for an osteopathic hospital is at least 3,000 discharges per year, as specified in section 1886(d)(5)(C)(i) of the Act.)

1. Case-Mix Index

Section 412.96(c)(1) provides that CMS will establish updated national and regional case-mix index values in each year's annual notice of prospective payment rates for purposes of determining rural referral center status. The methodology we use to determine the proposed national and regional case-mix index values is set forth in regulations at § 412.96(c)(1)(ii). The proposed national mean case-mix index value for FY 2004 in the May 19, 2003 proposed rule included all urban hospitals nationwide, and the proposed regional values for FY 2004 were the median values of urban hospitals within each census region, excluding those hospitals with approved teaching programs (that is, those hospitals receiving indirect medical education payments as provided in § 412.105). These proposed values were based on discharges occurring during FY 2002 (October 1, 2001 through September 30, 2002) and included bills posted to CMS' records through December 2002.

In the May 19, 2003 proposed rule, we proposed that, in addition to meeting other criteria, if they are to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 2003, rural hospitals with fewer than 275 beds must have a case-mix index value for FY 2002 that is at least—

- 1.3374; or
- The median case-mix index value (not transfer-adjusted) for urban hospitals (excluding hospitals with approved teaching programs as identified in § 412.105) calculated by CMS for the census region in which the hospital is located. (See the table set forth in the May 19, 2003 proposed rule at 68 FR 27201.)

Based on the latest data available (FY 2002 bills received through March 2003), in addition to meeting other criteria, hospitals with fewer than 275 beds, if they are to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 2003, must have a case-mix index value for FY 2003 that is at least—

- 1.3373; or
- The median case-mix index value (not transfer-adjusted) for urban hospitals (excluding hospitals with approved teaching programs as identified in § 412.105) calculated by CMS for the census region in which the hospital is located. The final median case-mix index values by region are set forth in the following table:

Region	Case-Mix index value
1. New England (CT, ME, MA, NH, RI, VT)	1.2245
2. Middle Atlantic (PA, NJ, NY)	1.2262
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.3146
4. East North Central (IL, IN, MI, OH, WI)	1.2489
5. East South Central (AL, KY, MS, TN)	1.2511
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.1841
7. West South Central (AR, LA, OK, TX)	1.2705
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.3482
9. Pacific (AK, CA, HI, OR, WA)	1.2845

Hospitals seeking to qualify as rural referral centers or those wishing to know how their case-mix index value compares to the criteria should obtain hospital-specific case-mix index values (not transfer-adjusted) from their fiscal intermediaries. Data are available on the Provider Statistical and Reimbursement (PS&R) System. In keeping with our policy on discharges, these case-mix index values are computed based on all Medicare patient discharges subject to DRG-based payment.

2. Discharges

Section 412.96(c)(2)(i) provides that CMS will set forth the national and regional numbers of discharges in each year's annual notice of prospective payment rates for purposes of determining rural referral center status. As specified in section 1886(d)(5)(C)(ii) of the Act, the national standard is set at 5,000 discharges. In the May 19, 2003 proposed rule, we proposed to update the regional standards based on discharges for urban hospitals' cost reporting periods that began during FY 2002 (that is, October 1, 2001 through September 30, 2002).

Therefore, in the May 19, 2003 proposed rule, we proposed that, in addition to meeting other criteria, a hospital, if it is to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 2003, must have as the number of discharges for its cost reporting period that began during FY 2002 a figure that is at least—

- 5,000 (3,000 for an osteopathic hospital); or
- The median number of discharges for urban hospitals in the census region in which the hospital is located. (See the table set forth in the May 19, 2003 proposed rule at 68 FR 27201.)

Based on the latest discharge data available for FY 2002, the final median number of discharges for urban hospitals by census region area are as follows:

Region	Number of discharges
1. New England (CT, ME, MA, NH, RI, VT)	7,476
2. Middle Atlantic (PA, NJ, NY)	8,906
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	9,497
4. East North Central (IL, IN, MI, OH, WI)	8,439
5. East South Central (AL, KY, MS, TN)	6,894
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	3,991
7. West South Central (AR, LA, OK, TX)	7,629
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	8,908
9. Pacific (AK, CA, HI, OR, WA)	7,021

We reiterate that if an osteopathic hospital is to qualify for rural referral center status for cost reporting periods beginning on or after October 1, 2003, the hospital must have at least 3,000 discharges for its cost reporting period that began during FY 2002.

We did not receive any comments on the criteria for rural referral centers.

C. Indirect Medical Education (IME) Adjustment (§ 412.105) and Disproportionate Share Hospital (DSH) Adjustment (§ 412.105)

1. Available Beds and Patient Days: Background (§ 412.105(b) and § 412.106(a)(1)(ii))

Section 1886(d)(5)(B) of the Act provides that subsection (d) hospitals that have residents in approved graduate medical education (GME) programs receive an additional payment for each discharge of Medicare beneficiaries to reflect the higher indirect patient care costs of teaching hospitals relative to nonteaching hospitals. The existing regulations regarding the calculation of this additional payment, known as the indirect medical education (IME) adjustment, are located at § 412.105. The additional payment is based on the IME adjustment factor, calculated using hospitals' ratios of residents to beds. The determination of the number of beds, based on available bed days, is specified at § 412.105(b). This determination of the number of available beds is also applicable for other purposes, including the level of the disproportionate share hospital (DSH) adjustment payments under § 412.106(a)(1)(i).

Section 1886(d)(5)(F) of the Act specifies two methods for a hospital to qualify for the Medicare DSH adjustment. The primary method, which is a subject of this final rule, is for a hospital to qualify based on a complex statutory formula under which payment adjustments are based on the level of the DSH patient percentage. The first computation includes the number of patient days that are furnished to patients who were entitled to both Medicare Part A and Supplemental Security Income (SSI) benefits. This number is divided by the total number of patient days that are associated with patients entitled to benefits under Medicare Part A. The second computation includes hospital patient days that are furnished to patients who, for those days, were eligible for Medicaid but were not entitled to benefits under Medicare Part A. This number is divided by the number of total hospital inpatient days in the same period.

Hospitals whose DSH patient percentage exceeds 15 percent are eligible for a DSH payment adjustment (prior to April 1, 2001, the qualifying DSH patient percentage varied, in part, by the number of beds (66 FR 39882)). The DSH payment adjustment may vary based on the DSH patient percentage and the type of hospital: the statute provides for different adjustments for urban hospitals with 100 or more beds and rural hospitals with 500 or more beds, hospitals that qualify as rural referral centers or SCHs, and other hospitals.

As described in the May 19, 2003 proposed rule, we are combining in this final rule our discussion of changes to the policies for counting beds and patient days, in relation to the calculations at §§ 412.105(b) and 412.106(a)(1) because the underlying concepts are similar, and we believe they should generally be interpreted in a consistent manner for both purposes. Specifically, we proposed to clarify that

beds and patient days that are counted for these purposes should be limited to beds or patient days in hospital units or wards that would be directly included in determining the allowable costs of inpatient hospital care payable under the IPPS on the Medicare cost reports. As a preliminary matter, beds, and patient days associated with these beds, that are located in units or wards that are excluded from the IPPS (for example, psychiatric or rehabilitation units), and thus from the determination of allowable costs of inpatient hospital care under the IPPS on the Medicare cost report, are not to be counted for purposes of §§ 412.105(b) and 412.106(a)(1).

The remainder of this discussion pertains to beds and patient days in units or wards that are not excluded from the IPPS and for which costs are included in determining the allowable costs of inpatient hospital care under the IPPS on the Medicare cost report. For example, neonatal intensive care unit beds are included in the determination of available beds because the costs and patient days associated with these beds are directly included in the determination of the allowable costs of inpatient hospital care under the IPPS. In contrast, beds, and patient days associated with the beds, that are located in excluded distinct-part psychiatric or rehabilitation units would not be counted for purposes of §§ 412.105(b) and 412.106(a)(1) under any circumstances, because the costs associated with those units or wards are excluded from the determination of the costs of allowable inpatient care under IPPS.

This policy has been upheld in the past by various courts. (*See,* for example, *Little Co. of Mary Hospital and Health Care Centers* v. *Shalala*, 165 F.3d 1162 (7th Cir. 1999; *Grant Medical Center* v. *Shalala*, 905 F. Supp. 460 (S.D. Ohio 1995); *Sioux Valley Hospital* v. *Shalala*, No. 93–3741SD, 1994 U.S. App. LEXIS 17759 (8th Cir. July 20, 1996) (unpublished table decision); *Amisub* v. *Shalala*, No. 94–1883 (TFH) (D.D.C. December 4, 1995) (mem.).) In these cases, the courts agreed with the Secretary's position distinguishing between the treatment of neonatal intensive care unit beds and well-baby nursery beds based on the longstanding policy of CMS that neonatal intensive care unit days are considered intensive care days (part of inpatient routine care) rather than nursery days.

Our policies on counting beds are applied consistently for both IME and DSH although the incentives for hospitals can be different for IME and DSH. For purposes of IME, teaching hospitals have an incentive to minimize their number of available beds in order to increase the resident-to-bed ratio and maximize the IME adjustment. On the other hand, for DSH purposes, urban hospitals with under 100 beds and rural hospitals with under 500 beds may have an incentive to increase their bed count in order to qualify for the higher DSH payments for urban hospitals with over 100 beds or rural hospitals with over 500 beds.

However, some courts have applied our current rules in a manner that is inconsistent with our current policy and that would result in inconsistent treatment of beds, patient days, and costs. 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. Similarly, in a recent decision in the Ninth Circuit Court of Appeals (*Alhambra* v. *Thompson*, 259 F.3d 1071 (Ninth Cir. 2001), the court 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.

These courts considered subregulatory guidance (program instructions) in formulating their decisions. Although this final rule clarifies the underlying principles for our bed and patient days counting policies and amends the relevant regulations to be consistent with these clarifications, we recognize the need to revise some of our program instructions to make them fully consistent with these clarifications and will act to do so as soon as possible.

While some of the topics discussed below pertain only to counting available beds (unoccupied beds) and some only to counting patient days (section 1115 waiver days, dual-eligible days, and Medicare+Choice days), several important topics are applicable to both bed-counting and day-counting policies (nonacute care beds and days, observation beds and days, and swing-beds and days). Therefore, for ease of discussion, we have combined all topics pertaining to counting available beds and patient days together in the following discussion.

Comment: One commenter expressed concern about our policy to use the same definition of beds for IME and DSH. The commenter argued that Congress used different terminology to define the types of beds that should be used for these two payment adjustments. Section 1886(d)(5)(B)(vi)(I) of the Act indicates the IME adjustment is to be based on ''the hospital's available beds (as defined by the Secretary).'' For purposes of the DSH adjustment, section 1886(d)(5)(F)(v) of the Act simply refers to the number of ''beds'' in the hospital. The commenter believed that, because the Act does not narrow the bed count for DSH purposes to those that are available, it is unlawful and inappropriate for CMS to use the available bed definition for DSH purposes.

Response: We believe both statutory references cited by the commenter provide the Secretary with administrative discretion to define beds, one explicitly and one implicitly. In light of this discretion, we strongly believe it is important to apply a consistent definition for purposes of both IME and DSH adjustments, particularly because many hospitals receive both types of adjustments. We note that we have used available beds for purposes of determining whether hospitals qualify for DSH payments Congress directed us to make this adjustment in 1988. Since that time, Congress has amended the DSH provisions in the Act on numerous occasions, and certainly could have made clear its intention that we not use available beds for DSH purposes if that was its intent. Therefore, we disagree with this comment.

2. Unoccupied Beds

We are still reviewing the large number of comments on our proposal on unoccupied beds in the May 19, 2003 proposed rule. Due to the number and nature of the comments we received on our proposed policy, we are addressing the public comments in a separate document. We refer individuals who are interested in reviewing the background information and discussion of the proposed policy to the May 19, 2003 proposed rule (68 FR 37202 through 37204).

3. Nonacute Care Beds and Days

As noted above, our policies for counting beds are generally consistent with the method of reporting patient days for the purpose of calculating 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 statutory references to beds and days 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 generally 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, in the May 19, 2003 proposed rule, we proposed to revise our regulations to be more specific. Therefore, we proposed 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, believe that a patient-by-patient, day-by-day review of whether the care received would be paid under the IPPS would be unduly burdensome. Therefore, we believe it is more practical to apply this principle (that is, that we should consider only the inpatient days to which the IPPS applies) by using a proxy measure that is based upon the location at which the services were furnished.

In particular, we proposed 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 (that is, a unit that provides an IPPS level of care is on the same floor of the hospital as a subacute care unit that does not provide an IPPS level of care).

Exceptions to this policy to use the level of care generally provided in a unit or ward as proxy for the level of care provided to a particular patient on a particular day are outpatient observation bed days 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 and days are discussed further below. Another exception is healthy newborn nursery days. The costs, days, and beds associated with 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. Newborn nursery costs, days, and beds are treated this way because the 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 proposed 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).

The 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 also 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 may be of a type that would be payable under the IPPS if the care was provided in an IPPS unit.

We proposed 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 care that would be payable under the IPPS cannot be counted. We also proposed 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 generally furnish a level of care that would generally be payable under the IPPS.

We note the proposed revisions were clarifications of our regulations to

reflect our longstanding interpretation of the statutory intent, especially relating to the calculation of the Medicare DSH patient percentage.

Comment: Several commenters objected to our proposal and indicated that we were attempting to codify the Secretary's litigation position in *Alhambra* and administratively overrule the Ninth Circuit's decision in that case. Commenters asserted that the flaw in the proposal is that it is inconsistent with the Act to base the Medicaid days calculation of the DSH patient percentage on whether or not Medicare pays for the services that are generally provided within a unit. Specifically, commenters believed the proposal would restrict the definition of patient days in a way that is not authorized by the Act.

Response: We disagree that our proposed clarification is inconsistent with the statute. First, the clarification is merely a codification of the Secretary's longstanding policy. In addition, we believe that interpreting the statute as we have historically done is reasonable and permissible. Section 1886(d)(5)(F)(vi)(II) of the Act governs the portion of the disproportionate share percentage made up of the percentage of patient days used by patients eligible for medical assistance under a title XIX State plan. Specifically, section 1886(d)(5)(F)(vi)(II) of the Act states that the numerator of such fraction equals the ''number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under title XIX, but who were not entitled to benefits under part A of this title.'' The statute does not define the term ''hospital's patient days.'' Thus, the statute is ambiguous, and the Secretary has the authority to reasonably interpret that term.

We note that although the calculation performed under section 1886(d)(5)(F)(vi)(II) of the Act includes a count of patient days used by Medicaid-eligible individuals, the calculation actually is used to determine how much additional payment the hospital should receive under Medicare for the higher Medicare costs associated with treating a disproportionate share of low-income individuals. This point is demonstrated in the rationale for establishing the DSH adjustment as described in the Committee Report accompanying Pub. L. 99–272: ''Hospitals that serve a disproportionate share of low-income patients have higher Medicare costs per case'' (H. Rept. No. 99–242(I), 99th Cong., 2d Sess., (1985), p. 16).

Furthermore, we view section 1886(d)(5)(F)(vi)(II) of the Act as purely a Medicare, inpatient hospital provision, given that there already exists a distinct formula for computing DSH payments under title XIX—the Medicaid title. Because the DSH formula in title XVIII of the Act is intended to provide an add-on payment to inpatient hospitals for additional amounts they incur in treating low-income, Medicare patients, we believe it is reasonable to count only those days spent in wards or units that would generally provide an acute level of care.

We believe it is reasonable to interpret the phrase, ''hospital's patient days,'' to mean only the hospital's inpatient days at a level of care that would be covered under the IPPS as a means to determine an IPPS payment adjustment. Further, we believe that it is administratively inefficient and impracticable to calculate a hospital's inpatient days based on a determination, on a day-by-day basis, of whether a particular patient in a particular inpatient bed is receiving a level of care that would be covered under the IPPS. Therefore, we proposed to use, as a proxy, the level of care that is generally provided in particular units or wards, and to exclude patient days attributable to units or wards in which care delivered is not generally of a type that would be covered under the IPPS.

We also do not believe that by placing our longstanding interpretation of our rules in regulations we are unlawfully overruling or nullifying the decision by the Ninth Circuit in *Alhambra Hospital* v. *Thompson*, 259 F.3d 1071 (9th Cir. 2001). The Ninth Circuit decision focused on an interpretation of CMS' previous regulation at § 412.106(a)(1)(ii)—not on an interpretation of the statute. (For example, when the court stated the ''Standard of Review'' it would use to decide the case, it referred only to ''[o]ur review of an agency's interpretation of its own regulations.'' *Alhambra* at 1074). Although we respectfully disagree with the Ninth Circuits interpretation of the existing regulations, we are nonetheless amending them, through notice and comment rulemaking to ensure that going forward the regulations clearly reflect our longstanding position. Therefore, we do not agree with the commenter's assertion that our proposed policy is an illegal attempt to administratively overrule the Ninth Circuit's decision in *Alhambra*. Therefore, going forward, we plan to apply the clarified regulation to hospitals in all U.S. jurisdictions, including hospitals in the Ninth Circuit.

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 unit or ward. 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 days that those beds are used for observation services should be excluded from the available bed day count (even if the patient is ultimately admitted as an acute inpatient).

A swing-bed is a bed that is otherwise available for use to provide acute inpatient care and is also occasionally used to provide SNF-level care. The criteria for a hospital to meet the requirements to be granted an approval from CMS to provide posthospital extended care services 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.[7]

Observation beds and swing-beds are both special, frequently temporary, alternative uses of acute inpatient care

[7] Ibid.

beds. That is, only the days an acute inpatient care unit or ward 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 as described above stem from the fact that these days are not payable under the IPPS.

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 available to hospitals with more than 100 beds. 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).

Although the Court in *Clark* found that Congress had not explicitly ''addressed the question of whether swing and observation beds should be included in the count of beds in determining whether a hospital qualifies for the DSH adjustment,'' Clark, 314 F.3d at 245, the Court found that observation and swing-bed days were included under the ''plain meaning'' of the regulation text at § 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 of the rule that promulgated the regulatory provision at § 412.106(a)(1)(ii) clarified its meaning (53 FR 38480, September 30, 1988):

''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 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 in *Amisub* v. *Shalala,* is based on the principle of counting beds in generally the same manner as the patient days and costs are counted. Our policy to exclude observation and swing-bed days under the regulations at § 412.105(b) and § 412.106(a)(1) stems from this policy.

In the May 19, 2003 proposed rule, although we reiterated our longstanding policy that observation beds and swing bed days generally are excluded, we proposed to amend our policy with respect to observation bed days of patients who ultimately are admitted. We are still in the process of reviewing the comments and defer action until a later rule with respect this issue—for example, patients in observation beds who are ultimately admitted to the hospital.

Comment: Some commenters objected to the exclusion of observation bed days from the available bed days count on the grounds that it is a flawed premise that the size of a hospital's bed complement should be impacted by the payment policy classification of the services provided to the patient. That is, a bed should not be excluded from the available bed day count because it is used to provide services not payable under the IPPS on a particular day.

Response: When the application of IPPS payment policy is dependent on a determination of a hospital's number of beds, it seems reasonable to base that determination on the portion of the hospital that generates the costs that relate to those IPPS payments. As stated above, our bed counting policies start with the premise that the treatment of beds should be consistent with the treatment of the patient days and the costs of those days on the Medicare cost report. Therefore, we continue to believe it is appropriate to exclude outpatient observation bed days, even when the beds used to provide that service is located in a routine inpatient care unit or ward.

5. Labor, Delivery, and Postpartum Beds and Days

Prior to December 1991, Medicare's policy on counting days for maternity patients was to count an inpatient day 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 to reflect our current policy.

Our current policy regarding the treatment of labor and delivery bed days is described in Section 2205.2 of the PRM, which 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 inpatient 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 inpatient 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, and postpartum rooms, to single multipurpose labor, delivery, and postpartum (LDP) rooms. In order to appropriately track the days and costs associated with LDP rooms, it is necessary to apportion them between the labor and delivery cost center, which is an ancillary cost center and the routine adults and pediatrics cost center. This is done under our policy by determining the proportion of the patient's stay in the LDP room that the patient was receiving ancillary services (labor and delivery) as opposed to routine adult and pediatric services (postpartum).

An example of this would be if 25 percent of the patient's time in the LDP room was for labor/delivery services and 75 percent for routine care, over the course of a 4-day stay in the LDP room. In that case, 75 percent of the time the patient spent in the LDP room is applied to the routine inpatient bed days and costs (resulting in 3 routine adults and pediatrics bed days for this patient, 75 percent of 4 total days). For purposes of determining the hospital bed count, the time that 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, in this example, 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 in the LDP room(s) during a typical month, and apply that percentage through the rest of the year.

Comment: Some commenters stated that the LDP days that patients spend in routine inpatient wards of hospitals prior to the day those patients give birth are in areas of the hospital where routine inpatient beds are located, and they are not excluded from the IPPS. Therefore, the commenters asserted that these days should be counted in the patient days and available bed days counts. Commenters also pointed out the LDP days are in licensed beds, and argued that these days should be counted in their entirety.

Other commenters supported our proposal to allow calculation of an average percentage of time LDP patients spend in labor/delivery compared to postpartum to be used to apportion LDP days. Commenters commended CMS for recognizing the cumbersome recordkeeping and reporting that would otherwise be required.

One commenter suggested that it is not necessary for our policy applicable to counting patient days for purposes of the DSH computation to comply with other Medicare cost reporting policies, such as the need to separately allocate the ancillary costs associated with LDP rooms. The commenter cited prior PRRB appeals in which CMS took this position.

Response: As we previously stated above and in the proposed rule, initially, Medicare's policy did count an inpatient day for an admitted maternity patient even if the patient was in the labor/delivery room at the census-taking hour. However, based on adverse court decisions, the policy was revised to state that the patient must first occupy an inpatient routine bed before being counted as an inpatient. With the development of LDP rooms, we found it necessary to apply this policy consistently in those settings, in order to appropriately apportion the costs between labor and delivery ancillary services and routine inpatient care.

Although we have not previously formally specified in guidance or regulations the methodology for applying this policy to LDP rooms, this is not a new policy. However, as suggested by the commenters, we believe this policy may not have been applied consistently. Therefore, we believe it is important to clarify the policy as part of our discussion of our policies pertaining to counting patient bed days.

We continue to believe the LDP apportionment described above is an appropriate policy and does not, in fact, impose a significant additional burden because hospitals are already required to allocate cost on the cost report between ancillary and routine costs. In addition, this allocation is already required to be consistent with our treatment of costs, days, and beds and is consistent with our other patient bed day policies. Therefore, this policy will be applied to all currently open and future cost reports. However, it is not necessary to reopen previously settled cost reports to apply this policy.

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 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 apply to 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, in the May 19, 2003 proposed rule, we proposed 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 (which was added to the law by section 9105 of COBRA and was effective for discharges occurring on or after May 1, 1986), 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 proposed 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 the 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.

The proposed revision addressed 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.

Comment: Some commenters questioned our authority to require a patient obtain to covered inpatient benefits under either a Medicaid State plan or a section 1115 demonstration, in order to be included in the numerator of the Medicaid ratio for the DSH computation. One commenter pointed out that there are many circumstances under which an individual may have income low enough to qualify for Medicaid but still not qualify due to other qualifying criteria, and requested that all patient days of such individuals be counted as Medicaid-eligible.

Response: As stated above and in the proposed rule, we do not believe patients covered under limited-benefit section 1115 demonstration projects that are so limited that they are not similar to the medical assistance available under a Medicaid State plan should not be included in the count of Medicaid-eligible patients.

Under a traditional State Medicaid program, States are required to offer inpatient benefits to all eligible beneficiaries (see section 1902(a)(10)(A) of the Act). However, under the 1115 demonstration authority, the Secretary has permitted coverage for a limited set of services, such as pharmaceuticals or family planning services, and thus inpatient hospital services may be excluded for expansion populations under some of the section 1115 demonstration programs.

Our intention in allowing hospitals to include patient days related to section 1115 expansion waiver populations was to include patient days of demonstration populations who receive benefits under the demonstration project that are similar to traditional Medicaid beneficiaries, including inpatient benefits.

Comment: One commenter requested that the effective date of the proposed change be delayed until January 1, 2004, to allow fiscal intermediaries to contact States and identify specific coverage for their various section 1115 waiver populations.

Response: Because the DSH adjustment is reconciled when hospitals' cost reports are settled, we do not believe it is necessary to delay the implementation of this policy until January 1, 2004. Furthermore, although we believe it would have been reasonable for hospitals or fiscal intermediaries to have applied this interpretation of our policy regarding the inclusion of section 1115 waiver days prior to this clarification, we recognize that there may be situations in which this policy was not already applied. Therefore, we are making this change and the regulation at § 412.106(b)(4)(i) will be effective for discharges occurring on or after October 1, 2003.

7. Dual-Eligible Patient Days

We are still reviewing the large number of comments received on the proposed provision relating to dual-eligible patient days in the May 19, 2003. Due to the number and nature of the comments we received on our proposed policies, we are addressing the public comments in a separate document. We refer individuals who are interested in reviewing the background information and discussions regarding this policy to the May 19, 2003 proposed rule (68 FR 27207–27208).

8. Medicare+Choice (M+C) Days

We are still reviewing the large number of comments we received on the proposed provision relating to the counting of Medicare+Choice days for purposes of the IME and DSH adjustments. Due to the number and nature of the comments we received on our proposed policies, we are addressing the public comments in a separate document. We refer individuals interested in reviewing the background information and the discussion regarding these policies to the May 19, 2003 proposed rule (68 FR 27208).

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.)

We now more fully understand this particular hospital's situation and we have the administrative authority to establish a policy allowing corrections for this particular set of circumstances, in the proposed rule, we solicited 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.

Comment: One commenter supported the proposed establishment of the exception. However, the commenter recommended that CMS consider allowing all hospitals to make corrections to the data that is used in reclassification determinations.

Response: We continue to believe that requiring wage data corrections by specified deadlines is essential to ensuring that wage data is finalized in an efficient manner. We also continue to believe that final wage data published in the annual IPPS final rules should be as complete and accurate as possible. However, we believe that, in the limited circumstances raised in our proposed rule where the hospital could not have foreseen that its wage data would later be used in a 3-year average, and the hospital was subject to the rural floor, it is feasible to permit a limited exception. Therefore, in this final rule, we are amending § 412.230(e)(2)(ii)(A) to allow, for the limited purpose of qualifying for geographic reclassification, hospitals demonstrating that they meet the limited circumstances described in the amended regulation be considered for reclassification after taking into account revisions subsequent to its use to construct the wage index for IPPS payment purposes. We are not adopting a broader exception, because we continue to believe it is important to ensure that final wage data published in the annual IPPS final rule are complete and accurate. Creating a broad exception to allow for corrections of prior years' data would affect the accuracy and stability in the wage indices from year to year. Therefore, we will continue to require hospitals—other than hospitals meeting the limited exception described in § 412.230(e)(2)(ii)(A)—to ensure that their wage data are correct by applicable deadlines and will not allow for wage data corrections after such deadlines.

Comment: Several hospitals who were interested in reclassifying, as a group, for purposes of the wage index, commented that their efforts to reclassify as an urban group have been unsuccessful primarily because they fail to meet the established requirement set forth in § 412.234(c)(2) that the requesting hospitals must demonstrate that their costs exceed their current payments by 75 percent of the additional payments they would receive through reclassification. The commenters submitted several recommendations for our consideration to clarify or improve our policies and regulations. They recommended that we consider:

- Allowing hospital groups to seek geographic reclassification for purposes of the wage index or standardized amount;
- Allowing hospital groups seeking geographic reclassification to areas where the reclassification would not result in a different standardized amount to seek reclassification for purposes of the wage index without having to satisfy the criteria applicable to hospitals seeking reclassification for purposes of the standardized amount;
- Allowing hospitals in NECMAs to seek reclassification to another MSA under the alternative criteria at § 412.236(c);
- Lowering the cost-to-payment threshold used to evaluate group reclassification applications; or
- In order to evaluate the interrelationship between the area where the hospitals are located and the target area in which they are seeking to reclassify, replacing the cost comparison criteria used to evaluate reclassification eligibility for purposes of the standardized amount with a better indicator of the connection such as, census commuting patterns.

Response: We appreciate the comments and recommendations presented by the hospitals and the importance of this issue. We note that, in developing the proposed rule, we did consider including a proposal to allow urban hospitals to reclassify as a group either for wage index or the standardized amount, or both. However, we did not go forward with the proposal because, upon further review, the criterion that hospitals demonstrate that their costs are in excess of their payments seemed appropriate. We will consider the commenters' recommendations in the future.

Comment: One commenter recommended that CMS consider lowering the applicable qualifying thresholds at § 412.230(c)(1)(iii) and (iv) for urban hospitals seeking reclassification for purposes of the wage index. The commenter specifically suggested that the threshold be lowered from 108 percent of the average hourly wage of hospitals in the area in which the hospital is located, and 84 percent of the average hourly wage of hospitals in the area to which the hospital seeks reclassification, to 106 percent and 82 percent, respectively, for urban hospitals. The commenter further recommended that, if the lower thresholds cannot be reduced for all urban hospitals, CMS consider implementing the lower thresholds for urban hospitals in areas where they are paid as if they are rural.

Response: As pointed out by the commenter, this issue was discussed, in detail, in the August 1, 2000 **Federal Register** (65 FR 47089 through 47090). While we will consider the recommendations for possible inclusion in a future proposed rule, we did not propose any changes or clarifications to the existing policy. Therefore, we are not adopting this comment.

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

1. Background

Medicare has historically paid providers for the program's 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 the May 19, 2003 proposed rule, we proposed 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 Pub. L. 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 Pub. L. 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 Pub. L. 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.

Prior to the issuance of the May 19, 2003 proposed rule, 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. In the proposed rule (68 FR 27210), we stated that our use of the term ''certification'' does 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 stated that we believe certification means 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, in the May 19, 2003 proposed rule, we stated that 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 stated that we understood 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 the distinction between continuing education programs and approved education programs in the context of reasonable cost pass-through payments for nursing and allied health education activities, in the May 19, 2003 proposed rule, we proposed 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 proposed 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.''

Comment: A large number of commenters responded to our proposal to clarify that, effective October 1, 2003, activities that do not lead to certification required to practice or begin employment in a nursing or allied health specialty would be treated as educational activities (continuing education) that are part of normal operating costs, and not as approved programs that are eligible for reasonable cost reimbursement. Many commenters strongly disagreed with the section of the proposed rule that included clinical pastoral education (CPE) as continuing education and stated that CMS must have been badly misinformed when writing the proposed rule. The commenters argued that CPE is a rigorous and structured education program accredited by the Association for Clinical Pastoral Education, Inc. (ACPE). The commenters stressed that, in varying amounts, CPE is a requirement for graduation for the master of divinity degree and for professional certification by the Association of Professional Chaplains (APC) as a health care chaplain, or as a CPE supervisor. Many commenters also noted prior Provider Reimbursement Review Board (PRRB) rulings that recognized chaplaincy as an allied health discipline, and asserted that hospitals that receive Medicare reasonable cost pass-through payment for CPE do so for the purpose of their professional CPE programs, not as continuing education for individuals already qualified to practice in hospital chaplaincy. Many commenters mentioned that the Joint Commission on Accreditation of Healthcare Organizations also recognizes chaplains as allied health professionals and considers them ''primary care providers.'' Similarly, commenters referred to various studies that have

shown the positive spiritual and therapeutic benefits of pastoral care. The commenters warned that removal of funding for CPE would represent a huge step backward for American health care. The commenters urged CMS to ensure continuing pass-through payments for CPE.

Response: In the May 19, 2003 proposed rule (68 FR 27210), we stated that we received an inquiry requesting further clarification of what is meant by continuing education. We proceeded to explain what constitutes ''continuing education'' for the purpose of determining whether a nursing or allied health education activity would or would not qualify for Medicare reasonable cost pass-through payments. We acknowledge that the definition of ''continuing education'' for Medicare payment purposes may differ from the academic view of what, in general, constitutes such activities. In the proposed rule, we stated that we believed that provider-operated programs that do not lead to any specific certification or the ability to perform in the specialty would be classified as ''continuing education.''

Our intent is to ensure that Medicare pass-through payments are only provided for programs that enable an individual to be employed in a capacity that he or she could not have been employed without having first completed a particular education program. We believe that, *for Medicare purposes,* training that enhances an individual's competencies, but does not permit that individual to be employed in a new capacity in which he or she could not have been employed without completing the additional training, would not qualify for Medicare reasonable cost pass-through payment. Medicare provides payments for such educational activities, but only under the methodology applicable to payment of normal operating costs. Our intent was simply to provide clarification for the purpose of distinguishing between those educational programs that qualify for reasonable cost pass-through payment (that is, programs that enable an individual to begin employment in a specialty as a whole) and those programs that should be paid as normal operating costs (that is, activities that are intended to enhance the current skill set of an individual's profession or advance an individual's professional career).

Since publication of the proposed rule, we have learned from information provided by the ACPE and the APC that there are several levels of CPE. Specifically, the ACPE accredits three different levels of CPE. The first level of CPE is generally geared to interns and beginning residents. The second level of CPE is generally geared to residents doing specialization and preparation for chaplaincy certification. The third level is supervisory training, which is geared toward preparation for certification by the ACPE as a CPE supervisor.

We understand that, as a part of the requirements for a master of divinity degree, many theological schools and seminaries require or strongly recommend completion of an internship, or 1 unit of CPE for graduation. A unit of CPE is 400+ hours of supervised CPE in a health care or institutional setting. Students taking either 1 or 2 units of CPE are generally referred to as interns. In addition, many faith groups require, at their national or regional levels, that individuals complete at least 1 unit of CPE in order for them to be ordained into professional ministry. Theological schools that offer doctoral degrees (for example, a doctor of philosophy, a doctor of ministry, or a doctor of theology) with specialties in pastoral counseling and related fields also generally require some amount of CPE as a part of those degree programs. Upon completion of a CPE internship, the health care institution typically reports to the theological school in which the student is enrolled that the student has successfully completed the internship, and the theological school subsequently awards credit for the training. Based upon information received from the commenters, we understand that completion of only an internship, or 400+ hours of CPE, would not qualify an individual for employment as a chaplain in a hospital setting.

In contrast to CPE internships, CPE residents generally participate in a 1-year, or occasionally a 2-year, full-time CPE program. A 1-year residency typically consists of 4 units of postgraduate CPE (that is, 1,600+ hours of supervised CPE), in a health care or institutional setting. Generally, individuals who undertake 1,600 hours of CPE do so in order to become a board-certified chaplain. The ACPE has established 4 units, or 1,600 hours of supervised CPE, as the national minimum amount of CPE that is required to become a board-certified chaplain. However, some certifying boards or particular programs may require some additional hours of CPE for board certification. We note that, in instances where academic credit is granted for completion of 1 unit, or 400 hours, of CPE prior to receipt of a degree, an individual seeking to become a board-certified chaplain generally must complete an additional 1,600 hours of CPE training.

The board certification of chaplains is carried out by nationally recognized organizations that are part of the Commission on Ministry in Specialized Settings (COMISS), an umbrella network for pastoral care organizations that share the same standards of educational preparation and clinical training. These organizations include the Association of Professional Chaplains (APC), the National Association of Catholic Chaplains (NACC), the National Association of Jewish Chaplains (NAJC), and the Canadian Association for Pastoral Practice and Education (CAPPE). The ACPE accredits CPE training for all of these certifying organizations.

Based on information received from the commenters, we understand that most health care organizations that are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) advertise for and recruit only board-certified chaplains, which means that qualified applicants for employment as hospital chaplains will usually have completed at least 1,600 hours of CPE.

Individuals who seek to develop a health care chaplaincy specialization (for example, hospice, pediatrics, cardiology, rehabilitation, neurology) may undertake a second year of CPE residency. A second year of residency consists of an additional 4 units of CPE (or 1,600+ hours of supervised CPE). However, there is currently no established board certification process for residents completing a second year of CPE residency training.

To be eligible to apply for supervisory CPE training, an individual must have completed at least 4 units (1 year) of CPE training. Upon completion of supervisory training, an individual becomes certified by the ACPE as a CPE supervisor and is qualified to develop and conduct CPE training for all ACPE-accredited programs.

Based on information submitted by the commenters on the different levels of CPE training, two important points relative to Medicare reimbursement have become clear to us. First, in instances where internship training is completed as a prerequisite for a degree granted by an educational institution other than a hospital, such training is *not* provider-operated, and, therefore, does *not* qualify for Medicare reasonable cost pass-through payment under § 413.85. Under § 413.85(f), a program is considered to be provider-operated only if the hospital directly incurs the training costs, directly 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). While a hospital may serve as the site for a CPE internship, such training is provided to satisfy curriculum requirements of a theological school, which grants the master degree upon completion of the internship. While the hospital might incur training costs and employ the supervising faculty, it would not ordinarily meet the other ''provider-operated'' criteria concerning controlling the curriculum and providing both the didactic and clinical training necessary for the degree. Thus, a CPE internship, or any other CPE training that is a requirement for a degree, whether it is undergraduate, graduate, or doctoral, is not eligible for Medicare reasonable cost pass-through payment.

Secondly, a CPE residency consisting of 1,600 hours of training could be a provider-operated program and could also lead to certification and the ability to be employed in a new or different capacity. Specifically, a CPE residency consisting of approximately 1,600 hours of training leads to board certification in chaplaincy, and, as we understand it, most JCAHO-accredited hospitals generally only employ board-certified chaplains. In consideration of these facts, the costs of CPE training programs that meet the requirements under § 413.85, including accreditation by a nationally recognized accrediting body, direct operation by a provider, and lead to certification that is generally a requirement for employment in a particular specialty, may be eligible for Medicare reasonable cost pass-through payment.

In the May 19, 2003 proposed rule (68 FR 27210), we proposed to revise the regulations at § 413.85(h)(3) to state that activities treated as normal operating costs include ''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.'' We proposed 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.'' However, it is apparent from the comments we received that our proposed definition of ''certification'' was not clear. Some commenters believed we intended, through the proposed definition, to allow pass-through payments for the costs of a program that would only enhance an individual's set of skills. However, that was not our intent. We believe it would have been more appropriate to use the word ''and'' instead of the word ''or'', to further emphasize that pass-through payment would only apply to activities that enable an individual to practice *and* begin employment in a specialty, but would *not* apply to activities that serve to add to or to enhance an individual's current skill set.

In addition, based on the comments received, we understand that there may be several distinct levels of training in a given health profession, and each level of training may be a requirement in order for an individual to work in a new capacity or ''specialty'' in that profession, but *not* a requirement to practice or begin employment in the specialty ''as a whole.'' Since a second level of training is not required to begin practicing in a profession, under the proposed definition, we would not have been able to allow for pass-through payments for a second (or potentially a third) level of training. Therefore, we understand that inclusion of the words ''as a whole'' in the proposed definition of ''certification'' was misleading. Consequently, where a subsequent level of training is a requirement to practice in a new specialty in a given profession, pass-through payment may be made for the subsequent level of training.

Finally, we have concluded that it is not necessary to include a specific definition of ''certification'' at § 413.85. In this final rule, we are deleting the proposed definition of ''certification'' from § 413.85(c), and amending § 413.85(h)(3) by removing the words ''certification required'' and inserting the words ''the ability.'' We are also changing the word ''or'' to ''and''. Specifically, we are amending the proposed regulations at § 413.85(h)(3) to state that activities treated as normal operating costs include ''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 the ability to practice and begin employment in a nursing or allied health specialty.''

Our view of a ''specialty'' in the nursing and allied health education context is based on what the industry views as the standard of practice in a specific area within a profession. The training required to allow a person to serve in the ''specialty'' is tailored to the skill level and context that an individual is expected to use in that ''specialty.''

Consistent with what we stated in the proposed rule, Medicare reasonable cost pass-through payments are only provided for programs that, according to industry norms, qualify an individual to be employed in a specialty in which the individual could not have been employed before completing a particular education program. Given the confusion expressed by commenters, we recognize the need to specify how we will determine whether completion of a particular education program enables an individual to be employed in a specialty. We will use ''industry norms'' as the standard to determine whether participation in a specialty enables an individual to be employed in a capacity that he or she could not have been employed without having first completed a particular education program. We are defining ''industry norm'' to mean that more than 50 percent of hospitals in a random, statistically valid sample require the completion of a particular training program before an individual may be employed in a specialty. (We understand that, in some instances, due to the unique staffing circumstances faced by many smaller hospitals, inclusion of small hospitals in the sample would introduce factors that are not typically representative of the industry as a whole and would skew the results inappropriately. In such a case, if appropriate, we would consider excluding hospitals with less than 100 beds, which would still retain over 75 percent of all hospitals in the universe).

Based on comments received, we believe that it is the ''industry norm'' to require a CPE residency and board certification for employment as a hospital chaplain. Since it is currently the ''industry norm'' for hospitals to employ only board-certified chaplains, and since completion of approximately 1,600 hours of CPE training is a requirement to practice and begin employment in hospital chaplaincy, we view hospital chaplaincy as a ''specialty'' of pastoral counseling. Consequently, a hospital that operates a CPE residency may be eligible for reasonable cost pass-through payment.

Specifically, assuming all requirements under § 413.85 are met, Medicare reasonable cost pass-through payments may only be made to hospitals for CPE hours that are *not* prerequisites for *any* academic degree, *and* are provided to students in order to obtain board certification in hospital chaplaincy. A hospital may not receive reasonable cost payment for any costs

incurred in connection with providing CPE that is undertaken to meet the requirements of an academic degree. In addition, since generally a minimum of approximately 1,600 hours of CPE is required to become a board-certified chaplain, any costs incurred for an individual participating in CPE training that exceeds the minimum number of hours required to obtain board certification would not be eligible to be paid on a reasonable cost basis.

However, we note that we do not completely defer to the information provided by industry representatives in order to determine the ''industry norm.'' Rather, if at any time we obtain information that calls our view of industry norms into question, we may make our own determination based on a random sample of hospitals. Therefore, assuming all other requirements under § 413.85 are met, a hospital may receive reasonable cost pass-through payment for the hours of CPE for which academic credit is *not* granted (since *those* CPE hours are not generally provider-operated), and for the hours of CPE that may be used to satisfy training requirements for board certification. We will continue to allow reasonable cost payment for CPE that leads to board certification as long as we do *not* have evidence indicating that, based on a statistically valid, random sample, the ''industry norm'' is *not* to require board certification for chaplains that are employed by hospitals.

We also recognize that industry norms are susceptible to change over time. Therefore, although it may not currently be the ''industry norm'' to require completion of a particular nursing or allied health education program in order to practice and begin employment in a particular specialty, it may become the ''industry norm'' in the future. If we find that it has become the ''industry norm,'' we may allow the hospitals operating those programs (and meeting the requirements at § 413.85) to be paid for the costs of those programs on a reasonable cost basis.

In relation to the commenters' recommendation that reasonable cost reimbursement should be provided for CPE supervisory training, we understand that, essentially, the purpose of the supervisory training is to prepare a chaplain to develop CPE programs and to teach interns and residents. We believe that CPE supervisors are practicing in the teaching profession, not within a nursing or allied health discipline. Furthermore, we do not believe that Congress intended to provide for reasonable cost pass-through payments for programs that are intended to produce instructors or teachers. While we recognize that CPE supervisors are necessary to train and prepare individuals for hospital chaplaincy, we believe that it is appropriate for the costs of supervisory programs in general to be treated as normal operating costs and paid accordingly.

Comment: One commenter stated that our proposed definition of provider-operated programs intended to exclude programs ''that do not lead to certification required to practice or begin employment in a nursing or allied health specialty * * *'' is not appropriate in light of the growing number of skills that require intensive clinical experiences. Another commenter stated that this proposal will seriously hinder reversal of the nursing shortage across the nation and, as a result, will have an adverse impact on the quality and safety of care provided in hospitals. The commenters used the example of nurse residencies, which a number of hospitals across the country are hosting for registered nurses. The commenters explained that these residencies, which are postgraduate and typically last 1 year, are designed to equip the newly licensed nurse with the skills to care for patients who require the most complex and sophisticated diagnostic and therapeutic services, and to prepare the nurses for leadership roles earlier in their careers and give them the tools to improve the quality of care and reduce medical errors. The commenters claimed that the Federal Government has thus far provided minimal funding to help ameliorate the nursing shortage and, therefore, the proposed rule is particularly distressing. They urged CMS to include criteria in the final rule for pass-through payment of nurse residencies.

Response: First, we do not believe that nurse residencies, which are intended to help integrate newly licensed nurses into complex acute care environments by enhancing their competencies and skills, are programs that qualify these nurses to be employed in a new specialty. Accordingly, it is more appropriate to treat such activities as normal operating costs. As we stated above, Medicare reasonable cost pass-through payment will only be provided for programs that, according to industry norms, qualify an individual to be employed in a specialty in which the individual could not have been employed prior to completing a particular education program. Second, we note that nurse residencies do not qualify for reasonable cost payment because they also do not meet the requirement for accreditation by a national approving body under § 413.85(d)(1)(i)(A). Therefore, while we are sympathetic to the commenters' concerns, we do not believe that it is appropriate at the present time to allow for pass-through payment to be made under the Medicare program for nurse residencies.

Comment: Some commenters stated that CMS was ''entirely correct'' in identifying CPE as continuing education and concurred with our proposal to discontinue pass-through payments for CPE. One commenter contended that ACPE-accredited training is not primarily used to prepare students to be health care chaplains. Rather, CPE is primarily ministry training, and there are various ways that one can choose to use CPE. One commenter added that very few individuals who train in CPE, including those individuals in 1-year residencies, become employed as health care chaplains. The commenter further stated that CPE is ''properly a funding responsibility of the church rather than the government''. The commenters argued that Medicare should not be supporting continuing education for religious care providers whose primary base and certifying group is their denomination or faith group.

Another commenter presented a similar argument concerning pharmacy residencies and questioned why Medicare (that is, taxpayers) should subsidize these residency programs. The commenter claimed that hospitals ''use government monies in order to hire these 'residents,' utilize them in 'clinical' positions under the guise of postgraduate training, thereby bypassing having to use FTEs in the hospital pharmacy budget.'' The commentator believed that if hospitals and pharmacists were truly concerned with improving patient care, hospital pharmacy departments would train their own staff pharmacists to perform the clinical aspects themselves, rather than having taxpayers provide the funding.

Response: We are sympathetic to the commenters' concerns. However, we understand that many CPE programs do occur in hospitals, and that, while there may be various kinds of CPE training, generally, completion of approximately 1,600 hours of CPE training is required for board certification and employment by a hospital. Therefore, we believe that CPE residencies that lead to board certification generally would not be considered continuing education.

In response to the commenters' concerns about the taxpayers, through the Medicare program, providing support for CPE and pharmacy residencies, we note Medicare payment for these and other similar programs are made in accordance with the Medicare

statute. Under section 1861(v) of the Act, Congress provides for Medicare payments to be made in support of certain medical education activities. Currently, if a program meets the regulatory requirements under § 413.85, which were specified earlier in this preamble, a hospital operating that program may qualify for Medicare reasonable cost pass-through payment.

Comment: One commenter explained that a dietetic internship is a post-baccalaureate program that is one of the requirements for practicing as a registered dietitian. The commenter pointed out that the Commission on Accreditation of Dietetic Education (CADE) of the American Dietetic Association accredits these internships and the interns contribute directly to patient care in a hospital. The commenter urged us to continue to pay health care organizations for dietetic internships.

Response: We appreciate the comment and note that, as long as a dietetic internship meets the requirements under § 413.85 (and we do not find that it is not the industry norm to require this training to be employed as a registered dietitian), the hospital operating the internship may qualify for Medicare reasonable cost pass-through payment.

Comment: A large number of commenters responded to our proposal to clarify that, effective October 1, 2003, training that does not lead to certification required to practice or begin employment in a nursing or allied health specialty would be treated as educational activities (continuing education) that are part of normal operating costs, and not as approved programs that are eligible for reasonable cost pass-through payments. Many commenters strongly disagreed with our proposal that included pharmacy residencies in the type of training that is considered continuing education and claimed that the proposed rule reflected a fundamental misunderstanding of pharmacy education. The commenters stated that educational seminars, workshops, and continuing education programs are generally performed outside the provider setting, and in most instances do not exceed 40 hours per year, whereas a pharmacy residency is a full-time commitment that lasts for 1 year. The commenters emphasized that the pharmacy residencies are structured, intensive programs that incorporate direct patient care experience where residents work as part of a clinical team and are required to complete a comprehensive project. The commenters contended that residency experience provides focused, invaluable training that yields proven positive clinical and financial outcomes. The commenters also noted that, while residencies are not a requirement for all hospital pharmacy positions, they are a requirement for most clinical specialist positions. The commenters maintained that residencies would be a more universal hiring requirement were it not for the current shortage of pharmacists and residency programs. The commenters stressed the benefits of clinical pharmacist involvement in patient care and cautioned that CMS' attempt at short-term cost savings will result in significant long-term cost of care increases. The commenters urged CMS to ensure continuing reasonable cost pass-through payments for pharmacy residencies.

Response: As we stated above in response to the comments received from the clinical pastoral counseling community, in the May 19, 2003 proposed rule (68 FR 27210), we explained what constitutes ''continuing education'' for the purpose of determining whether a nursing or allied health education activity would or would not qualify for Medicare reasonable cost pass-through payments. We acknowledge that the definition of ''continuing education'' for Medicare payment purposes may differ from the academic view of what, in general, constitutes such activities. As we stated earlier, we believe that provider-operated programs that do not lead to any specific certification, or the ability to perform in the specialty, would be classified as ''continuing education.''

Our intent is to ensure that Medicare reasonable cost pass-through payments are only provided for programs that enable an individual to be employed in a capacity that he or she could not have been employed without having first completed a particular education program. We believe that, *for Medicare purposes,* training that enhances an individual's competencies, but does not permit that individual to be employed in a new specialty in which he or she could not have been employed without completing the additional training, would not qualify for Medicare reasonable cost pass-through payment. Medicare provides payment for such educational activities, but only under the methodology applicable to payments for normal operating costs. Our intent was to provide clarification for the purpose of distinguishing between those educational programs that qualify for reasonable cost pass-through payment (that is, programs that enable an individual to begin employment in a specialty), and those programs that should be paid as normal operating costs (that is, activities that are intended to enhance the current skill set of an individual for a profession or advance an individual's professional career).

Since publication of the proposed rule, we have learned from information provided by the commenters that there are two categories of pharmacy residencies—pharmacy practice residencies and specialized pharmacy residencies, both of which are accredited by the American Society of Health-System Pharmacists (ASHP). If a pharmacist chooses to participate in residency training, he or she would generally do so after completion of an undergraduate bachelor of science degree or a doctor of pharmacy degree. (In some cases, residencies are offered as a part of a postgraduate degree (a master of science or a doctor of pharmacy). However, these programs would *not* meet our provider-operated criteria.) A pharmacy practice residency is typically a 1-year, organized, directed, postgraduate training program in a defined area of pharmacy practice that may take place in a variety of settings, including hospitals. For those seeking additional skills in a focused area of pharmacy practice (for example, oncology), an individual may choose to complete a second year of specialized pharmacy residency. Currently, ASHP, in partnerships with other professional organizations, accredits 17 second-year pharmacy residencies, in areas such as cardiology, geriatrics, infectious diseases, and oncology.

Of the 17 second-year pharmacy residencies, only 5 of these residencies currently lead to board certification. The Board of Pharmaceutical Specialties (BPS) is the organization that administers the certifying examinations after completion of each of these five residencies. Upon completion of a residency in 1 of the other 12 second-year residencies, the hospital in which the resident has trained issues a certificate to the pharmacist.

We understand that many employers, including hospitals, increasingly are requiring completion of an ASHP-accredited first year pharmacy practice residency as a condition for employment as a clinical (''on the floor'') or direct patient care pharmacist. While a licensed pharmacist who has not completed a pharmacy practice residency might be hired by a hospital as a staff or distribution pharmacist, a hospital typically would only hire an individual who has completed at least a 1-year pharmacy practice residency to fill a position that requires direct work with hospital patients. Some hospitals may even require their pharmacists to have completed a second-year

specialized residency before allowing those pharmacists to specialize on a particular group or type of patients. For example, before a pharmacist may work exclusively to design, implement, and monitor a course of treatment for oncology patients, some hospitals require that the pharmacist complete a residency in oncology pharmacy. However, many hospitals may employ pharmacists who have only completed a pharmacy practice residency to treat these groups or types of patients, including oncology patients.

As we explained above in response to the comments on CPE, in the May 19, 2003 proposed rule (68 FR 27210), we proposed to revise the regulations at § 413.85(h)(3) to state that activities treated as normal operating costs include ''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.'' We proposed 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.'' However, it is apparent from the comments we received that our proposed definition of ''certification'' was not clear. Some commenters believed we intended, through the proposed definition, to allow pass-through payments for the costs of a program that would only enhance an individual's set of skills. However, that was not our intent. We believe it would have been more appropriate to use the word ''and'' instead of the word ''or'' to further emphasize that pass-through payment would only apply to activities that enable an individual to practice *and* begin employment in a specialty, but would *not* apply to activities that serve to add to or to enhance an individual's current skill set.

In addition, based on the comments received, we understand that there may be several distinct levels of training in a given health profession, and each level of training may be a requirement in order for an individual to work in a new capacity or ''specialty'' in that profession, but *not* a requirement to practice or begin employment in the specialty ''as a whole.'' Since a second level of training is not required to begin practicing in a profession, under the proposed definition, we would not have been able to allow for pass-through payments for a second (or potentially a third) level of training. Therefore, we understand that inclusion of the words ''as a whole'' in the proposed definition of ''certification'' was misleading. Consequently, where a subsequent level of training is a requirement to practice in a new specialty in a given profession, pass-through payment may be made for the subsequent level of training.

Finally, we have concluded that it is not necessary to include a specific definition of ''certification'' in the regulations at § 413.85. In this final rule, we are deleting the proposed definition of ''certification'' from § 413.85(c), and amending § 413.85(h)(3) by removing the words ''certification required'' and inserting the words ''the ability.'' We are also changing the word ''or'' to ''and''. Specifically, we are amending the proposed § 413.85(h)(3) to state that activities treated as normal operating costs include ''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 the ability to practice and begin employment in a nursing or allied health specialty.''

As we stated above in response to the comments concerning CPE, our view of a ''specialty'' in the nursing and allied health education context is based on what the health care industry views as the standard of practice in a specific area within a profession. We are defining ''industry norm'' to mean that more than 50 percent of hospitals in a random, statistically valid sample require the completion of a particular training program before an individual may be employed in a specialty. (We understand that, in some instances, due to the unique staffing circumstances faced by many smaller hospitals, inclusion of small hospitals in the sample would introduce factors that are not typically representative of the industry as a whole and would skew the results inappropriately. In such cases, we would consider excluding hospitals with less than 100 beds, which would still retain over 75 percent of all hospitals in the sample universe.)

Based on comments received, we believe that it is currently the ''industry norm'' for hospitals to generally hire only pharmacists who have completed a pharmacy practice residency to work directly in patient care. Specifically, without having completed a pharmacy practice residency, a pharmacist would typically be employed by a hospital as a staff or distribution pharmacist, but not as a clinical pharmacist who works directly with patients to develop treatment plans. Since completion of a pharmacy practice residency has become a requirement by hospitals to practice or begin employment in a position that involves direct patient care, we would view ''hospital pharmacy'' as a ''specialty'' of the pharmacy profession. Accordingly, pharmacy practice residency training programs that meet the requirements under § 413.85, including accreditation by a nationally recognized accrediting body, direct operation by a provider, and lead to certification that is a requirement for employment, may be eligible for Medicare reasonable cost pass-through payment.

However, it is apparent from the comments that it is *not* unusual for a hospital to employ a pharmacist that has only completed a pharmacy practice residency in an area in which an accredited second-year program exists (that is, geriatrics, cardiology, or oncology), without requiring the pharmacist to first complete that second-year residency program. For example, we would view further training in oncology pharmacy or cardiology pharmacy as specializations within the pharmacy field under the policy in this final rule. However, these second-year residencies would *not* qualify for reasonable cost pass-through payment because, based on information received from commenters, it is not currently the ''industry norm'' to require completion of these programs before beginning work in these specialties. If we find in the future that it has become the ''industry norm'' for hospitals to require second-year pharmacy residencies, we may allow the hospitals operating those programs to be reimbursed for the costs of those programs on a reasonable cost basis.

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

Another matter that has come to our 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. In the May 19, 2003 proposed rule, we proposed 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 proposed 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 proposed that Medicare would not recoup reasonable cost payment from hospitals that have received pass-through payments for portions of cost reporting periods occurring before October 1, 2003 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 proposed 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 further proposed 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 the 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, we note that the proposed policy would 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 the 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 October 1, 2003 because our policy with respect to programs by a wholly-owned subsidiary of a hospital will have been clarified by that date (the date that this final rule is effective).

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

Comment: Several comments supported our proposal. Specifically, the commenters believed that the proposed rule is consistent with the recent expressions of Congressional intent reflected in the conference report to the 2003 Consolidated Appropriations Resolution, which recognize that there is a shortage of nursing and allied health professionals, and that payments made for programs that are operated by wholly-owned subsidiary educational institutions of hospitals should not be retrospectively recouped and may continue in the future.

However, several commenters disagreed with the proposal under proposed § 413.85(g)(3)(iii) that, effective for portions of cost reporting periods occurring on or after October 1, 2003, eligible hospitals could receive payment for the clinical training costs and for the classroom costs, but only those classroom costs incurred by the hospital for the courses that were included in the program(s) that had originally been provider-operated before transfer of operation of the program(s) to a wholly owned subsidiary educational institution. One commenter stated that such criteria regarding reimbursement of classroom costs appears to presume that while a hospital was operating its own program before transferring the operation of the program to a wholly-owned subsidiary, the hospital must have offered fewer or different programs. The commenter believed that our example in the preamble of the proposed rule seems to suggest that ''noncore'' or nonnursing related classes would be excluded from reasonable cost reimbursement, effective October 1, 2003. The commenter contended that we have incorrectly assumed that diploma programs include only nursing courses because, in fact, such diploma programs typically included general courses for English, basic science, math, and similar subjects. The commenter asked that we revise the preamble to clarify that courses for which costs were historically reimbursed would continue to qualify for reasonable cost payment without regard to whether they are ''core'' or ''noncore'' nursing courses.

Other commenters argued that restricting reimbursement to courses originally offered by the provider-operated program would discourage providers from ensuring that training of health care professionals is kept up to date and would not allow providers to meet evolving requirements of accrediting organizations. One commenter noted that the conference report accompanying the Consolidated Appropriations Resolution for FY 2003 states that ''* * * 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 program(s) * * *'' (Emphasis added) (H.R. Rept. No. 108–10, 108th Cong., 1st Sess., 1115 (2003)). The commenter believed this language indicates that Congress intended that schools should be reimbursed, not particular courses.

In addition, commenters expressed concern that capping reimbursement for educational programs effective October 1, 2003, would further aggravate the existing shortage of appropriately trained healthcare workers. Finally, commenters suggested that the October 1, 2003 effective date be postponed because this date will cause hardship for institutions currently in the process of creating educational organizations for the purpose of transitioning their programs to those educational organizations.

Response: We acknowledge the commenters' general support of the proposed changes. In response to the commenters who disagreed with our proposal for limiting payment to certain classroom costs, as we stated in the preamble to the proposed rule (68 FR 27210), this proposed exception to the reasonable cost payment policy for programs operated by wholly-owned subsidiary educational institutions was based on a question that we received from a hospital pertaining to the language in the January 12, 2001 **Federal Register** (66 FR 3363) concerning hospitals that established their own educational institutions to meet accreditation standards. Specifically, the hospital that raised the issue previously received Medicare reasonable cost payment for the direct operation of nursing and 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 in question has continued to receive Medicare payments after the hospital moved operation of the programs to the wholly-owned subsidiary college. The hospital believed that, based on the cited preamble language in the January 12, 2001 **Federal Register** 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, that it is still the direct operator of the programs and should continue to receive pass-through treatment.

As we stated in the proposed rule, 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).

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).

We explained that we understood that some hospitals 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. Accordingly, although we proposed to clarify in the proposed rule that, in general 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), we believed it would be unfair to recoup Medicare payments that have already been made to such a hospital that meets *this very narrow fact pattern.* Therefore, we proposed to add a *limited* exception to § 413.85 to reflect the unique circumstances of such a hospital.

First, we proposed that, for portions of cost reporting periods occurring on or before October 1, 2003, Medicare would not recoup reasonable cost payment from such a hospital that has received pass-through payments 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.

Second, since we believed that such a hospital's programs were no longer provider-operated, and therefore, should not continue in the future to receive *full* reasonable cost payments for the clinical and classroom costs of programs that are now operated by the wholly owned subsidiary educational institution, we proposed 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 further proposed 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 were included in the hospital's provider-operated program(s) could continue to be reimbursed on a reasonable cost basis. That is, we proposed that 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).

In proposing that, effective for portions of cost reporting periods occurring on or after October 1, 2003, we would only continue to pay on a reasonable cost basis for classroom costs associated with the courses that relate to the theory and practice of the particular nursing or allied health discipline(s) that were offered by the hospital when the hospital was the direct operator of the program(s), and *not* for additional classes needed to meet degree requirements provided as part of the nursing or allied health education programs, we did assume, as a commenter suggested, that diploma nursing programs typically only include courses related to the theory and practice of nursing. However, regardless of whether diploma programs include additional general courses other than ''core'' nursing courses, we continue to believe it is more appropriate to pay a hospital that meets the limited exception that allows continued payment for only those costs associated with courses included in the program(s) when the hospital was still the direct operator of the program(s). If, in fact, a hospital that meets the limited exception currently offers the same courses that it had offered when it was still the direct operator of the programs, we would continue to pay for the classroom costs associated with those courses, even if those courses do not relate directly to the theory and practice of the nursing or allied health program(s). However, if new courses, whether or not they are nursing-related or allied health-related course, have been added after the operation of the program(s) was transferred to a wholly owned subsidiary educational institution, we would not pay on a reasonable cost basis for the classroom costs associated with those new courses, effective October 1, 2003. If the courses offered currently are the same as the courses offered prior to transfer of the programs to the wholly owned subsidiary, but, for example, the names of the courses have changed, or there have been course substitutions, we would evaluate each course on an individual basis to determine whether we would continue to allow reasonable cost payment for those courses. All other things being equal (that is, after adjusting for inflation and changes in enrollment), our intent is not to pay more on a reasonable cost basis as of October 1, 2003, for classroom costs to such a hospital than we had paid to the hospital when the hospital was still the direct operator of the program(s).

In response to the comments we received that urged us not to restrict the number of courses for which we would provide reasonable cost reimbursement due to concerns about evolving accreditation requirements and the existing nursing shortage, we emphasize again that this proposal is not at all broad in scope. Rather, based on the information we currently have available to us, we believe this provision would have a limited application.. Therefore, we do not believe that our proposal will aggravate the nursing shortage or adversely affect hospitals that otherwise meet the requirements for reasonable cost payment under § 413.85 but add courses to their programs. Similarly, we do not believe that the effective date of October 1, 2003, will cause hardship to other providers that are currently in the process of transitioning their programs to educational organizations, since the proposed changes would only apply to a provider that had *already* created its own educational institution. We also note that, as indicated above, programs that transition in some respect to educational institutions created by providers could possibly be considered ''provider-operated'' under § 413.85(f) and, if all other requirements are met, could qualify to receive reasonable cost reimbursement.

Comment: One commenter disagreed with our statement in the proposed rule (68 FR 27211) 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).'' Rather, the commenter believed that programs that are wholly owned or wholly controlled by a hospital are provider-operated programs. The commenter asserted that CMS'' distinction between provider-operated programs and wholly owned programs conflicts with CMS'' regulations at § 413.17(c)(2) which state that ''If the provider obtains items of services, facilities, or supplies from an organization, even though it is a separate legal entity, and the organization is owned or controlled by the owner(s) of the provider, in effect the items are obtained from itself.'' The commenter also referenced § 412.2(c)(5)(i) concerning the DRG 3-day payment window that applies to services provided by a hospital or by an entity wholly owned or operated by the hospital, and asserted that there is ''no rational basis'' for treating wholly owned or wholly controlled affiliates differently for purposes of pass-through payment.

Response: The commenter is incorrect in stating that, in the proposed rule, we indicated that wholly owned (or wholly controlled) programs by definition cannot meet the provider-operated criteria and, therefore, would not qualify for reasonable cost pass-through payments. In fact, as we have stated in the January 12, 2001 final rule (66 FR 3363), and reiterated in the preamble to the proposed rule, if the hospital that wholly owns the educational institution meets the provider-operated criteria, the hospital would qualify to receive reasonable cost pass-through payment. Specifically, we stated in the proposed rule (68 FR 27210) that ''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. * * * 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 premises of the hospital (emphasis added). Thus, while we still believe 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) (68 FR 27211), we reiterate that only in instances where the hospital continues to meet the provider-operated criteria under § 413.85(f) would the hospital continue to qualify for reasonable cost pass-through payments, as it did prior to transferring operation of a provider-operated program(s) to a wholly owned educational institution.

The commenter also mentioned the generally applicable ''related-entity'' rules, and suggested that a wholly owned school would be a related entity that should be treated as if it is the provider. Thus, a wholly owned educational institution would remain provider-operated. However, we note that, for purposes of nursing or allied health education payment under § 413.85, it is not sufficient for a program to be operated by a related entity. Rather, the ''related entity'' principles do not apply under the agency's nursing and allied health education payment policy because, as indicated in previous rulemakings, that policy requires that a program be directly operated by the provider itself. Requiring direct operation of a program by the provider ensures that, under § 413.85(c), costs borne by related organizations (that is, the community) are not redistributed to the hospital and claimed as a pass-through under the Medicare program.

Comment: Commenters requested clarification on whether the proposed change regarding providers that created wholly owned subsidiary educational institutions to meet accreditation requirements would have any effect on provider-operated nursing or allied health programs that have entered into written contracts with colleges or universities to award their degrees.

Response: As we have explained in response to a previous comment, the proposed change was extremely limited in scope and only relates to hospitals with a unique set of circumstances surrounding operation of their programs by a wholly owned subsidiary educational institution. Therefore, the proposed changes do not have any impact on existing policy related to hospitals that enter into contracts with academic institutions to award their degrees. However, we stress that, in the instance where an academic institution other than the hospital grants the final certificate or degree upon completion of the program, the burden of proof is on the hospital to demonstrate that it, in fact, meets the ''provider-operated'' criteria under § 413.85(f) before reasonable cost payment may be made to that hospital.

Comment: One commenter believed that it is inappropriate to use the term ''wholly owned'' in reference to entities that, in many cases, are nonprofit institutions because, technically, nonprofit organizations are public trusts. The commenter suggested that it would be more accurate to refer to ''wholly owned'' or ''wholly controlled'' educational institutions.

Response: We believe that, for purposes of payment under § 413.85, it is appropriate to use the term ''wholly owned.'' Although we recognize that nonprofit entities would not technically be ''wholly owned'' since they do not issue stock, we do not agree with the commenter that ''wholly controlled'' is an appropriate alternative because of the potential for confusion over issues relating to ''control'' and ''provider operation.'' Further, we believe that the term ''wholly owned'' is commonly used in the context of nonprofit entities, and implies the kind of relationship we intend—where there is a single founder or member. Therefore, we will continue to use the term ''wholly owned subsidiary'' in the context of payment under § 413.85.

We are finalizing the two proposals associated with programs operated by wholly owned subsidiary educational institutions of hospitals. Specifically, we are finalizing the proposal under new § 413.85(g)(3) that, 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, and then operation of the programs) 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). Further, reasonable cost payment will be made if a provider received 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 this wholly owned subsidiary educational institution (and ceased to be provider-operated program(s)). Such a provider would receive reasonable cost payments for: (a) The clinical training costs incurred for the program(s), and (b) classroom costs, but only those classroom costs incurred by the provider for the courses that were included in the programs that were

originally provider-operated prior to the transfer to a wholly owned subsidiary educational institution. That is, Medicare would pay on a reasonable cost basis for the classroom costs associated with the courses provided as part of the nursing or allied health education programs that were offered by the hospital when the hospital was the direct operator of the program(s). We would not allow such a hospital to be paid for additional classroom costs for courses that were not paid on a reasonable cost basis to the hospital in conjunction with its provider-operated programs.

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 away,* 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. 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, in the May 19, 2003 proposed rule, we proposed 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 proposed this policy 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 proposed 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 proposed 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 proposed 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) contained two provisions. Proposed § 413.86(i)(1) stated the principles of community support and redistribution of costs: In relation to community support, we proposed 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 proposed 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 already proposed to make 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 Pub. L. 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 Pub. L. 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 Pub. L. 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 Pub. L. 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 believed it was 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 proposed 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 proposed 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 stated 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 all 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 the 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.

We received a large number of comments from the public on this proposal. Following is a summary of these comments and our responses:

Comment: Some commenters supported our proposed application of redistribution of cost and community support to direct GME. One commenter stated: ''We believe that the proposed changes * * * will result in more accurate and consistent reimbursement to providers. The changes provide more definitive guidance to providers and to intermediaries in applying the regulations. In addition, the changes will more closely match Medicare reimbursement with actual IPPS-type services. This is especially true in the case of dental residents, who typically spend little or no time caring for patients receiving IPPS type services.''

Response: We agree with the commenters' assertions and appreciate the commenters' support of our proposals on redistribution of costs and community support.

Comment: Many commenters disagreed with our proposed application of redistribution of cost and community support to direct GME. In general, they believed they did not receive proper notice of the application of the principles. One commenter stated: ''[t]he proposed change to the rules midstream, and only with respect to subsequent payment years, distorts the balance on which the established payment formula depends.'' Other commenters believed that, in the past, CMS has never suggested that incurring the costs of offsite training in the then-current year would be a condition to hospitals' claiming those costs in future years. The commenters contended that nowhere in the regulations promulgated has CMS stated that, in order to receive GME and IME payments, a hospital must meet an additional requirement of incurring the training costs since the inception of the training program. The commenters believed it is inequitable to impose such a ''retroactive requirement.''

The commenters stated that many hospitals that were contemplating whether to initiate a training program in a nonhospital setting, notified CMS in advance of establishing such a program, and requested CMS's approval. One commenter stated that, in numerous cases, ''including some of the cases discussed in the regulatory preamble, CMS issued a written approval of the proposed training program. In such approval letters, CMS never mentioned the redistribution of costs and community support principles.''

Finally, another commenter stated that there is nothing in the direct GME and IME statutes that supports CMS' decision to apply redistribution of costs and community support principles.

Response: The principles of redistribution of cost and community support associated with Medicare's payments for GME have been in existence for over 35 years, that is, since the inception of the Medicare program in 1965. The principles have been continually reiterated in various regulations, manual provisions, and implementing instructions to fiscal intermediaries. We do not believe we have given the public any reason to conclude that the principles would not continue to be applicable. Several examples of our views on the principles

of redistribution of cost and community support were mentioned in the proposed rule. These included:

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 away,* 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. Rept. No. 404, 89th Cong., 1st Sess., 36 (1965); H.R. Rept. 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 regulations that evolved from the authorizing legislation, first published on November 22, 1966 (31 FR 14814), as well as Chapter 4 of the Provider Reimbursement Manual in 1971, echoed the congressional committee report language from 1965 that Medicare would share in the costs of educational activities until communities bore them in some other way.

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)

Although the above language was written in the context of a regulation that clarified Medicare policy for provider (hospital) operated nursing and allied health education programs, we note that GME and nursing and allied health education programs were historically paid under the same regulations (the latest of which was codified at § 413.85) and the same cost principles. The quoted language is indicative of this relationship and the Agency's mindset that, while direct GME may have changed in the method of payment to a prospective payment, some principles, such as redistribution of cost and community support, continue to apply as they do with nursing and allied health education at § 413.85(c). Further evidence of continued application is at existing § 413.85(c) in the definition of ''redistribution of cost'': ''* * * costs for a school of nursing or allied health education or a medical school that were incurred by an educational institution and were not allowable to the provider [hospital] in its prospective payment or a rate-of-increase limit base year cost report, or graduate medical education per resident amount calculated under § 413.86, *are not allowable costs in subsequent fiscal years.*'' (Emphasis added.) Therefore, even codified in regulations now is a policy that applies the principle of redistribution of cost to direct GME payments *in subsequent years.*

Furthermore, § 413.85(c), which was a codification of longstanding Medicare policy, was originally issued in the **Federal Register** on September 30, 1986 (51 FR 34793) and was further refined, but conceptually left unchanged, as of March 12, 2001 (*see* 66 FR 3358). Section 413.85(c) addressed the Congressional intent not to increase program costs resulting from redistribution of 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.''

We note that the guidance 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. 15–1, section 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.)

We believe we have continually put the public on notice that the Medicare program has applied and continues to apply the principles of redistribution of costs and community support to payments for education costs, including direct GME payments to hospitals. Therefore, we *do not* believe that we have proposed changes to the rules ''in midstream'' as one commenter suggested. Nor do we believe, as the commenters suggested, that we have proposed a ''retroactive requirement.'' We have never disavowed the principles of redistribution of cost and community support. Rather, we have continually promulgated rules and program guidance on the application of the principles since the inception of the Medicare program.

We again point to the Supreme Court case, *Thomas Jefferson,* to demonstrate CMS' *longstanding* policy on community support and redistribution of costs in the GME context. In *Thomas Jefferson,* the Secretary of Health and Human Services interpreted the regulation at § 413.85(c) to deny reimbursement of educational costs that were borne in prior years by a hospital's affiliated medical school for purposes of calculating the direct GME base year allowable cost for the PRA. The U.S. Supreme Court affirmed the Secretary's interpretation of the redistribution of costs regulation. The Court found that:

''The regulation [at § 413.85(c)] 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).

In addition, in response to the argument by the provider that CMS (then HCFA) had been silent in internal operating instructions in a 1978 operating memorandum on the policies of redistribution and community support, as well as in another exchange of memoranda in 1982 and other agency documentation, the Court stated that the omission in these documents of discussion of redistribution and community support is not indicative of a contrary policy on GME reimbursement: ''* * * the mere failure to address [the redistribution principle in an intermediary letter] hardly establishes an inconsistent policy on the part of the Secretary.'' *Thomas Jefferson,* 512 U.S. at 516.

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 legislation that enacted Medicare, to impose a substantive limitation on medical education payment, even in the arguably novel context of calculating a hospital's GME costs for purposes of the base year PRA.

To address the commenters' point that CMS ''never mentioned the redistribution of costs and community support principles'' in CMS ''approval letters'' to hospitals that requested ''approval'' from CMS in advance of establishing a relationship with a nonhospital site in order to count the residents training in that setting, we note that when the letters were written to CMS in fiscal year end 1999–2002, it was not clear at all from the incoming correspondence that hospitals were not, in fact, rotating the hospital-based residents to the nonhospital setting in accordance with statutory intent. In other words, it was not clear from the incoming correspondence that a redistribution of costs was being contemplated by the hospitals. In addition, the letters did not explicitly mention that the costs of the program were currently being borne by the community in the contemplated arrangements. In the last 2 or 3 years, when hospitals met with or wrote to CMS for guidance on the nonhospital site policy under § 413.86(f)(4), we provided responses that were limited to the scope of the inquiries. We answered questions about the requirements of § 413.86(f)(4). It did not seem necessary to bring up the issue of ''redistribution'' or ''community support'' because it was not apparent that the community had previously incurred the direct GME costs. It was not until the relatively recent audits by our fiscal intermediaries of the fiscal year ending 1998 and 1999 cost reports of certain hospitals that CMS became aware that cost shifting was occurring. With this awareness came the necessity to explicitly reassert and explain the application of the longstanding Medicare principles of redistribution of costs and community support.

Comment: Several commenters have stated that the principles of redistribution of cost and community support do not apply in determination of a hospital's FTE resident count for direct GME. One commenter argued, in part relying on a Federal district court case, *Episcopal Hospital* v. *Shalala*, 1997 U.S. Dist. Lexis 8701 (E.Da.Pa. 1997), to state: ''* * * CMS has argued, and the courts have agreed, that Medicare cost principles have no effect with respect to the direct GME payment method prescribed by section 1886(h) of the Act * * * these principles implement the statutory provision in section 1861(v) of the [Social Security] Act for payment of reasonable cost.'' This commenter also quoted extensively from the September 29, 1989 final rule to argue that the GME regulation ''construes the GME statute so as to preclude consideration of allowable costs incurred in connection with a resident's training.''

Similarly, another commenter believed that Congress ''replaced the old reasonable cost payment system'' with a prospective payment methodology, and that those principles that formed the basis for reasonable cost payments for GME were no longer relevant. The commenter believed the redistribution of costs and community support principles have no application to the current payment methodology, which relies on FTEs and PRAs.

Several commenters also disputed our citation to the *Thomas Jefferson* case for application of the principles to FTE counts. The commenters believed that CMS should not use this case in support of our policy because the case did not discuss applying the principles to the counting of residents. In addition, they believe the case was ''very limited'' and ''only discussed the establishment of base year resident costs, which were used in developing base payment rates.''

Response: We disagree with the commenters that the principles of redistribution of costs and community support do not apply in determination of a hospital's FTE resident count for direct GME. When Congress enacted section 1886(h) of the Act as part of section 9202 of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (Pub. L. 99–272) on April 7, 1986, it did not altogether ''preclude'' consideration of allowable costs in connection with a resident's training, as the first commenter suggests. Upon enactment of the new legislation, CMS (then HCFA) considered a hospital's allowable reasonable costs, and applied reasonable cost principles (*including* redistribution of costs and community support, as we have explained) to calculate a hospital's direct GME costs and FTE resident count in order to determine hospital-specific PRAs in the base year. Although in cost reporting years after the PRA base year, the applicable PRAs are largely determined by the statute, we believe that *costs* continue to be a factor in determining the number of FTE residents that may be counted by a hospital. For example, a hospital may only count FTE residents training *at the hospital* for which, as repeatedly described in the September 29, 1989 final rule, the hospital almost necessarily incurs *some* direct GME costs. Hospitals may also count FTE residents training in nonhospital sites *only if* the hospital incurs all or substantially all the training *costs* of the program at that site (and meets other regulatory requirements.) Thus, it cannot be said that our view of the statute ''precludes'' consideration of allowable costs associated with training residents.

Although Congress did implement a prospective payment system for direct GME costs by enacting section 902 of COBRA 1985, we do not believe this means that all reasonable cost principles are no longer applicable under the revised system. Section 1886(h)(1) of the Act provides that: ''[n]ot withstanding section 1861(v) [defining reasonable cost], instead of any amounts that are otherwise payable under this title with respect to the reasonable costs of hospitals for direct graduate medical education costs, the Secretary shall provide for payments for such costs in accordance with paragraph (3) of this subsection.'' The statute literally provides that the reasonable cost payment method in section 1861(v) of the Act does not apply to section 1886(h)(3) of the Act (but those principles do apply to the remainder of section 1886(h) of the Act), which is the paragraph that specifies the general prospective payment formula for direct GME (the direct GME PRA). Thus, section 1886(h)(1) of the Act does not, as the commenter suggested, preclude

any consideration of reasonable costs associated with the training of residents. Indeed, section 1886(h)(1) of the Act provides that, instead of payment under section 1861(v) of the Act, ''the Secretary shall provide for payment for *such* costs'', which refers back to ''the reasonable costs of hospitals for direct graduate medical education costs.'' Thus, the statutory provisions governing direct GME payments continue to contemplate that Medicare payments to hospitals will be made for reasonable costs even under the prospective payment that is based on direct GME PRAs and FTE residents. Therefore, we do not believe the statute precludes application of reasonable cost principles, including the principles of redistribution of costs and community support.

Although we do recognize that certain reasonable cost principles are inherently contrary to a prospective payment system, others are compatible and may continue to be relevant, even upon implementation of the prospective payment. For example, in the case cited by the commenter, the Secretary and the court acknowledged that the principle of ''cross-subsidization'' found in section 1861(v)(1)(A) of the Act does not apply under a prospective payment context. The cross-subsidization provision requires that, in determining the reasonable costs of services, the Medicare program must ensure that it bears fully, but exclusively, ''the necessary costs of efficiently delivering covered services'' to Medicare beneficiaries. Simply put, the provision requires the Medicare program to pay for all the costs associated with care for its beneficiaries, and no more, so that other parties are not subsidizing care provided to Medicare beneficiaries, and Medicare is not subsidizing care provided to non-Medicare beneficiaries. However, when Medicare payments are determined prospectively, the Medicare program necessarily ceases to be concerned about whether cross-subsidization occurs—in other words, it is expected that a particular provider's costs may be higher or lower than the prospectively-determined payment (hence, the underlying premise that prospective payment systems create incentives for providers to control costs and operate efficiently).

In contrast, the principles of redistribution of costs and community support are completely congruent with the prospective payment system under section 1886(h) of the Act. Redistribution of costs and community support principles derive from legislative intent that was expressed at the enactment of the Medicare program, that the program should not assume payment for education costs that were previously funded by other sources. There is no reason to conclude that this intent changed with the enactment of the prospective payment methodology in section 1886(h) of the Act, with the addition of the FTE caps specified in section 1886(h)(4)(e) of the Act, or with the amendments that allow hospitals to count residents training in nonhospital sites for purposes of direct GME and IME payments. We do not believe that Congress intended by any of these enactments to enable an expansion in Medicare direct (or indirect) GME payments that result from cost shifting to hospitals. Rather, we believe section 1886(h) of the Act and later amendments were primarily directed toward limiting expansion of Medicare direct GME and IME payments. Therefore, we believe that the principles of redistribution of costs and community support are consistent with, and continue to be applicable under, the current direct GME payment system.

We also believe it is appropriate to cite the Supreme Court in the *Thomas Jefferson* case. The commenters believed that the scope of the Supreme Court's opinion that supported the agency's application of the principles of redistribution of costs and community support is limited to the calculation of hospitals' reasonable costs of GME for the purpose of determining the base period PRA. However, as we stated above, the statutory provisions governing direct GME payments continue to contemplate that Medicare payments to hospitals will be made for ''such costs'' even under the prospective payment methodology specified in section 1886(h) of the Act. In calculating the base year PRAs, the Agency allowed hospitals to count FTE residents where the hospitals were incurring direct GME costs associated with training those residents. This policy was clearly consistent with the principles of redistribution of costs and community support because the calculation of base year PRAs was dependent on the proper counting of FTE residents. Any opinion from the Court on the application of the principles to the base year costs would equally apply to FTE resident counts. Therefore, we believe the relevance of the *Thomas Jefferson* case is not limited to the establishment of base year costs, as the commenters suggested. Rather, the Court's opinion recognized that the principles of redistribution of costs and community support legitimately continue to apply under section 1886(h) of the Act. The Supreme Court's opinion is entirely relevant to the calculation of direct GME payments to hospitals in cost reporting periods on or after the PRA base year.

Finally, to address the commenters' reference to the 1989 final rule to support the argument that CMS interpreted the statute to preclude consideration of costs in connection with counting FTE residents, we note that the cited rule is *replete* with suggestions that CMS expected hospitals to continue to incur some level of direct GME costs for training residents, even under the direct GME PRA-based payment methodology. For example, the final rule at 54 FR 40298 states:

''Nothing in section 1886(h) of the Act indicates that the bearing of costs in connection with particular residents is a factor in determining who should be counted. The law simply requires the Secretary to determine the average amount incurred to train residents during the specified base period and to make GME payments for the residents in the hospital's programs thereafter on that basis. There was no authorization to establish a two-tiered system to account both for residents whom the hospital incurs full training costs and for residents whom hospitals incur only supervisory and overhead costs because the residents' salaries are paid by another entity.'' (*Ibid.*)

We believe the language quoted above from the 1989 rule is exemplary of the Agency's mindset (as well as of the mindset of the commenter in that rule) that the question of whether costs were incurred by the hospital was, and would continue to be, a consideration for purposes of direct GME payment.

Comment: One commenter appeared to agree with what we stated in the proposed preamble at 68 FR 27216 that because IME regulations on counting residents at nonhospital sites cross-reference the direct GME nonhospital provisions, the provisions on redistribution of costs and community support would equally apply to IME FTE counts, as well as direct GME FTE counts, when counting residents in nonhospital settings. However, the commenter requested clarification on the issue of whether IME FTE residents counts in hospital settings would be subject to the community support and redistribution of costs provisions.

Another commenter argued that the redistribution of costs and community support principles do not apply to FTE counts for purposes of IME payment. This commenter argues that there is no evidence indicating that a teaching hospital's operating costs bear any relation to past or present sources of funding for residents' training.

Response: In response to the commenters' concerns regarding the application of the redistribution of costs principles and community support to counting residents for purposes of determining payments for IME for training in hospital settings, we agree with the commenters; the redistribution of costs and community support principles do not apply to FTE counts for residents training in *hospital settings* for purposes of IME payment. As we have explained in several regulations, the object of IME payments associated with resident training in hospital settings is to address the additional indirect operating costs that teaching hospitals incur in furnishing patient care (see 66 FR 39896 or 54 FR 40286). Even if the redistribution of costs and community support principles could theoretically apply to training inside the hospital, we do not know how *all* of these additional indirect operating costs incurred by a hospital could be ''redistributed'' to a nonhospital entity or could be borne by the community. As long as the hospital had consistently incurred at least some of those indirect costs, there could be no violation of redistribution of costs and community support principles, and no resulting disallowance of FTEs in calculating the hospital's IME adjustment. In any event, as stated above, we agree with the commenters because we believe the legislative history that gave rise to the principles of redistribution of costs and community support was focused on Medicare payments for direct GME.

However, we note that, for training that occurs in nonhospital settings, the application of the principles of redistribution of costs and community support to direct GME FTE counts does have implications for IME payment for residency training in nonhospital settings. Under existing § 412.105(f)(1)(ii)(C), which is 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 § 413.86(f)(4)(iv) (the paragraph that specifically applies redistribution of costs and community support principles to FTE counts for purposes of direct GME) 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, IME payments are based on the concept that, as a direct result of the hospital's resident training program, the hospital incurs increased indirect costs for patient care. When Congress added section 1886(d)(5)(B)(iv) of the Act as part of Pub. L. 105–33, the circumstances under which IME payments to a hospital could be made were broadened to allow the hospital to count the number of residents training outside the hospital setting under certain conditions, even though it is clear residents training outside the hospital cannot have any impact on the hospital's indirect patient care costs. Nevertheless, Congress authorized hospitals to receive IME payments by allowing hospitals to count FTE residents training in a nonhospital setting in accordance with section 1886(d)(5)(B)(iv) of the Act. As we have stated, we believe Congress intended the provisions of Pub. L. 105–33 to create an incentive (or remove a disincentive), 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. However, we believe IME payment to the hospital would be contrary to Congressional intent if there is a redistribution of costs or community support associated with residents training in a nonhospital site. We also believe the IME payment to the hospital was only intended by Congress to encourage the hospital to rotate residents from the hospital to the nonhospital site, not to encourage (or enable) existing training programs to transfer their costs to the hospital and thereby expand the hospitals Medicare IME payments.

In addition, when Congress added section 1886(d)(5)(B)(iv) to the Act as part of Pub. L. 105–33, the statutory authority for IME payment for residents training at a nonhospital site 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 Pub. L. 105–33; section 1886(d)(5)(B)(iv) of the Act.) The statute requires a hospital to incur ''all or substantially all of the costs for the training program'' in the nonhospital setting in order to count FTE residents training there for purposes of both direct GME and IME payment. The link between the IME regulation at existing § 412.105(f)(1)(ii)(c) and direct GME regulations at § 413.86(f)(4) implement this shared statutory requirement. As we have stated, we believe Congress intended hospitals to facilitate training in nonhospital sites that would not have occurred without the hospital's sponsorship, and for the hospital also to incur direct GME costs of the program in the nonhospital site as a precondition to counting the FTE residents training in nonhospital settings for purposes of IME payment. Thus, in the situation where a hospital currently is incurring direct GME costs at the nonhospital site but there has been a redistribution of costs or community support, a disallowance of direct GME payments, as well as a disallowance of IME payments, is appropriate.

Comment: One commenter noted that proposed § 413.86(i) (redistribution of costs and community support provision) applies not only to subparagraph (f)(4), the nonhospital site provision, but also to the remaining provisions of paragraph (f) and also to paragraphs (g)(4) through (g)(6). The commenter requested that CMS specify that the principles affect only the counting of residents in nonhospital sites and not the count of residents being trained in hospitals, both the inpatient and outpatient settings. In addition, this commenter believes such a clarification would also be consistent with other Medicare policy on counting FTE residents, such as the policy detailed in the August 1, 2002 final rule (67 FR 50077) concerning when residents rotate to other hospitals: ''which entity may count the residents for IME and Direct GME payments is based on where the actual training occurs, not which hospital is incurring the costs.''

Response: While the primary reason we proposed to make the principles of redistribution of costs and community support explicit in the direct GME regulations was to specifically address the inappropriate scenarios described in the proposed rule whereby hospitals increase their FTE resident counts by assuming payment of training costs for residents in nonhospital sites that were previously funded by a nonhospital entity, we do not believe the principles are applicable in only this circumstance. In other words, the principles of community support and redistribution of costs apply generally to direct GME FTE counts, as we have explained. This holds true whether the counts relate to residents training in nonhospital sites (where we have seen the most