inappropriate counting), or to residents training *inside* the hospital—inpatient or outpatient. Thus, it *is* technically possible to have a redistribution of direct GME costs for the training of residents inside the hospital setting (as well as in the nonhospital setting). Therefore, we are not adopting the commenter's suggestion to limit application of the principles to § 413.86(f)(4) (the nonhospital site provision). However, we note that we believe a redistribution of *all* of the direct GME costs for training that occurs in a hospital setting would be rare. *All* of the direct costs of the program—resident salaries, teaching physician salaries, overhead expenses, etc., would need to be redistributed to an outside entity in order for there to be a disallowance of direct GME FTE residents for training inside the hospital due to redistribution of costs or community support.

We contrast this application of the principles of redistribution of costs and community support in the current prospective payment system that depends upon PRA and FTE resident counts to application of the principles in the previous reasonable cost payment methodology that was based on cost finding and cost allocations. Under the former reasonable cost methodology, a hospital was eligible to receive direct GME payment for those direct GME costs that it incurred; however, any direct GME costs that were redistributed to the hospital were not allowable. We note that 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.)

Thus, under the previous cost payment scheme, the principles of redistribution of costs and community support were applied to direct GME reasonable cost payment using a cost finding methodology. In contrast, in the current context where payment is no longer based solely on reasonable costs incurred, but on PRA and FTE resident counts, if the hospital can demonstrate that it has continuously incurred *some* of the direct GME costs of training the residents since the inception of the residency program at a training site, then no redistribution of costs or community support has taken place. As noted, current direct GME payments are no longer based on detailed cost finding of allowable costs of hospitals. Therefore, we believe it is appropriate to require that a hospital demonstrate that there has been no redistribution of costs or community support by proving that the hospital has incurred *some* of the direct GME costs of the program continuously since the inception of the program. Finally, contrary to the commenter's assertion, we believe we have been consistent with the other Medicare policies on counting residents, including the policy cited by the commenter concerning the prohibition on counting residents training at other hospitals. (See the August 1, 2002 final rule (67 FR 60077). As stated above, there would be no redistribution of costs or community support if a hospital counts a resident when another hospital incurs the resident's salary, as long as the first hospital still incurs other direct GME costs associated with the training of that resident. In any case, as we explained above and also in the proposed rule, the principles of redistribution of costs and community support are not applicable to cost shifted between the hospitals, only costs shifted between a hospital and educational institutions or other organizations that are not Medicare providers.

Comment: One commenter stated that a hospital was ''required'' to include in the calculation of its average per resident amount, time spent in the hospital by residents who were paid by ''other entities.'' This commenter quoted the September 29, 1989 final rule: ''the 1989 GME rule was modified after publication of the proposed rule in order 'to *require* Medicare hospitals to count residents who are working in their facility even if the residents' salaries are fully paid by other entities, either Federal or non-Federal. This revised policy will *apply to both GME base period and cost reporting periods subject to the new payment methodology.*' 54 FR 40299 (emphasis added).''

Response: We believe the language quoted above by the commenter from the 1989 final rule has been taken out of context. In essence, the commenter has generalized from the language selectively quoted above to support an argument that Medicare would have required a hospital to count resident time when the residents were ''paid by other entities,'' thereby supporting the commenter's argument that Medicare not only condones redistribution of costs but, in fact, would seem to ''require'' them. However, we believe the language quoted by the commenter from a particular comment and response in the 1989 rule, if quoted in its full context, actually supports the CMS policy on the application of the principles of redistribution of costs and community support that as long as the hospital has continuously incurred at least some of the direct GME cost of the residency program since the inception of the program, there has been no redistribution of costs or community support and the hospital may count the FTE residents. Specifically, the commenters in that rule at 54 FR 40298 asked in relevant part: ''A particular problem referred to was the treatment of residents who are paid by medical schools, faculty practice plans, and others rather than by hospitals that participate in Medicare. It was pointed out that teaching hospitals incur other costs such as teaching physicians' salaries and overhead costs in connection with these residents, and it would be unfair not to count these residents for payment purposes.'' In our response to this comment, we stated, also in relevant part on 54 FR 40299: ''we note that some of the comments have led us to believe that, in addition to Federally-employed residents (for example, residents in Veterans Administration or Department of Defense programs), a significant number of residents are paid a salary by non-Federal, nonprovider entities (for example, medical schools or philanthropic agencies). As noted by the commenters, although no hospital participating in Medicare incurs salary costs for these residents, *hospitals do incur other substantial GME costs associated with these residents.* Therefore, we are modifying our proposed rule to require Medicare hospitals to count residents who are working in their facility even if the residents' salaries are fully paid by other entities, either Federal or nonfederal.'' (Emphasis added). It becomes apparent when the language quoted by the

commenter on this final rule is read in context that, even as far as back as the 1989 final rule, we acknowledged that hospitals may count the FTE residents where other entities may have incurred the residents' salaries, but where the hospitals still ''incur other substantial GME costs associated with these residents.'' This view is entirely consistent with the CMS application of redistribution of costs and community support. In a scenario where a nonhospital entity, such as a medical school, incurs the residents' salaries, we continue to believe that the hospital may count the FTE residents if the hospital can demonstrate that it has incurred other direct GME costs, such as the supervisory physician salaries, since the inception of the program.

Comment: One commenter argued that when we explained our policy in the July 31, 1998 **Federal Register** (63 FR 40954) to require a written agreement indicating that the hospital must provide reasonable compensation for physicians' supervision of residents' training in the nonhospital setting, ''nothing was said about an additional requirement that a hospital must have continuously incurred this additional cost, as well as the residents' compensation required under the prior regulations, since the inception of the training program.'' This commenter further makes the point that in the final rule at 63 FR 40986, in response to a comment that hospitals did not compensate nonhospital sites for supervisory teaching physician costs and it would not be fair to shift these costs to teaching hospitals, CMS responded:

> Hospitals and nonhospital sites will have 5 months following publication of this final rule to negotiate agreements that will allow hospitals to continue counting residents training in nonhospital sites for indirect and direct GME. These arrangements are related solely to financial arrangements for training in nonhospital sites. We do not believe that the agreements regarding these financial transactions will necessitate changes in the placement and training of residents.
>
> In response to the comment that it is unfair to shift costs to the hospital, we believe that it is appropriate to include supervisory costs in the nonhospital site as part of ''all or substantially all'' of the costs that hospitals must incur to count the resident. Currently, the hospital is able to count the resident even though the costs for that resident may be lower during the time when the resident trains outside the hospital. At the same time, the nonhospital site may have incurred costs for which it received no compensation. We believe that requiring the hospital to incur the costs associated with training in the nonhospital site is equitable to both the hospital and the nonhospital site and is consistent with the statutory requirement that the hospital must incur ''all or substantially all'' of the costs.

(63 FR 40995 (emphasis added by commenter).)

The commenter believed that this explanation of the changes to the GME and IME rules, effective January 1, 1999, ''belies CMS' current assertion of a longstanding policy of applying the redistribution of costs and community support principles in the determination of the resident counts used to compute payment for GME and IME.''

Response: The commenter has used the language quoted above from the 1998 final rule to argue that when CMS (then HCFA) described the policy on counting residents in nonhospital sites for IME, ''nothing was said about an additional requirement that a hospital must have continuously incurred this additional cost * * * since the inception of the training program.'' The commenter has inferred from the language quoted above that CMS has *not* had a longstanding policy of applying the redistribution of costs and community support principles. However, we believe the language actually *supports* the longstanding existence of our policy in two ways. First, the quoted language demonstrates the agency's view that the nonhospital site policy was written from the standpoint of addressing the counting of residents when hospitals *rotate* residents from the hospital to the nonhospital site. Second, the quoted language is also indicative of the Agency's policy that as long as the hospital has continuously incurred at least some of the direct GME cost of the residency program since the inception of the program, there has been no redistribution of costs or community support and the hospital may count the FTE residents (assuming that other requirements are met).

Specifically, the comment relating to the portion of the 1998 final rule quoted above stated at 63 FR 40994, in relevant part: ''One commenter noted that some arrangements between hospitals and nonhospital settings for the training of residents predate the GME base year. This commenter stated that hospitals did not compensate nonhospital sites for supervisory teaching physician costs and it would not be fair to shift these costs to teaching hospitals. *The commenter also stated that teaching hospitals have already entered into written agreements with nonhospital sites under the existing rules.*'' (Emphasis added.) In addition, as quoted above in the comment, we responded, in relevant part at 63 FR 40995 (with different emphasis):

> * * * hospitals and nonhospital sites will have 5 months following publication of this final rule to negotiate agreements that will allow hospitals to *continue counting residents* training in nonhospital sites for indirect and direct GME. These arrangements are related solely to financial arrangements for training in nonhospital sites. We do not believe that the agreements regarding these financial transactions will necessitate changes in the placement and training of residents.
>
> In response to the comment that it is unfair to shift costs to the hospital, we believe that it is appropriate to include supervisory costs in the nonhospital site as part of ''all or substantially all'' of the costs that hospitals must incur to count the resident. Currently, the hospital is able to count the resident even though the costs for that resident may be lower *during the time when the resident trains outside the hospital.* At the same time, the nonhospital site may have incurred costs for which it received no compensation. We believe that requiring the hospital to incur the costs associated with training in the nonhospital site is equitable to both the hospital and the nonhospital site and is consistent with the statutory requirement that the hospital must incur ''all or substantially all'' of the costs. *Ibid.*

We believe the quoted comment and response from the 1998 rule paint a picture of a hospital that has had a pre-existing relationship with a nonhospital site involving *rotation of residents from the hospital to the nonhospital site for a period of time* during the residency program. The language we emphasized in the response—that the hospital may ''*continue to count* residents'' when they train in the nonhospital sites, and that the hospital ''may count the resident even though the costs for the resident may be lower *during the time* when the resident trains outside the hospital''—clearly refers to a rotational arrangement between the hospital and the nonhospital site. In addition, according to the circumstances described by the commenter in the 1998 rule, the hospitals had been incurring the residents' salaries, a direct GME cost, because they had formerly complied with the earlier regulation requiring that hospitals incur residents' salaries for purposes of meeting ''all or substantially all of the costs'' under § 413.86(f)(3). We had no reason to believe that the hospitals had not incurred at least the residents' salaries since the inception of the training program (the commenters state that the arrangements ''predate the GME base year''). In that event, the counting of residents in the nonhospital sites would not result in a redistribution of costs if, as of January 1, 1999, the hospital was required to incur the additional direct GME cost for supervisory physician costs while the residents rotate to the

nonhospital site. We believe that the commenter in the 1998 rule simply did not agree with the additional regulatory requirement finalized in the 1998 final rule that the hospital must also incur the supervisory physician costs for purposes of incurring ''all or substantially all of the costs,'' and hoped to label this new regulatory requirement as a ''cost shift'' in order to avoid it. As we have explained, it appears that there has been no redistribution in the case described by the 1998 final rule commenter because it can be inferred that the hospital had incurred at least some of the direct GME costs (the residents' salaries) since the inception of the program.

Therefore, we believe the language the commenter quotes from the 1998 rule is consistent with our clarifications in this final rule on redistribution of costs and community support. In addition, the language cited by the commenter supports our interpretation of the policy on counting residents in nonhospital sites that it was intended to address the situation when hospitals rotate residents from the hospital to the nonhospital site.

Comment: Some commenters disputed the CMS interpretation of Congressional intent as discussed in the preamble of the proposed rule (see 68 FR 27213). One commenter stated: ''there is no support in the legislative history of the non-provider setting amendments [the 1986 and 1997 amendments of the Act] for the Secretary's view that these changes were not intended to shift new costs to hospitals in support of on-going training in non-provider settings * * * it can be reasonably inferred that Congress was aware, and even intended, that some costs of existing residency training programs in non-provider settings would be shifted to hospitals in order for the hospitals to qualify for direct GME and IME funding under the 1986 and 1997 amendments of the Act.'' Similarly, another commenter stated that the Secretary ''must look elsewhere to the statute [other than section 1886(h)(4) of the Act] for support for his proposed rule; he cannot simply create out of whole cloth an interpretation that is inconsistent with the amendment's other provisions.''

Response: The commenters would have us interpret and implement policy in a statutory vacuum. We believe we have reasonably discerned Congressional intent by interpreting the plain language of the statute at sections 1886(d)(5)(B) and 1886(h) of the Act *in conjunction with* the accompanying legislative history of these sections.

As we stated in the preamble to the proposed rule, 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. In section 1886(d)(5)(B) of the Act (IME), the statute does not specify at all how FTE counts should be determined, and the plain language in the statute under section 1886 (h)(4) of the Act (direct GME) indicates that the Secretary ''shall establish rules'' for direct GME consistent with the statute. We also considered the deference expressed in 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—''[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.''(H.R. Conf. Rep. No. 105–217, 105th Cong., 1st Sess., 821 (1997).

Thus, in the absence of statutory specificity on determining FTE counts and the declared Congressional delegation 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.

In addition, we have *not*, as the second commenter suggests, ''created out of whole cloth'' an interpretation of the policy concerning counting residents in nonhospital settings that is ''inconsistent with the amendment's other provisions,'' nor do we at all believe that ''it can be reasonably inferred that Congress was aware, and even intended, that some costs of existing residency training programs in non-provider settings would be shifted to hospitals in order for the hospitals to qualify for direct GME and IME funding under the 1986 and 1997 amendments of the Act,'' as the first commenter suggests. Rather, as we have stated, we believe that when Congress created the provisions on counting resident FTEs in nonhospital settings, it was creating a monetary incentive for hospitals to rotate residents *from* the hospital *to* nonhospital settings. We have drawn this conclusion, as we explained, from the legislative history of both the direct GME and IME provisions authorizing payments to hospitals for training in 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 inception 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 do not believe Congress intended 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 that authorizes 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 from the hospital 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 ''loss'' of IME payments acted as a disincentive and discouraged hospitals from rotating residents out of the hospital. It appears from the legislative history that 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 ''add-on'' 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 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 situations where either the hospital rotated residents from the hospital to the nonhospital settings or where the hospital started new programs in the nonhospital settings (and incurred the direct GME costs from the programs' inception). The illustrative situations described above and in the proposed rule 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.

Comment: One commenter cited section 1886(h)(5)(J) of the Act to support the general argument that CMS lacks the authority under the statute to ''impose additional conditions'' on counting FTE residents training in nonhospital sites—that is, the principles of redistribution of costs and community support. The commenter stated:

> This conclusion is further supported by Congress' treatment of family practice residency programs. In 42 U.S.C. § 1395ww(h)(5)(J), Congress provided a special payment provision for family practice residency programs. Specifically, Congress authorized hospitals to claim costs related to such programs even if, during the GME prospective payment base year—a year reimbursed under the reasonable cost system and a year to which the community support principle applied—the cost of such programs had been paid by the United States, a State, a political subdivision of the State, or an instrumentality of the State or political subdivision. Congress also provided that, in the event that such program payments were part of the PRA calculation during the GME base year, the payment in future years would be reduced ''in an amount equal to the proportion of such program funds received during the cost reporting period involved * * *.'' Thus, Congress has spoken to the issue of whether hospitals may claim costs in the current year if those costs have been paid in the past by third parties, and it has allowed reduction in current-year payments only if: (1) During the GME PPS base year, a third party had paid for the cost of the hospital's family practice residency program; and (2) as a result, the hospital had received a PRA that included an ''estimate of the amount that would have been recognized as reasonable * * * if the hospital had not received such funds.'' 42 U.S.C. § 1395ww(h)(5)(J)(i). In all other situations, I submit, Congress does not permit the Secretary to reduce payments in the current year simply because, in the past, some third party may have paid the cost.

Response: We disagree with the commenter that section 1886(h)(5)(J) of the Act supports the assertion that ''Congress has spoken to the issue'' of whether a hospital may claim third party costs and has allowed reductions in direct GME reimbursement resulting from redistribution of costs or community support in only the very limited circumstance of that exception in the Act. Generally, section 1886(h)(5)(J) of the Act did two things: first, in subparagraph (J)(i)(1), Congress specifically allowed a hospital that *only* has an approved training program in family medicine and received a PRA in the base year of less than $10,000 for its family practice program, to receive a revised PRA that reflects the inclusion of ''funds from the United States, a State, or a political subdivision of a State * * *'' for the hospital's family practice program. Thus, the provision recognizes that ordinarily such funds would not be included in the hospital's base year per resident amount (because they were not incurred by the hospital in the base year). However, Congress explicitly created a narrow exception to the ''cost finding'' principles to allow such a hospital to include Federal, State, or local government grants to be included in the hospital's PRA base year calculation. Second, subparagraph (J)(i)(2) requires that direct GME payment to such a hospital that received a revised PRA amount under subparagraph (J)(i)(1) must also be reduced in subsequent cost reporting periods by the proportionate amount of funding the hospital receives from Federal, State, or local government payments. In other words, what subparagraph (J)(i)(2) does is to prohibit this hospital from receiving duplicative payments for the same GME program—both through the adjusted PRA and through continued Federal, State, and local government funding.

The commenter argues that subparagraph (J)(i)(2) is the ''only'' situation where Congress has ''spoken'' about reductions in current year payment because of third party reimbursement. However, as we stated above, we believe the effect of subparagraph (J)(i)(2) is to prevent of duplicative payments for the same program that could otherwise occur in the narrow circumstances of the exception provided by section 1886(h)(5)(J), and has nothing to do with the continued applicability of the principles of redistribution of costs and community support. To the contrary, as we have stated, we believe that subparagraph (J)(i)(1) addresses a limited theoretical ''retroactive redistribution'' of costs and community support to allow a very narrow *exception* of allowing costs to be included in direct GME payment. Thus, we believe section 1886(h)(5)(J) of the Act would support our assertion that Congress intends application of redistribution of costs and community support to direct GME payment (except in the narrow circumstance of the type of hospital described in that section), rather than support the commenter's contrary assertion that the section is inconsistent with our proposal on application of the principles.

Comment: One commenter suggested that the redistribution of costs and community support principles at nonhospital sites should apply on a ''year-by-year basis,'' such that if another entity funds a training program during a particular fiscal year, the hospital would not be allowed to include the residents in its count for that fiscal year.

Response: We believe the commenter's suggestion of a ''year-by-year basis'' policy is, in effect, already in place under existing Medicare policy without reference to the redistribution of costs or community support principles. Under the existing policy, where another entity funds a training program in a particular year while the residents are training at a nonhospital site—that is, incurs the residents' salaries and fringes, and the supervisory

physician costs (''all or substantially all of the costs''), the hospital may not include the residents in its FTE count for that fiscal year. This requirement, of course, is independent of the redistribution of costs and community support policy. It is based on the statutory requirement that allows a hospital to count residents training at nonhospital sites only if the hospital has incurred for all or substantially all of the costs of the program at that site during the hospital's fiscal year.

Comment: One commenter stated that the 1989 final rule made clear that a hospital's resident count may also include residents for whom ''community support was received'' through a State or local grant. Similarly, another commenter stated ''certain family medicine training programs that may have received outside funds, for example, State dollars, at any time in the past will be prohibited [by the hospital we proposed] from receiving GME reimbursement.''

Similarly, another commenter stated that ''it is axiomatic'' that State-supported and public teaching hospitals receive State appropriations to support their residency programs. The commenter urged CMS to clarify that the application of the redistribution of costs and community support principles would not apply to State or local appropriations to public hospitals, with respect to the counting of FTE residents in either the hospital or the nonhospital setting.

Response: As we explained in the 1989 final rule (54 FR 40302), grants that were restricted (those grants that were designated by the donor to pay for certain specified provider costs) or unrestricted were considered allowable costs of the hospital (including direct GME costs) when Medicare paid hospitals on a reasonable cost basis. The policy allowing payment to hospitals for costs that had been funded by grants was authorized by section 901 of the Omnibus Budget Reconciliation Act (OBRA) of 1980 (Pub. L. 96–499), which added section 1134 of the Act. Section 1134 of the Act applies to ''the reasonable costs of services provided by nonprofit hospitals or critical access hospitals.'' Section 1134(1) of the Act specifies that a ''grant, gift or endowment or income therefrom which is to or for such a hospital * * *'' may not be deducted from the operating costs of such hospitals that are paid on a reasonable cost basis. Therefore, when hospitals were paid on a reasonable cost basis for direct GME costs, the ''community support'' that came from ''grants, gifts, or endowments'' was allowable under Medicare. We are clarifying in this final rule, that under the direct GME prospective payment methodology under section 1886(h) of the Act, if a hospital had received a grant, gift or endowment to subsidize its residency programs at the hospital, and the hospital requested direct GME payment for training the residents, it would not be considered community support. Under section 1134 of the Act, it is as if the hospital had itself incurred the cost for which it had received the grant subsidy. For example, if in 2003 a hospital received a State grant to fund its family practice program at the hospital, the grant would not be considered community support under our regulation. This is because we would treat the hospital as if itself incurred the costs for the family practice program, instead of the State grant.

However, we note that this policy would *not* include ordinary State and local appropriations. As we mentioned in the January 12, 2001 final rule at 66 FR 3367, ''In administrative, legal and policy matters, we have consistently maintained that State appropriations for the cost of medical education activities constitute community support that is to be offset from a provider's allowable costs.'' Therefore, if a program were entirely funded by State or local appropriations, an inappropriate redistribution of costs would occur if the hospital subsequently begin to incur the costs of the residency program—for training inside or outside the hospital. Although, for most hospitals that receive State and local appropriations for their residency programs, the hospitals continuously incur (since the inception of the programs) some direct GME costs, there would be no disallowance of FTEs due to community support.

We contrast the situation of a grant to a hospital with the situation of a grant to a nonhospital site. If, hypothetically, nonhospital sites were reimbursed by Medicare on a reasonable cost basis, and the nonhospital site had received grants to subsidize all of the direct GME costs for the residency program there, under section 1134 of the Act, we would treat the costs the grant subsidized as if they were costs of the nonhospital site. If a hospital then tried to incur the direct GME costs, this *could* be a redistribution of costs or community support issue, since the hospital would be claiming FTE residents who had historically trained at the nonhospital site for whom the community had assumed the cost of that training, as described in the scenarios at 68 FR 27213.

Comment: Several commenters objected to the sentence in the preamble to the proposed rule that stated: ''* * * 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.'' One commenter explained that there are a number of situations where a hospital is truly incurring the cost of having a resident at a site, but the hospital is not incurring the cost of the entire complement of residents. ''For example, if two different hospital programs each elect to send residents to the same clinic, under the interpretation in the [proposed rule], neither of the two hospitals would be able to count any of the residents because neither of the two programs would incur the cost of the full complement of residents.'' Another commenter believed that ''this change'' runs contrary to other current Medicare policies that focus on the resident rather than the program. The commenter believed that both the direct GME and IME regulations ''are replete with references to 'resident' rather than 'program'.'' The commenter believed that ''residency program'' is referenced only in the context of the requirement that, for residents to be counted for direct GME and IME payments, they must be part of an ''approved program'' (§ 413.86(f)(1)).

Response: We understand the concerns of the commenters about the requirement for a hospital to incur ''all or substantially all of the cost'' of training residents in a training *program* at a nonhospital site. However, we *do not* believe this is a *change* in policy. We believe that the policy that requires a hospital to incur the cost of ''the program'' in the nonhospital site has existed since the passage of the direct GME provisions, section 9314 of the Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99–509), and the passage of the IME provision, section 4621(b)(2) of the Balanced Budget Act of 1997 (Pub. L. 105–33), that permitted hospitals to continue to count residents in nonhospital sites, for purposes of direct GME and IME payment, if the hospital incurred ''all or substantially all of the cost'' of residents training in the program.

As we explained in the proposed rule, 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.) Therefore, we believe a better reading of this language is that hospitals must incur all

or substantially all of the cost for the full complement of residents in the training program at the nonhospital site.

We note that the policy that requires the hospital to incur the cost of the *program does* appear to be somewhat of a departure from other current Medicare policies on graduate medical education that focus on the resident rather than the program, as the commenter suggests. However, we believe the statutory provisions cited above require hospitals to assume the cost of the full complement of residents training in the program at the nonhospital sites in order to count any FTE residents training at that site.

In addition, as we noted at 68 FR 27217 of the proposed rule, and also above, under policy on the application of the redistribution of costs and community support principles, it is permissible 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 is not permitted to count the existing FTE residents due to the application of the redistribution of costs or community support rules. In the nonhospital setting, as a result of the interaction of these two separate FTE-counting requirements—(1) that the hospital must not violate the redistribution of costs and the community support principles in order to count the resident FTEs in the nonhospital settings; and (2) that the hospital must incur ''all or substantially all'' of the costs for the training program in that setting—a hospital would be prohibited from counting FTE residents added to an existing program at a nonhospital site unless the hospital incurs all or substantially all of the costs of training *all* of the residents in that program at that setting. That is, even if the hospital incurs all or substantially of the costs for all of the training program at the nonhospital site, the hospital would only be able to count the additional FTE residents who were not excluded by application of the redistribution of costs or community support principles.

Comment: Several comments cited a letter from CMS (then the Health Care Finance Administration, or ''HCFA'') dated March 30, 1999 to C. Scott Litch of the American Association of Dental Schools (now the American Dental Education Association). Specifically, these commenters cited a sentence in the letter to Mr. Litch which stated: ''If a hospital establishes a new relationship with a dental clinic and meets the conditions for counting residents training outside the hospital, the hospital may count more residents currently for indirect and direct graduate medical education than were counted in 1996 if those residents are dental residents.'' One commenter stated that the ''new relationship'' referred to in the letter from CMS presupposes the existence of an ongoing program whose costs presumably had been met by means other than the hospital before the affiliation with a nonhospital dental clinic began. This commenter believed that this letter provided assurance to many hospitals that new affiliations with preexisting dental programs were permissible.

Response: We do not agree with the commenter that the sentence in the letter to Mr. Litch ''presupposes the existence of an ongoing program'' where the costs of such a program ''had been met by means other than the hospital''. Rather, we believe the ''new relationship'' between the hospital and the dental clinic could be reconciled with application of the principles of redistribution of costs and community support and characterized by two possible interpretations, both of which would allow for the counting of residents in nonhospital sites—(1) where the hospital would rotate residents from the hospital to the nonhospital site; or (2) where the hospital would fund new training slots at the nonhospital site (the dental clinic referred to in the Mr. Litch's letter). Such assignments from the hospital to the dental clinic, or new residency training slots, would be the ''new relationship,'' but in either case, no redistribution would occur. Therefore, we do not believe the letter from 1999 is necessarily inconsistent with the principles of redistribution of costs and community support described in the proposed rule.

Comment: Many commenters, while remaining generally opposed to application of redistribution of costs and community support principles, requested that if CMS were to finalize the proposed rule, CMS apply the principles prospectively. One commenter, a dental school, explained that it had just admitted a new class of residents, many of whom will not complete their programs until 2006. The commenter believed that, in the application of the principles, CMS seeks to remove all Medicare funding for these residents retroactively. Along a similar vein, another commenter pointed out in support of the suggestion to apply the principles only prospectively, that the implementation of the proposed regulation would result in ''substantial dislocation and hardship to hospitals, dental and other schools, and the residents themselves.'' Therefore, the commenter believed CMS should indicate specifically in the final rule that such changes will only be applied to a provider's cost reporting period beginning on or after October 1, 2003, and CMS should not apply its final GME policy on redistribution of costs and community support to any prior cost reporting periods that remain open or unsettled, or are settled but potentially subject to reopening under the Medicare rules.

In addition, several commenters requested clarification regarding the effective date for the proposed application of the principles of redistribution of costs and community support to FTE counts. Specifically, the commenters point to the following language in the proposed rule:

- ''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.'' (68 FR 27215)
- ''We 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.'' (68 FR 27216)
- ''[i]f 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 payment with respect to those FTE residents would certainly be required.'' (68 FR 27216)
- ''We are proposing that, effective October 1, 2003, in order for a hospital to receive IME and direct GME payment, the hospital must have been continuously incurring the direct GME cost of residents training in a particular program since the date the residents first began training in the program in order for the hospital to count the FTE residents.'' (68 FR 27417)

Response: We have stated that we believe the principles of redistribution of costs and community support are *longstanding* Medicare policy. While we have reminded the public of the continuing application of the principles in various regulations and program guidance, we also recognize that CMS has not had occasion to invoke them in Agency policy expressions relating specifically to direct GME payments since the direct GME PRA base year.

As we have stated, we believe redistributions would occur only in rare circumstances for residency training inside the hospital. Between 1987 and 1997 when hospitals could count FTE

residents training in nonhospital sites for purposes of direct GME payments, but not IME payments, we did not observe the kinds of inappropriate counting of FTE residents we described in our proposed rule. It is only since hospitals have been allowed to count FTE residents training in nonhospital sites for purposes of IME payment, that CMS has become aware that cost shifting has become prevalent in the hospital industry, which has implicated the principles of redistribution of costs and community support. Therefore, in general, we are implementing a prospective effective date of October 1, 2003, for purposes of payment. That is, for direct GME, effective for portions of cost reporting periods beginning with October 1, 2003, and for IME, effective for discharges occurring on or after October 1, 2003, a hospital must have been continuously incurring direct GME costs of residents training in a particular program since the date the residents first began training in the program in order for the hospital to count the FTE residents. We note that the effective dates apply only as they relate to disallowances of FTEs and bear no relation to determinations of redistributions or community support. Therefore, in general, a fiscal intermediary that determines that a redistribution of costs has taken place for a particular hospital prior to October 1, 2003, may disallow FTEs based on that determination beginning with October 1, 2003. For example, if a fiscal intermediary determines that a redistribution of costs has occurred that affected 10 FTEs for direct GME and IME during the hospital's cost report ending in fiscal year ending in 1999, the fiscal intermediary would take disallowances for those 10 FTEs, but not until October 1, 2003, for purposes of direct GME and IME payment.

In addition, because we have received a large number of public comments expressing surprise and confusion regarding our policy on these principles, we are grandfathering residents who began training in a program on or before October 1, 2003. That is, an FTE resident who began training in a residency program on or before October 1, 2003 (the effective date of this final rule), and with respect to whom there has been a redistribution or community support, may continue to be counted by a hospital for purposes of direct GME and IME payments after October 1, 2003, until the resident has completed training in that program, or until 3 years after the date the resident began training in that program, whichever comes first. We believe continued direct GME and IME payments to the hospital while the ''redistributed'' residents finish their training for up to 3 years is appropriate to address many situations in which nonhospital sites have made arrangements with hospitals to shift the costs of training those residents. We understand that, in nonhospital sites, virtually all dental residency programs are of a duration of 3 years in length or less. This policy addresses the situation pointed out by the dental school commenter and other commenters that a school may have just admitted a new class of residents, many of whom will not complete 3-year programs until 2006.

We note that this prospective ''grandfather'' policy *does not* apply to resident FTEs with respect to whom there has been a redistribution of costs or community support, and who begin training after October 1, 2003. In addition, those residents described above who began training in a program on or before October 1, 2003, may be counted until those particular residents finish their training in that program (or 3 years, whichever comes first). In order to count such residents, we are requiring that hospitals identify those residents (by social security number) to their fiscal intermediary and specify the length of time the hospital will be counting these FTE residents for direct GME and IME payment purposes.

We note that the policy described above that effectively ''grandfathers'' residents who began their training on or before October 1, 2003, applies only as it relates to payments to hospitals for those specified FTE residents, and bears no relation to determinations of whether a redistribution of costs or community support has taken place. Therefore, if a fiscal intermediary determines that a redistribution of costs has taken place with respect to residents counted by a particular hospital even prior to October 1, 2003, the intermediary will disallow any FTEs based on that determination, beginning October 1, 2003, except for the ''grandfathered'' residents. Hospitals that continue to count grandfathered FTE residents (where the costs of whom had been redistributed) may only do so until those residents finish their training in the specific program they were training in on or before or to October 1, 2003 (which would be no later than September 30, 2006, 3 years after October 1, 2003).

For example, a fiscal intermediary determines for a hospital's FYE December 31, 2003 cost report that a redistribution of costs has taken place with respect to certain FTEs the hospital counted for direct GME and IME (that is, the costs of training residents at a nonhospital site were incurred by a university from 1990 through 1999). Assume that 5 FTEs began training in a 2-year orthodontics program in a dental school on July 1, 2003, and another 5 residents begin their training in the same program on July 1, 2004. The 5 FTEs who began training on July 1, 2003, are ''grandfathered,'' and, therefore, the fiscal intermediary would not disallow these 5 FTEs as of October 1, 2003. The hospital may continue to count these 5 FTEs that began training on July 1, 2003 through June 30, 2005, when they finish the 2-year orthodontics program. We note that subsequent to completion of the 2-year orthodontics program on June 30, 2005, if any of these 5 FTEs participate in additional GME training programs, the fiscal intermediary would disallow these FTEs because disallowances for redistribution of costs and community support relate to FTE slots and not specific residents.

However, the 5 FTEs that began training in the 2-year orthodontics program on July 1, 2004 are not ''grandfathered,'' and, therefore, beginning July 1, 2004 of the hospital's December 31, 2004 cost report, the fiscal intermediary will disallow IME and direct GME payment associated with these 5 FTE slots.

Comment: Commenters disputed the situations we cited in the preamble to the proposed rule that were supposed to be illustrative of what we believe to be inappropriate application of Medicare direct GME and IME policy at 68 FR 27213. One commenter, in particular, requested information on the identity of programs cited in the examples.

Response: We do not believe it is appropriate to disclose the identities of those cited in the examples. Therefore, we are unable to respond to the commenters' points on the matter, except to state that the situations in the examples represent what we believed are the more ''egregious'' scenarios involving redistribution of costs and community support principles and inappropriate counting of FTE residents, we note that the same issues arise, and the same principles apply, whether the counting of residents relates to training that is taking place in another country, another State, or on the same hospital campus, as the hospital.

Comment: One commenter believed that CMS's policy on the application of the redistribution of costs and community support will lead to considerable, ''but needless,'' litigation over what it means to ''incur'' the costs of off-site training.

Response: We disagree with the commenter and see no reason to be

concerned that these clarifications would result in any more litigation than other Medicare payment policies that are conditioned on whether a provider incurs costs. For example, for several decades, Medicare policy required that hospitals ''incur'' costs in order to receive payment from Medicare. The Medicare statute and regulations currently require that a hospital incur certain costs in order to count FTE residents training in nonhospital sites for purposes of direct GME and IME payments. We are unsure why the requirement under the policy on redistribution of costs and community support that a hospital ''incur'' the direct GME cost continuously for a residency program at a training site is any more complex than other cost requirements under Medicare.

Comment: One commenter suggested that we craft a narrower solution to the issue of inappropriate counting of FTE residents in nonhospital sites by focusing the language on salary and benefits for residents. The commenter believed that CMS could state that, unless the hospital in 1999 had incurred the costs of salary and benefits for FTE residents who were training in offsite locations, the hospital may not receive direct GME and IME payment for training those FTE residents at the nonhospital sites today.

Response: We do not believe a policy such as the one the commenter suggested—determining redistribution of costs based upon whether a hospital continuously incurs the residents' salaries and benefits during training in the nonhospital site— is necessary or appropriate. This is because, under the policy on redistribution of costs and community support we describe in the proposed rule and in this final rule, a hospital that continuously incurs the residents' salaries and benefits (from 1999 or before) while the residents train in the nonhospital site, or even inside the hospital, would *not* be redistributing costs if the nonhospital site later incurs the other direct GME costs (such as supervisory physician salaries) in the nonhospital site. There would be no redistribution of costs because the hospital would have continuously incurred at least some of the direct GME costs (the residents' salaries and benefits) since the inception of the program. However, we note that even if there has not been a redistribution of costs or community support with FTE residents training in a nonhospital site in such a scenario, the hospital would still need to meet the requirements in the existing regulations (at § 413.86(f) and § 412.105(1)(ii)(c)) in order to count those FTE residents for purposes of direct GME and IME payment.

For example, Hospital A has had a family practice program with 10 FTE residents for about 20 years, for which the hospital has incurred the residents' salaries and fringes and some other (but not all) direct GME costs for the program. For the first time, in fiscal year ending 2003, Hospital A rotates 2 FTE residents to an ambulatory clinic (a nonhospital site), and fulfills the requirements at § 413.86(f)(4), including incurring ''all or substantially all of the costs'' of the training program in the nonhospital site. There is no redistribution of costs with respect to these 2 FTE residents because Hospital A has continuously incurred some of the direct GME costs of the program—the residents' salaries—and therefore it may count the 2 FTE residents training at the clinic (up to the hospital's FTE cap), since it also has complied with the requirements at § 413.86(f)(4).

Comment: Some commenters suggested that the application of redistribution of costs and community support principles would impose large administrative burdens on hospitals to demonstrate which entity has been ''continuously incurring'' the costs of the residency training. One commenter stated: ''[t]his burden would be additive to a policy that already is fraught with excessive administrative requirements.''

One commenter asked if hospitals would be required to document responsibility for the costs of training residents prior to January 1, 1999.

Response: If the hospital has continuously been incurring at least some of the direct GME costs (for example, resident salaries or supervisory physician salaries) since the inception of the residency program, we do not believe any additional documentation is necessary beyond which hospitals are already required to maintain. If resident or supervisory physician salaries, for instance, are paid through the hospital payroll, the hospital will have kept documentation of such costs for Federal tax purposes.

In response to the second comment, we stated in the proposed rule that January 1, 1999 should be used by our fiscal intermediaries as the date for determinations of whether a hospital or another entity has been incurring the costs of a training in a particular program at a training site for purposes of determining whether there has been a redistribution of costs or community support. This date was chosen as an administrative convenience because we believe it could otherwise be difficult for our fiscal intermediaries to obtain contemporaneous documentation that the hospitals have appropriately been incurring costs in earlier years. Therefore, we believe that, for purposes of determining redistribution of costs or community support, most hospitals would only be required to maintain appropriate documentation to demonstrate that they have continuously been incurring the direct GME costs from January 1, 1999 forward. However, as we mentioned in the proposed rule, if the fiscal intermediaries determine that there was a redistribution of costs or community support for a fiscal year ending for a cost report for a particular hospital prior to January 1, 1999, the hospital would be required to show contemporaneous documentation to prove otherwise.

Comment: One commenter stated that it may be difficult to track residents that have been funded by some type of community support. The commenter described a scenario where a program at a hospital has four internal medicine residents and one is covered by some type of community support for a 3-year period. The commenter stated that it may be difficult to track that slot over the next 5, 10, or 20 years to avoid submitting it for future direct GME or IME payments.

Response: As we stated above, we understand there may be administrative issues that hospitals must confront in their efforts to comply with the principles of redistribution of costs and community support. However, we do not believe it would very difficult to track the FTEs in a program that receives community support. Once the FTE residents for which community support is received have been identified, the hospital will know the number of FTE residents to remove from the count that is submitted in future cost reports (all of which will be subject to audit by our fiscal intermediaries). Using the commenter's example, if direct GME costs for one out of four FTEs in an internal medicine program is identified as being entirely subsidized by community support for three years (the duration of an internal medicine program), the hospital would know to refrain from counting one FTE in future cost reports, even after the 3 years of training for a particular resident has passed. This is because, as the commenter seemed to understand, the redistribution of costs and community support principles are applied to the FTE resident training slots of a hospital; the principles are not associated with a particular resident, to which the principles could apply differently from year to year.

Comment: One commenter disagreed with the choice of words used in the

proposed definition of ''redistribution of costs'' at proposed § 413.86(b). As proposed, the definition states: ''*Redistribution of costs* means an attempt by a hospital to increase the amount it is allowed to receive from Medicare under this section by counting FTE residents who were in medical residency programs where the costs of the programs had previously been incurred by the educational institution.'' In particular, the commenter objected to the first part of the definition: ''an *attempt* by a hospital to increase the amount it is allowed to receive from Medicare.'' The commenter believed that the phrase was unnecessary to the definition and should be deleted.

Response: We understand the concern of the commenter. However, we have used ''the attempt'' language at § 413.86(b) for the proposed definition of ''redistribution of costs'' primarily because we have adopted the language of the existing regulation at § 413.85(c) that defines ''redistribution of costs'' (now applicable to costs of approved nursing and allied health education activities). The language was not intended to be offensive. Rather, we meant it to be descriptive of a possible motive for a redistribution of costs. In light of the commenter's suggestion, we are revising the language to be purely descriptive of the scenario of the redistribution and not reflect a possible motive. Accordingly, we are revising the language at § 413.86(b) to state: ''Redistribution of costs'' occurs when a hospital counts FTE residents in medical residency programs and the costs of the programs had previously been incurred by an educational institution. In the future, we will consider conforming changes to the definition of ''redistribution of costs'' at § 413.85(c) as well.

Comment: Some commenters believed that, through the enactment of the 1996 cap on the count of allopathic and osteopathic residents, Congress has already dealt with the problem that CMS is attempting to revisit with the proposed rule. The commenters believed that when Congress exempted the dental residents from the caps, it intended to create hospital incentives for dental training. The commenters believed that the CMS redistribution of costs and community support policy contradicts this Congressional intent.

Response: We do not believe that when Congress instituted the caps on the count of residents with the Balanced Budget Act of 1997, it was aware that inappropriate counting of FTE residents could occur through redistribution of costs. CMS, itself, did not become aware that many hospitals were engaging in these cost shifting arrangements, very often involving dental residents since at least October 1, 1997, when hospitals were authorized to count FTE residents for purposes of IME payments, as well as direct GME payments, for training in nonhospital sites. As we stated above, it is only since the audits by our fiscal intermediaries of the fiscal year ending 1998 and 1998 cost reports that have occurred within the last 2 years that CMS became aware that significant cost shifting was taking place. Therefore, we do not believe Congress would have been in a position to consider whether to authorize cost shifting in its 1997 legislation. Thus, we do not believe, as the commenters do, that Congress expected, or tacitly condone, cost shifting to dental residents as a result of exempting the dental residents from the 1996 caps. Rather, we believe that when Congress exempted dental residents from the 1996 caps, it intended to allow more dental training to occur in the hospital, not to authorize cost shifting from dental schools to hospitals and to the Medicare program.

Comment: One commenter asked what types of costs the hospital is required to incur for training in nonhospital sites in order for there to be no redistribution of costs or community support. Specifically, the commenter described a scenario under which a teaching hospital and a medical school are related parties and asked whether the teaching hospital is required to pay for the teaching physician services relating to offsite rotations at a medical school clinic before the FTE residents participating in the rotation can be counted for purposes of IME or direct GME payment.

Response: We understand from the scenario described by the commenter that hospital-based residents are being rotated to the medical school clinic. As such, we assume that the hospital is already incurring at least the residents' salary and fringe benefits. Therefore, when rotating the residents to the clinic, the hospital is incurring at least some of the direct GME costs of training the residents. Under these circumstances, a redistribution of costs has not taken place. However, according to the requirements for counting FTE residents in nonhospital settings under § 413.86(f)(4), among other requirements, the hospital is required to incur the portion of the teaching physicians' salaries and fringe benefits attributable to direct GME (by the term ''related party,'' we are assuming that the medical school clinic is not provider-based as specified under § 413.65, and therefore, is not considered part of the hospital). Thus, under the commenter's scenario, the hospital may be prohibited from counting the FTE residents, not because of redistribution of costs but because of failure to incur ''all or substantially all of the cost'' under § 413.86(f)(4) if the hospital is not incurring the supervisory physician's salary attributable to direct GME.

Comment: A number of commenters argued that the proposed application of the redistribution of costs and community support principles is bad public policy from the perspective of access, quality and cost-effectiveness of oral health care.

Response: We understand that dental training programs provide much needed oral health care to the American public and did not intentionally target them with our policy on redistribution of costs and community support. However, we believe much of the inappropriate cost sifting to hospitals and to the Medicare program is related to dental residency programs—which is probably due to the fact that dental residents are exempted from the statutory 1996 FTE caps. Although we regret that publication of this rule may upset some newly formed relationships between hospitals and dental schools, we continue to believe that the Medicare program should not pay for nonhospital dental residency training that had previously been funded by other sources, without any sponsorship by hospitals or the Medicare program.

Comment: One commenter stated that by establishing a PRA floor equal to 85 percent of the locality-adjusted national average PRA, Congress created an exception to the principles of community support and redistribution of costs. The commenter noted that this floor increased reimbursement to a number of teaching hospitals around the country whose own PRAs were low ''precisely'' because the community or another educational institution had been bearing the training costs in the GME PRA base year. Therefore, the commenter argued, the PRA floor ''picked up'' some of those disallowed costs, and that Medicare is, in effect, currently paying for those costs in the PRAs that were raised to the floor.

Response: The commenter is referring to section 311 of the Balanced Budget Refinement Act (BBRA) of 1999 (Pub. L. 106–113), which, for FY 2001, established a floor PRA at 70 percent of the locality-adjusted national average PRA, and to section 511 of the Benefits Improvement and Protection Act (BIPA) of 2000 (Pub. L. 106–554), which, for FY 2002, established a floor PRA at 85 percent of the locality-adjusted national average PRA. Regulations concerning

these provisions are implemented at § 413.86(e)(4). These provisions were intended, in part, to narrow the disparities (both high and low) in direct GME payments to teaching hospitals across the country. One of the reasons a number of hospitals had low base year PRAs is because a significant amount of their GME costs in the PRA base year was incurred by another entity (that is, the ''community''). (Variations in base year PRAs were otherwise due to differences in hospital-specific accounting practices and differences in reimbursement methods for supervising physician and resident salaries.) By providing for increased GME payments to certain hospitals with low PRAs, we do not believe Congress implicitly condoned, or made an exception to, the redistribution of costs and community support principles. We note that Congress provided for an increase to the floor PRA for *all* hospitals that had PRAs below the floor, *not* just to hospitals that, in the base year, did not incur certain GME costs. Rather, we believe Congress intended to provide increased GME payments to hospitals with low PRAs, regardless of the reasons those particular hospitals may have had low PRAs, in an attempt to even out some of the disparity in PRAs, nationally.

Comment: A commenter noted that the among the examples cited in the proposed rule at 68 FR 27213 as illustrative of inappropriate application of Medicare IME and direct GME policy, we described a situation where a hospital on the East Coast of the United States is counting dental residents training in nonhospital sites in Hawaii. The commenter believed that we have incorrect information regarding this program, and that there is, in fact, no redistribution of costs from the community to the Medicare program with respect to the program in Hawaii. Specifically, the commenter explained that in August 2002, a hospital in New York placed one dental resident in a clinic located in Honolulu. The New York hospital pays the costs of the resident's stipend and the supervising faculty's salary, and there is a written agreement between the hospital and the clinic. The commenter stated that in the future, the program anticipates placing additional residents at other nonhospital sites in Hawaii.

Response: As we stated in the preambles to the proposed rule and this final rule, there would be no redistribution of costs or community support if, from the outset of the program, a hospital incurs direct GME costs. Therefore, if, in fact, a hospital in New York has been incurring direct GME costs for a training program located in a clinic in Hawaii since the program's inception, then there would be no redistribution of costs or community support. The hospital in New York could count FTE residents training in the nonhospital site as long as the applicable requirements are met.

Comment: One commenter that described a scenario in which a university funded a family practice program for many years. However, in 2000, a Federally Qualified Health Center (FQHC) entered into a written agreement with the university and began reimbursing the university for ''all or substantially all'' of the costs of the program. The FQHC has been receiving Medicare direct GME payments since that time. The commenter stated that under the terms of the proposed rule, this FQHC would be ineligible for receipt of GME payments, since, prior to 2000, the program was funded exclusively by the university.

Response: The commenter raised the point that the redistribution of costs and community support principles are applicable to providers other than hospitals that may receive Medicare payments for residency training. Specifically, FQHCs and RHCs under § 405.2468, CAHs under § 413.70, and Medicare+Choice organizations (MCO) under § 422.270 may qualify to receive payments for direct GME costs. We note that the existing regulations at § 405.2468(f)(6) for FQHCs and RHCs, and at § 422.270(c) for MCOs, already clearly state that the allowable direct GME costs of these entities are subject to the redistribution of costs and community support principles in § 413.85(c). We agree with the commenter and are also clarifying the regulations at § 413.86(i) to clearly state that the principles of redistribution of costs and community support apply equally to hospitals, FQHCs, RHCs, CAHs, and MCOs. Therefore, we agree that, in the situation described by the commenter the FQHC would *not* be eligible for Medicare direct GME payments since the family practice program represents a redistribution of costs from the community (that is, the university) to the Medicare program (that is, the FQHC through direct GME payments).

3. Rural Track FTE Limitation for Purposes of Direct GME and IME for Urban Hospitals That Establish Separately Accredited Approved Medical Programs in a Rural Area (§§ 412.105(f)(1)(x) and 413.86(g)(12))

a. Change in the Amount of Rural Training Time Required for an Urban Hospital To Qualify for an Increase in the Rural Track FTE Limitation

To encourage the training of physicians in rural areas, section 407(c) of Pub. L. 106–113 amended sections 1886(d)(5)(B) and 1886(h)(4)(H) of the Act to add a provision that, in the case of an urban hospital that establishes separately accredited approved medical residency training programs (or rural tracks) in a rural area or has an accredited training program with an integrated rural track, an adjustment shall be made to the urban hospital's cap on the number of residents. For direct GME, the amendment applies to payments to hospitals for cost reporting periods beginning on or after April 1, 2000; for IME, the amendment applies to discharges occurring on or after April 1, 2000.

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

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

We implemented the rural track program provisions of section 1886(d)(5)(B) and 1886(h)(4)(H) of the Act to address these ''1–2'' programs and to account for other programs that are not specifically ''1–2'' programs but that include rural training components. As stated above, since there is no existing definition of ''rural track'' or ''integrated rural track,'' we define at § 413.86(b) a ''rural track'' and an ''integrated rural track'' as an approved medical residency training program established by an urban hospital in which residents train for a portion of the program at the urban hospital and then rotate for a portion of the program to a

rural hospital(s) or to a rural nonhospital site(s). We have previously noted that the terms ''rural track'' and ''integrated rural track,'' for purposes of this definition, are synonymous.

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

Generally, the rural track policy is divided into two categories: Rural track programs in which residents are rotated to a rural area for at least two-thirds of the duration of the program; and rural track programs in which residents are rotated to a rural area for less than two-thirds of the duration of the program. Currently, family practice is the only specialty that has separately accredited rural track programs. As previously noted, to account for other specialties that have program lengths greater than or less than 3 years, or that are not ''1–2'' programs, but may establish separately accredited rural track residency programs that are longer than 3 years, our regulations specify that residents must train in the rural area for ''two-thirds of the duration of the program,'' rather than ''2 out of 3 program years,'' in order for the urban hospital to count FTEs in the rural track (up to the rural track FTE limitation) in addition to the residents included in the hospital's FTE limitation. Thus, for example, under current policy, if a surgery program, which is a 5-year program, were to establish a separately accredited rural track, the urban hospital must rotate the surgery residents to the rural area for at least two-thirds of the duration of the 5-year program in order to qualify to count those FTEs in excess of the hospital's FTE cap, as provided in § 413.86(g)(12) and § 412.105(f)(1)(x).

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

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

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

We believe that an urban hospital that operates a program that is separately accredited by the ACGME as a ''1–2'' program, but in which residents train in rural areas for more than half but less than two-thirds of the duration of the program, should still be allowed to count those FTE residents for GME payment purposes. Therefore, to be consistent with the ACGME accreditation practices, in the May 19, 2003 proposed rule, we proposed to revise our regulations. Proposed § 413.86(g)(12) still addressed our policy that an urban hospital qualifies for an adjustment to the FTE cap for training in rural areas based upon the proportion of time the residents spend training in the rural areas. However, instead of using ''two-thirds'' as the criterion to specify the amount of time residents training in the rural areas under regulations at §§ 413.86(g)(12)(i) through (iv) and 412.105(f)(1)(x), as under current policy, the proposal would use ''one-half'' as the criterion. This proposal addressed the limited cases where ACGME separately accredits programs as ''1–2'' rural tracks but residents in those programs train in the rural areas less than two-thirds of the time, although greater than one-half of the time. Specifically, we proposed at § 413.86(g)(12) to state:

- If an urban hospital rotates residents to a separately accredited rural track program at a rural hospital(s) for at least two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2000 and before October 1, 2003, or for more than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003, the urban hospital may include those residents in its FTE count for the time the rural track residents spend at the urban hospital.
- If an urban hospital rotates residents to a separately accredited rural track program at a rural nonhospital site(s) for at least two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2000, and before October 1, 2003, or for more than one-half of the duration of the program for cost

reporting periods beginning on or after October 1, 2003, the urban hospital may include those residents in its FTE count, subject to the requirements under § 413.86(f)(4).

• If an urban hospital rotates residents in the rural track program to a rural hospital(s) for less than two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2002, and before October 1, 2003, or for one-half or less than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003, the rural hospital may not include those residents in its FTE count (if the rural track is not a new program under § 413.86(g)(6)(iii), or if the rural hospital's FTE count exceeds that hospital's FTE cap), nor may the urban hospital include those residents when calculating its rural track FTE limitation.

• If an urban hospital rotates residents in the rural track program to a rural nonhospital site(s) for a period of time that is less than two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2002, and before October 1, 2003, or for one-half or less than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003, the urban hospital may include those residents in its FTE count, subject to the requirements under § 413.86(f)(4).

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

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

Comment: Several commenters supported our proposal that, effective for cost reporting periods beginning on or after October 1, 2003, an urban hospital would be allowed to include residents in its FTE count above its FTE cap for the time that the residents train at the urban hospital, if the residents rotate to a separately accredited rural track program in a rural area for more than one-half of the duration of the program. The commenters believed that this proposed policy better reflects Congressional intent to encourage training in rural areas, while allowing residency programs the flexibility to rotate residents back to urban areas for needed clinical experiences that are not available in the rural setting.

One commenter recommended that the proposal should reduce the required rural training time even further, since research suggests that more than 50 percent of family practice residents who spend as little as 3 months training in rural areas end up practicing in rural settings.

Response: We agree with the commenters that an urban hospital that operates a program that is separately accredited by the ACGME as a ''1–2'' program, but in which residents train in rural areas for more than half but less than two-thirds of the duration of the program, should still be allowed to count those FTE residents for GME payment purposes. However, we do not agree that urban hospitals should be allowed to receive an increase in their FTE caps to include residents in its FTE count for the time that the residents train at the urban hospital, if the residents rotate to a rural area for one-half or less than one-half of the duration of the program. As we stated in the August 1, 2001 **Federal Register** (66 FR 39904–39905), we interpret section 1886(h)(4)(H)(iv) of the Act as only allowing for an urban hospital to receive an adjustment under the rural track provision if the rural track program is ''*separately accredited*.'' In order to be separately accredited as a rural track, the program must meet the ACGME's ''1–2'' criteria; that is, the residents are typically spending approximately two-thirds of the duration of the program in the rural area. We also explained that while we agree that post-residency retention in rural areas is important, we also believe it is important to prevent hospitals from receiving adjustments to their FTE caps in situations when only a nominal amount of training occurs in the rural area. Therefore, we are not adopting the commenter's request to allow an urban hospital to receive an increase in its FTE caps to include residents in its FTE count for the time that the residents train at the urban hospital, if the residents rotate to a rural area for one-half or less than one-half of the duration of the program.

Comment: One commenter that works for a community health center (CHC) that treats a high percentage of patients below the poverty line expressed concern about the detrimental effects that shrinking hospital revenues are having on the training of family practice residents at the CHC and at other rural and community-based settings. The commenter noted that doubling the number of CHCs is a goal of the President, and urged that, if there should be further ''restraint'' on teaching programs, programs that expand into CHCs should be exempt from such restrictions.

Response: We appreciate the comment. However, we note that since we did not specifically make any proposals related to residency training in community health centers, this comment is outside the scope of this final rule. Therefore, we are not responding to it at this time.

b. Inclusion of Rural Track FTE Residents in the Rolling Average Calculation

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

Medicare patient load to determine Medicare direct GME payments).

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

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

In the May 19, 2003 proposed rule, we proposed to revise the regulations at § 413.86(g)(5) to add a new paragraph (vii) to clarify that, subject to regulations at § 413.86(g)(12), except for new rural track programs begun by urban hospitals that are first establishing an FTE cap under § 413.86(g)(6)(i), when an urban hospital with an existing FTE cap establishes a new program with a rural track (or an integrated rural track), or expands an existing rural track (or an integrated rural track) program, the FTE residents in that program that are counted by the urban hospital are included in the urban hospital's rolling average FTE resident count immediately. We also proposed to revise §§ 413.86(g)(12)(i)(A), (g)(12)(ii)(B), and (g)(12)(iv)(A) to indicate that for the first 3 years of the rural track's existence, the rural track FTE limitation for each urban hospital will be the actual number of FTE residents, subject to the rolling average, training in the rural track at the urban hospital.

Comment: Commenters supported our proposal to revise § 413.86(g)(5) to clarify that the FTE residents in that program that are counted by the urban hospital are included in the urban hospital's rolling average FTE resident count immediately. The commenters stated that allowing immediate inclusion of rural track resident counts will serve to assist urban hospitals in their development of educational partnerships with rural hospitals.

Response: We appreciate the commenters support and, as explained below, are adopting revisions to the regulations concerning inclusion of rural track residents in the rolling average count of urban hospitals as final.

Except for new rural track programs begun by urban hospitals that are first establishing an FTE cap under § 413.86(g)(6)(i), or for rural hospitals that are establishing new rural track programs under § 413.86(g)(6)(iii), we are implementing sections 1886(d)(5)(B) and 1886(h)(4)(H) of the Act to require that FTE residents that are counted by an urban hospital based on the residents' participation in a rural track are included in the rolling average calculation. Accordingly, for IME and direct GME purposes, unless the rural track program is a new program under § 413.86(g)(13) and qualifies for a cap adjustment under § 413.86(g)(6)(i) or (g)(6)(iii), in instances where an urban hospital increases the number of residents it trains due to the establishment of a new or an expansion of an existing rural track program, the additional FTE residents in the rural track program are only gradually included (over a 3-year period) in the urban hospital's FTE count, since they are immediately included in the rolling average calculation of the urban hospital.

The following is an example of how residents in a rural track would be included in the rolling average calculation:

Assume that urban Hospital A, with a fiscal year end (FYE) date of June 30, had 10 unweighted FTE residents training in its cost reporting period ending June 30, 1996, thereby establishing an FTE cap of 10. Hospital A only trains primary care residents. In its cost reporting periods ending on June 30, 2002, and June 30, 2001, Hospital A again trained 10 FTE residents. However, in July 2002, Hospital A starts a rural training track program, adding 2 FTE residents. Since the additional rural track residents are included immediately in the rolling average, in FYE June 30, 2003, Hospital A's FTE residents for payment purposes equal 10.67 FTEs (12 + 10 + 10 / 3) and not 12 FTEs [(10 + 10 + 10 / 3) + 2], which would be the FTE count if FTEs in a rural track program were not subject to the rolling average calculation.

We are finalizing our proposed revision of § 413.86(g)(5) to add a new paragraph (vii) as explained above. In addition, we are finalizing our revision of §§ 413.86(g)(12)(i)(A), (g)(12)(ii)(B), and (g)(12)(iv)(A) to indicate that for the first 3 years of the rural track's existence, the rural track FTE limitation for the urban hospital will be the actual number of FTE residents, subject to the rolling average, training in the rural track at the urban hospital.

4. Technical Change Relating to Affiliated Groups and Affiliation Agreements

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

We are aware that there has been some confusion at times among members of the provider community when using the term ''affiliation agreement,'' since the term is used in contexts other than for Medicare GME payment purposes. For example, an ''affiliation agreement'' is a term historically used in the academic community that generally relates to agreements made between hospitals and medical schools or among sponsors of medical residency education programs. To help prevent further confusion, in the May 19, 2003 proposed rule, we proposed to change the term in the regulations to ''Medicare GME affiliation agreement.'' We believe this will help to distinguish these agreements used for purposes of GME payments from agreements used for other purposes in the provider community. We proposed to revise the regulations at § 413.86(b) to state ''Medicare GME affiliated group,'' and ''Medicare GME affiliation agreement''. We proposed to make similar revisions to § 413.86(g)(4)(iv), (g)(7)(i) through (v), and § 412.105(f)(1)(vi) for IME payment purposes.

Comment: Commenters supported our proposal to change the terms ''affiliated group'' and ''affiliation agreement'', as defined in § 413.86(b), to ''Medicare GME affiliated group'' and ''Medicare GME affiliation agreement'', respectively. The commenters believed that the changes in terminology will help distinguish these terms from other affiliation agreements that are entered into by hospitals, medical schools, and other institutions that sponsor residency training.

Response: We agree with the commenters and are adopting as final the proposed changes throughout § 412.105 for IME and § 413.86 for direct GME.

Out of Scope Comments Relating to GME

Comment: Several comments addressed miscellaneous IME and direct GME issues, including the initial residency period (IRP) and volunteer physicians.

Response: Because we did not propose any changes in policy concerning these issues, we are unable to respond to these comments at this time. We will consider them for purposes of future rulemaking.

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

1. Background

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

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

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

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

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

2. Updated RCE Limits

In the May 19, 2003 proposed rule, we indicated our intent to publish updated payment limits on the amount of allowable compensation for services furnished by physicians to providers in this FY 2004 IPPS final rule. These revised RCE limits are based on updated economic index data and replace the limits that were published in the **Federal Register** on May 5, 1997 (62 FR 24483). We calculated the revised RCE limits by using the methodology published in the **Federal Register** on October 31, 1997 (62 FR 59075). These limits are specified in the chart below and are effective for cost reporting periods beginning on or after January 1, 2004.

The revised RCE limits are mere updates that have been calculated by applying the most recent economic index data. In the proposed rule, we did

not propose to change the methodology used to determine the limits. We indicated that, in accordance with § 415.70(f), we are allowed to publish the revised RCE limits in a final rule without prior publication of a proposed rule for public comment. Furthermore, indicated our belief that publication of the revised RCE limits in a proposed rule with opportunity for public comment was unnecessary, and that we found good cause to waive the procedure.

Comment: One commenter was encouraged to learn of our proposal to publish updated RCE limits and suggested that these updates occur on an annual basis.

Response: We will continue to review the RCE limits on a regular basis by applying the most recent economic index data and publish updates as necessary.

3. Application of RCE Limits

This section, as well as the two following sections, is not describing new policy, but rather is simply a discussion of a continuation of the existing policies with respect to the application of and exceptions to the RCE limits and the geographic area classifications used for purposes of establishing the RCE limits. We will continue to use the RCE limits to compute Medicare payments when a physician is compensated by a provider that is subject to the RCE limits in some or all of its areas. We also will use these limits when the physician is compensated by any other related organization for physician administrative, supervisory, and other provider services paid under Medicare. In applying the RCE limits, the intermediary will assign each compensated physician to the most appropriate specialty category. If no specialty category is appropriate (for example, in determining the reasonable cost for an emergency room physician), the fiscal intermediary will use the RCE level for the ''Total'' category, which is based on income data for all physicians. The fiscal intermediary will determine the appropriate geographic area classification given in Table 9 of the addendum of this final rule.

If the physician's contractual compensation covers all duties, activities, and services furnished to the provider and to its patients and the physician is employed full-time, the appropriate specialty compensation limit will be used and adjusted by the physician's allocation agreement to arrive at the program's share of allowable costs as physician compensation costs. In the absence of an allocation agreement, we generally will assume that 100 percent of the compensation was related to services paid under the physician fee schedule and that there are no allowable costs for the physician's services to the provider.

If a physician's compensation from the provider represents payment only for services that benefit patients generally (that is, the physician bills fees for all services furnished to individual patients), the appropriate specialty compensation limit will be used. If a physician is employed by a provider to furnish services of general benefit to patients on other than a full-time basis, the RCE amount will be adjusted upward or downward to reflect the percentage of time his or her actual hours related to a full work year of 2,080 hours.

4. Exceptions to the RCE Limits

Some providers, particularly but not exclusively small or rural hospitals, may be unable to recruit or maintain an adequate number of physicians at a compensation level within the prescribed limits. In accordance with section 1887(a)(2)(C) of the Act, if a provider is able to demonstrate to the intermediary its inability to recruit or maintain physicians at a compensation level allowable under the RCE limits (as documented, for example, by unsuccessful advertising through national medical or health care publications), the intermediary may grant an exception to the RCE limits established under these rules.

5. Geographic Area Classifications for RCE Limits

We adjust the RCE limits to account for differences in salary levels by location as well as by specialty. Under our methodology for establishing limits, and in the limits set forth below, we have classified geographic areas into three types: nonmetropolitan areas, metropolitan areas less than 1 million, and metropolitan areas greater than 1 million.

As we do for purposes of the IPPS and the physician fee schedule, we use the most current MSA designations for purposes of establishing the RCE limits. In New England, we use the NECMAs for this purpose. Tables 4A and 4B of the Addendum to this final rule includes information that identifies, by type of location (urban and rural), the geographic areas affected; that is, they list all MSAs and their constituent counties and identifies whether their population are classified as large urban. Any county not listed in the tables and all other affected U.S. possessions and territories not part of a State are considered rural areas. This information will enable providers, physicians, Medicare fiscal intermediaries, and other members of the public to determine which RCE limit level will apply in specific areas.

ESTIMATES OF FTE ANNUAL AVERAGE NET COMPENSATION LEVELS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JANUARY 1, 2004 *

Specialty	Nonmetropolitan areas	Metropolitan areas less than one million	Metropolitan areas greater than one million
Total	159,800	171,400	177,200
General/Family Practice	142,500	136,700	138,700
Internal Medicine	150,200	154,100	165,600
Surgery	182,900	204,100	208,000
Pediatrics	130,900	152,100	140,600
OB/GYN	200,300	194,500	196,400
Radiology	217,600	231,100	225,300
Psychiatry	138,700	142,500	154,100
Anesthesiology	167,500	200,300	200,300
Pathology	208,000	219,500	215,700

*All figures are rounded to the nearest $100.

V. PPS for Capital-Related Costs

In the May 19, 2003 proposed rule, we did not propose any changes in the policies governing the determination of the payment rates for capital-related costs for short-term acute care hospitals under the IPPS. However, for the readers' benefit, in this section of this final rule, we are providing a summary of the statutory basis for the PPS for hospital capital-related costs, the methodology used to determine capital-related payments to hospitals, and a brief description of the payment policies under the PPS for capital-related costs for new hospitals, extraordinary circumstances, and exception (regular and special) payments. (Refer to the August 1, 2001 IPPS final rule (66 FR 39910) for a more detailed discussion of the statutory basis for the system, the development and evolution of the system, the methodology used to determine capital-related payments to hospitals both during and after the transition period, and the policy for providing regular and special exceptions payments.)

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

Federal fiscal year (FY) 2001 was the last year of the 10-year transition period established to phase in the PPS for hospital inpatient capital-related costs. Beginning in FY 2002, capital PPS payments are based solely on the Federal rate for the vast majority of hospitals. The basic methodology for determining capital prospective payments based on the Federal rate is set forth in § 412.312. For the purpose of calculating payments for each discharge, the standard Federal rate is adjusted as follows: (Standard Federal Rate) × (DRG Weight) × (Geographic Adjustment Factor (GAF)) × (Large Urban Add-on, if applicable) × (COLA Adjustment for hospitals located in Alaska and Hawaii) × (1 + DSH Adjustment Factor + IME Adjustment Factor, if applicable) Hospitals also may receive outlier payments for those cases that qualify under the thresholds established for each fiscal year that are specified in § 412.312(c) of existing regulations.

During the 10-year transition period, a new hospital (as defined at 412.300(b)) was exempt from the capital PPS for its first 2 years of operation and was paid 85 percent of its reasonable costs during that period. Originally, this provision was effective only through the transition period and, therefore, ended with cost reporting periods beginning in FY 2002. As we discussed in the August 1, 2002 final rule (67 FR 50101), this payment provision was implemented to provide special protection to new hospitals during the transition period in response to concerns that prospective payments under a DRG system may not be adequate initially to cover the capital costs of newly built hospitals. Therefore, we believe that the rationale for this policy applies to new hospitals after the transition period as well, and in that same final rule, we established regulations under § 412.304(c)(2) that provide the same special payment to new hospitals for cost reporting periods beginning on or after October 1, 2002. Therefore, a new hospital, defined under § 412.300(b), is paid 85 percent of its allowable Medicare inpatient hospital capital-related costs through its first 2 years of operation unless the new hospital elects to receive fully prospective payment based on 100 percent of the Federal rate. (For more detailed information regarding this policy, see the August 1, 2002 IPPS final rule (67 FR 50101).)

Regulations at § 412.348(f) provide that a hospital may request an additional payment if the hospital incurs unanticipated capital expenditures in excess of $5 million due to extraordinary circumstances beyond the hospital's control. This policy was established for hospitals during the 10-year transition period, but we established regulations at § 412.312(e) to specify that payments for extraordinary circumstances are also made for cost reporting periods after the transition period (that is, cost reporting periods beginning on or after October 1, 2001). (For more detailed information regarding this policy, refer to the August 1, 2002 **Federal Register** (67 FR 50102).)

During the transition period, under §§ 412.348(b) through (e), eligible hospitals could receive regular exception payments. These exception payments guaranteed a hospital a minimum payment of a percentage of its Medicare allowable capital-related costs depending on the class of hospital (§ 412.348(c)). However, after the end of the transition period, eligible hospitals can receive additional payments under the special exceptions provisions at § 412.348(g), which guarantees an eligible hospital a minimum payment of 70 percent of its Medicare allowable capital-related costs. Special exceptions payments may be made only for the 10 years after the cost reporting year in which the hospital completes its qualifying project, which can be no later than the hospital's cost reporting period beginning before October 1, 2001. Thus, an eligible hospital may receive special exceptions payments for up to 10 years beyond the end of the capital PPS transition period. Hospitals eligible for special exceptions payments were required to submit documentation to the intermediary indicating the completion date of their project. (For more detailed information regarding the special exceptions policy under § 412.348(g), refer to the August 1, 2001 IPPS final rule (66 FR 39911 through 39914) and the August 1, 2002 IPPS final rule (67 FR 50102).)

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

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

1. Payments to Existing Excluded Hospitals and Hospital Units

Section 1886(b)(3)(H) of the Act (as amended by section 4414 of Pub. L. 105–33) established caps on the target amounts for certain existing hospitals and hospital units excluded from the IPPS for cost reporting periods beginning on or after October 1, 1997 through September 30, 2002. For this period, the caps on the target amounts apply to the following three classes of excluded hospitals or units: psychiatric hospitals and units, rehabilitation hospitals and units, and LTCHs.

In accordance with section 1886(b)(3)(H)(i) of the Act and effective for cost reporting periods beginning on or after October 1, 2002, payments to these classes of existing excluded hospitals or hospital units are no longer subject to caps on the target amounts. In accordance with existing §§ 413.40(c)(4)(ii) and (d)(1)(i) and (ii), where applicable, excluded psychiatric hospitals and units continue to be paid on a reasonable cost basis, and payments are based on their Medicare inpatient operating costs, not to exceed the ceiling. The ceiling would be computed using the hospital's or unit's target amount from the previous cost reporting period, updated by the rate-of-increase specified in § 413.40(c)(3)(viii) of the regulations, and then multiplying this figure by the number of Medicare discharges. Effective for cost reporting

periods beginning on or after October 1, 2002, rehabilitation hospitals and units are paid 100 percent of the Federal rate. Effective for cost reporting periods beginning on or after October 1, 2002, LTCHs also are no longer paid on a reasonable cost basis but are paid under a DRG-based PPS. As part of the PPS for LTCHs, we established a 5-year transition period from reasonable cost-based reimbursement to a fully Federal PPS. However, a LTCH, subject to the blend methodology, may elect to be paid based on a 100 percent of the Federal prospective rate. (Sections VI.A.3. and 4. of this preamble contain a more detailed discussion of the IRF PPS and the LTCH PPS.)

2. Updated Caps for New Excluded Hospitals and Units

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

The amount of payment for a ''new'' psychiatric hospital or unit would be determined as follows:

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

The amounts included in the following table reflect the updated 110 percent of the national median target amounts of new excluded psychiatric hospitals and units for cost reporting periods beginning during FY 2004. These figures are updated with the most recent data available to reflect the projected market basket increase percentage of 3.4 percent. This percentage change in the market basket reflects the average change in the price of goods and services purchased by hospitals to furnish inpatient hospital services (as projected by the Office of the Actuary of CMS based on its historical experience with the IPPS). For a new provider, the labor-related share of the target amount is multiplied by the appropriate geographic area wage index, without regard to IPPS reclassifications, and added to the nonlabor-related share in order to determine the per case limit on payment under the statutory payment methodology for new providers.

Class of excluded hospital or unit	FY 2004 labor-related share	FY 2004 nonlabor-related share
Psychiatric	$7,294	$2,899

Effective for cost reporting periods beginning on or after October 1, 2002, this payment limitation is no longer applicable to new LTCHs because they are paid 100 percent of the Federal rate. Under the LTCH PPS, a new LTCH is defined as a provider of inpatient hospital services that meets the qualifying criteria for LTCHs specified under § 412.23(e)(1) and (e)(2) and whose first cost reporting period as a LTCH begins on or after October 1, 2002 (§ 412.23(e)(4)). (We note that this definition of new LTCHs should not be confused with those LTCHs first paid under the TEFRA payment system for discharges occurring on or after October 1, 1997, and before October 1, 2002.) New LTCHs are paid based on 100 percent of the fully Federal prospective rate (they may not participate in the 5-year transition from cost-based reimbursement to prospective payment). In contrast, those ''new'' LTCHs that meet the definition of ''new'' under § 413.40(f)(2)(ii) and that have their first cost reporting periods beginning on or after October 1, 1997, and before October 1, 2002, may be paid under the LTCH PPS transition methodology. Since those hospitals by definition would have been considered new before October 1, 2002, they would have been subject to the updated payment limitation on new hospitals that was published in the FY 2003 IPPS final rule (67 FR 50103). Under § 413.40(f)(2)(ii), the ''new'' hospital would be subject to the same cap in its second cost reporting period; this cap would not be updated for the new hospital's second cost reporting year. Thus, because the same cap is to be used for the new LTCH's first two cost reporting periods, it is no longer necessary to publish an updated cap for new LTCHs.

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

3. Implementation of a PPS for IRFs

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

On August 7, 2001, we issued a final rule in the **Federal Register** (66 FR 41316) establishing the PPS for inpatient rehabilitation facilities, effective for cost reporting periods beginning on or after January 1, 2002. Under the IRF PPS, for cost reporting periods beginning on or after January 1, 2002, and before October 1, 2002, payment consisted of 33⅓ percent of the facility-specific payment amount (based on the reasonable cost-based reimbursement methodology) and 66⅔ percent of the adjusted Federal prospective payment. For cost reporting periods beginning on or after October 1, 2002, payments are based entirely on the Federal prospective payment rate determined under the IRF PPS. We plan to issue in the **Federal Register** by

August 1, 2003 a final rule that will update the payment rates under the IRF PPS for FY 2004, to be effective for discharges occurring on or after October 1, 2003 and before October 1, 2004.

4. Development of a PPS for Inpatient Psychiatric Facilities

We are in the process of developing a proposed rule that would establish a per diem PPS for inpatient psychiatric facilities (IPFs) (previously referred to as psychiatric hospitals and units) that is required under the provisions of section 124 of Pub. L. 106.113.

5. Implementation of a PPS for LTCHs

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

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

We published in the **Federal Register** on June 6, 2003 a final rule (68 FR 34122) that updated the payment rates for the LTCH PPS and made policy changes effective for a new LTCH PPS rate year of July l, 2003 through June 30, 2004.

6. Report of Adjustment (Exception) Payments

Section 4419(b) of Pub. L. 105–33 requires the Secretary to publish annually in the **Federal Register** a report describing the total amount of adjustment (exception) payments made to excluded hospitals and units, by reason of section 1886(b)(4) of the Act, during the previous fiscal year. However, the data on adjustment payments made during the previous fiscal year are not available in time to publish a report describing the total amount of adjustment payments made to all excluded hospitals and units.

The process of requesting, adjudicating, and awarding an adjustment payment is likely to occur over a 2-year period or longer. First, an excluded hospital or unit must file its cost report for a fiscal year with its intermediary within 5 months after the close of its cost reporting period. The fiscal intermediary then reviews the cost report and issues a Notice of Program Reimbursement (NPR) within approximately 2 months after the filing of the cost report. If the hospital's operating costs are in excess of the ceiling, the hospital may file a request for an adjustment payment within 6 months from the date of the NPR. The intermediary, or CMS, depending on the type of adjustment requested, then reviews the request and determines if an adjustment payment is warranted. This determination is often not made until more than 6 months after the date the request is filed. Therefore, it is not possible to provide data in this final rule. However, in an attempt to provide interested parties with data on the most recent adjustments for which we do have data, we are publishing data on adjustments that were processed by the fiscal intermediary or CMS during FY 2002.

The table below includes the most recent data available from the fiscal intermediaries and CMS on adjustment payments that were adjudicated during FY 2002. As indicated above, the adjustments made during FY 2002 only pertain to cost reporting periods ending in years prior to FY 2001. Total adjustment payments awarded to excluded hospitals and units during FY 2002 are $8,541,349. The table depicts for each class of hospital, in the aggregate, the number of adjustment requests adjudicated, the excess operating cost over ceiling, and the amount of the adjustment payment.

Class of hospital	Number	Excess cost over ceiling	Adjustment payments
Rehabilitation	14	$6,330,380	$1,058,646
Psychiatric	7	7,524,434	3,717,465
Long-Term Care	2	23,462,335	1,713,364
Children's	4	3,336,306	997,269
Cancer	1	70,078,995	1,018,919
Christian Science	2	113,304	35,686

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

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

Sections 412.22(h) and 412.25(e), relating to satellites of hospitals and hospital units, respectively, excluded from the IPPS, define a satellite facility as a part of a hospital or unit that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital. Sections 412.22(h)(3) and 412.25(e)(3) provide for the grandfathering of excluded hospitals and units that were structured as satellite facilities on September 30, 1999, to the extent they operate under the same terms and conditions in effect on that date.

In providing for the grandfathering of satellite facilities of hospitals and hospital units, we believed it was appropriate to require that the satellite facilities operate under the same terms and conditions that were in effect on September 30, 1999. There are similarities between the definition of satellite facilities and the definition of hospitals-within-hospitals (that is, hospitals-within-hospitals and satellite facilities are both physically located in acute care hospitals that are paid for their inpatient services on a prospective

payment basis). Also, satellite facilities of both excluded hospitals and hospital units and hospitals-within-hospitals provide inpatient hospital services that are paid at a higher rate than would apply if the facilities were treated by Medicare as part of an acute care hospital.

In the May 19, 2003 proposed rule, we proposed to revise § 412.22(f) to specify that, effective with cost reporting periods beginning on or after October 1, 2003, a hospital operating as a hospital-within-a-hospital on or before September 30, 1995, is exempt from the criteria in § 412.22(e)(1) through (e)(5) only if the hospital-within-a-hospital continues to operate under the same terms and conditions in effect as of September 30, 1995. The intent of the grandfathering provision was to ensure that hospitals that had been in existence prior to the effective date of our hospital-within-hospital requirements should not be adversely affected by those requirements. To the extent hospitals were already operating as hospitals-within-hospitals without meeting those requirements, we believe it is appropriate to limit the grandfathering provision to those hospitals that continue to operate in the same manner as they had operated prior to the effective date of those rules. However, if a hospital changes the way it operates (for example, adds more beds) subsequent to the effective date of the new rules, it should no longer receive the benefit of the grandfathering provision.

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

Comment: Several commenters disagreed with our proposal to require grandfathered hospitals-within-hospitals to continue to operate under the same terms and conditions that were in place on September 30, 1995 (for example, adding beds). These commenters believed that the adoption of this proposal could result in a decertification of a number of LTCHs, thus depriving Medicare beneficiaries of specialized services and unique programs. They asserted that CMS is requiring these grandfathered hospitals-within-hospitals to either reverse their previously approved changes or lose their certification, which would retroactively reverse prior governmental approvals of LTCH changes. The commenters further asserted that there is no good reason to treat these hospitals any differently from other providers participating in the Medicare program, a practice that the commenters believed would result in inequitable treatment of patients as well as employees. Furthermore, the commenters expressed concern that the proposed effective date timeframe for implementation (that is, 60 days) is too short for purposes of implementing this proposed change because it would not allow adequate time for providers to undo previous changes.

Response: We have reviewed the commenters' concerns with regard to our proposal to require ''grandfathered'' hospitals-within-hospitals to continue to operate under the same terms and conditions that were in place on September 30, 1995. We understand the commenters' concern that adoption of this change as proposed could adversely impact some grandfathered hospitals-within-hospitals that, over the years, have made changes to the terms and conditions under which they operate.

After careful consideration of the comments, we have decided to revise § 412.22(f) to state that if a hospital-within-a-hospital was excluded from the IPPS under the provisions of § 412.22(f) on or before September 30, 1995, and at that time occupied space in a building also used by another hospital or in one or more buildings located on the same campus as buildings used by another hospital, the provisions of § 412.22(e) do not apply to the hospital as long as the hospital meets either of two conditions: First, under § 412.22(f)(1), the hospital continues to operate under the same terms and conditions, including the number of beds and square footage considered to be part of the hospital for purposes of Medicare participation and payment, in effect on September 30, 1995. Second, under § 412.22(f)(2) a hospital that changed the terms and conditions under which it operates after September 30, 1995 but before October 1, 2003, may continue in its grandfathered status if it continues to operate under the same terms and conditions, including the number of beds and square footage considered to be part of the hospital for purposes of Medicare participation and payment, in effect on September 30, 2003. The second condition was added in recognition of commenters who suggested that hospitals be held harmless for past changes in their terms and conditions of operation. We note that any changes occurring on or after October 1, 2003, including changes in number of beds or square footage, could lead to a loss of grandfathered status.

We want to reiterate that, in establishing grandfathering provisions, our general intent has been to protect existing hospitals from the potentially adverse impact of recent, more specific regulations that we now believe to be essential to the goals of the Medicare program. However, a hospital that continues to be excluded from the IPPS through grandfathered status may wish to alter the terms and conditions that were in effect either on September 30, 1995, or after October 1, 2003, as provided in revised § 412.22(h). In that circumstance, in order to continue being paid as a hospital excluded from the IPPS, the hospital would need to comply with the general hospital-within-a-hospital requirements set forth in § 412.22(e).

We plan to review the issue of whether further revisions to this regulation should be made to allow more changes in operation by grandfathered hospital-within-hospitals, and welcome specific suggestions on this issue.

C. Clarification of Classification Requirements for LTCHs

Under § 412.23(e)(2), to qualify to be excluded from the IPPS as a LTCH and to be paid under the LTCH PPS, a hospital must have an average Medicare length of stay of greater than 25 days (which includes all covered and

noncovered days of stay for Medicare patients) as calculated under the criteria of § 412.23(e)(3). In calculating this average Medicare inpatient length of stay, data from the hospital's most recently filed cost report are used to make this determination. However, if the hospital has not yet filed a cost report or if there is an indication that the most recently filed cost report does not accurately reflect the hospital's current Medicare average length of stay, data from the most recent 6-month period are used.

Our interpretation of § 412.23(e)(3)(ii) and (e)(3)(iii) was to allow hospitals that submit data for purposes of exclusion from the IPPS to use a period of at least 5 months of the most recent data from the preceding 6-month period. This longstanding policy interpretation was necessary in order to comply with the time requirement in § 412.22(d) that specifies that, for purposes of the IPPS, status is determined at the beginning of each cost reporting period and is effective for the entire cost reporting period. Therefore, in the May 19, 2003 proposed rule, we proposed to revise §§ 412.23(e)(3)(ii) and (iii) to reflect our longstanding interpretation of the regulations.

Comment: One commenter suggested that we clarify the source of our data for computing the average length of stay for purposes of designation as a LTCH.

Response: Although we did not propose any policy change regarding the average length of stay calculation, we did describe the data source for this calculation, which is set forth at § 412.23(e)(3). Therefore, we will take this opportunity to correct an inadvertent misstatement of the data source for this calculation and clarify present data collection procedures. In the proposed rule, we stated that we relied on data from a ''. . . hospital's most recently filed cost report . . .'' for determining whether it qualified as a LTCH. However, the regulation does not specify or require that the hospital's cost report (Hospital and Hospital Health Care Complex Cost Report, CMS Form 2552–96) be the source of these data used in the determination for LTCH classification. Specifically, the regulation only notes that the calculation requires dividing the total Medicare inpatient days by the total number of Medicare discharges occurring for the *hospital's most recent complete cost reporting period* (§ 412.23(e)(3)). (A detailed description of the designation process is included in the August 30, 2002 IPPS final rule (67 FR 55970 through 55974).)

Prior to the October 1, 2002 implementation of the LTCH prospective payment system, we did rely on data from the most recently *submitted* cost report for this purpose. In addition, the calculation, for purposes of qualifying as a LTCH, was based on total days and discharges for all LTCH inpatients. However, with the implementation of the LTCH PPS, we revised § 412.23(e)(3)(i) to only count total days and discharges for Medicare inpatients (67 FR 55970, August 30, 2002). Presently, we are unable to capture these data on our present cost reporting forms. Therefore, until the cost reporting form is revised, for purposes of the average length of stay calculation, we will be relying upon patient census data extracted from MedPAR files that reflect each LTCH's cost reporting period. Fiscal intermediaries and LTCHs have been informed of this course of action through official agency transmittals, but we want to emphasize that this temporary shift in data sources should have no effect on the evaluation policy set forth in regulations at §§ 412.22(d) and 412.23(e)(3) and the procedures described in the August 30, 2002 final rule.

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

Section 1820 of the Act provides for the establishment of Medicare Rural Hospital Flexibility Programs, under which individual States may designate certain facilities as critical access hospitals (CAHs). Facilities that are so designated and meet the CAH conditions of participation in 42 CFR Part 485, Subpart F, will be certified as CAHs by CMS. Section 1834(g) of the Act states that the amount of payment for outpatient services furnished by a CAH will be the reasonable costs of the CAH in providing these services.

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

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

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

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

To clarify our policies in this area and avoid possible misunderstandings about the scope of the CAH benefit, in the May

19, 2003 proposed rule, we proposed to revise § 413.70(b)(2)(iii) to state that payment to a CAH for outpatient clinical diagnostic laboratory tests will be made on a reasonable cost basis only if the individuals for whom the tests are performed are outpatients of the CAH, as defined in § 410.2, ''and are physically present in the CAH'' at the time the specimens are collected. (We note that, in some cases, the CAH outpatients from whom specimens are collected at the CAH may include individuals referred to the CAH from RHCs or other facilities to receive the tests.) We proposed to further revise this paragraph to state that clinical diagnostic laboratory tests for individuals who do not meet these criteria but meet other applicable requirements will be paid for only in accordance with the provisions of sections 1833(a)(1)(D) and 1833(a)(2)(D) of the Act, that is, payment will be made only on a fee schedule basis. We emphasize that the second proposal does not mean that no payment would be made for clinical diagnostic laboratory tests performed by CAHs that do not meet the revised criteria. On the contrary, such tests would be paid, but on a fee schedule basis. We believe these clarifications are appropriate, as the CAH is not providing CAH services but is acting as an independent laboratory in providing these clinical diagnostic laboratory tests.

Comment: Some commenters stated that a major goal of the Medicare Rural Hospital Flexibility Program, under which reasonable cost payment to CAHs is authorized, is to ensure that isolated rural hospitals have access to critical health care services. The commenters believed that our proposal would undermine that goal by paying less than reasonable cost amounts for certain services. These commenters stated that, in some rural communities, there may be few, or no, reasonable alternatives to having laboratory tests performed by a CAH. Because of this, the commenters believed reasonable cost payment for CAH-performed laboratory tests is warranted, even when specimens are collected in settings other than the CAH from patients who are being registered as CAH patients for the sole purpose of generating higher Medicare payment for the tests.

Response: We agree that an important goal of the CAH legislation is to pay on a reasonable cost basis for services that CAHs provide in their facilities to their inpatients and outpatients. However, we do not believe that legislation can or should be read so broadly as to authorize payment on a reasonable cost basis for laboratory services to patients who do not come to the CAH for those services, but receive them in other settings, including settings in which coverage for the services is available. We also do not agree that because the CAH may be one of only a few sources of laboratory services that the CAH should therefore be paid a higher amount for those services than would otherwise be the case. Therefore, we are not making any change to our proposal based on this comment.

Comment: Several commenters stated that even when a sample is collected outside a CAH, the cost of processing in a CAH laboratory is incurred by the CAH. Because of this circumstance, the commenters recommended that payment be based on the payment method applicable to the site where the processing is done, so that payment for laboratory tests processed at a CAH would be paid on a reasonable cost basis, not under the fee schedule.

Response: We believe the approach recommended by these commenters could create an inappropriate incentive to CAHs to expand their testing activities far beyond their normal service areas, in order to gain cost reimbursement for patients who have no other connection with the CAH other than having a specimen processed by the CAH. In some cases, this could result in payment being made on a cost basis for laboratory services to patients residing in suburban or even urban areas where there is no shortage of qualified laboratories. Such a result would only inappropriately increase payment to CAHs and create market distortions, because non-CAH laboratories performing exactly the same services may be paid substantially less for them. Therefore, we are not adopting this recommendation.

Comment: One commenter agreed with our proposal as it applies to laboratory specimens drawn in health care providers or suppliers other than CAHs, such as SNFs or RHCs, but recommended that we allow reasonable cost payment for clinical diagnostic laboratory tests on specimens drawn in physician clinics that are located in close proximity to the CAH, if the CAH owns the clinic and supplies the personnel who collect the specimens.

Response: While we considered this suggestion, we are not adopting it. A clinic of the type described by the commenter is not a part of the CAH, but is a physician office. We see no basis for treating such a non-CAH setting differently from other non-CAH facilities (such as RHCs) that are similarly owned and located. In the case of an ambulatory patient being seen in a physician office located in close proximity to the CAH, we do not believe it is unreasonable to expect the patient to go to the CAH for the laboratory service as he or she would for therapy or any other CAH outpatient service. Alternatively, the specimen may be collected during the physician visit and payment could be made to the CAH under the laboratory benefit, generally on a fee schedule basis.

Comment: Some commenters stated that the proposed revision is not a clarification but a change from past policy.

Response: We disagree with the commenter, but we do recognize from the questions raised on the issue that there has been some confusion about the policy among rural facilities. To clarify the agency policy in this area and ensure that all relevant issues are publicly noted, we set forth the clarification through notice and comment rulemaking procedures rather than through other processes, such as a program memorandum, a set of responses to ''frequently asked questions,'' or other document.

Comment: One commenter stated that it is inappropriate for proposed changes to CAH payment to be published in the proposed IPPS regulation. The commenter recommended that if changes are to be made to the payment methodology for those facilities excluded from the IPPS rule, they should be published separately in the **Federal Register**, not in a proposed rule that would not normally be reviewed by officials associated with CAHs.

Response: The IPPS proposed and final rules are published on an established and regular annual cycle and have been read for many years by a large health care population, including national, State, and local hospital associations as well as individual hospitals, including hospitals paid under the reasonable cost payment system as well as those paid under the IPPS. Because we recognize this as an important tool for disseminating information, we have used the IPPS publication in order to implement several major payment issues relating to CAHs. For example, changes in the CAH payment rules in § 413.70 were included in the IPPS final rule published on August 1, 2002 (67 FR 49982) and the IPPS final rule published on August 1, 2001 (66 FR 39828). We believe this is an appropriate vehicle in providing the information necessary to allow the CAHs access to the information they need to continue to participate knowledgeably in the Medicare program. In fact, we received over 40 comments on the provision alone.

Comment: Some commenters recommended that we withdraw our proposal because reasonable cost payment for clinical diagnostic laboratory tests on specimens collected in non-CAH settings can be an important revenue source for CAHs and yet would generate only a small amount of additional cost to the Medicare program.

Response: For the reasons stated above and in the preamble to the proposed rule, we do not believe it is appropriate to pay on a reasonable cost basis for these laboratory tests. Moreover, doing so might create an unintended incentive for laboratories processing a substantial volume of tests to affiliate with CAHs, in order to obtain the higher level of payment for tests on individuals who are only nominally patients of the CAH. Therefore, we are not adopting this recommendation.

Comment: Some commenters stated that beneficiaries, particularly frail, elderly individuals residing in remote rural areas, could be inconvenienced by our proposed clarification because they would now be required to travel to the CAH to obtain laboratory services payable on a reasonable cost basis. These commenters expressed concern that frail, elderly patients confined to nursing homes could be required by this policy to travel to CAHs to obtain needed laboratory tests.

Response: Under our proposed clarification, Medicare would not deny payment for medically necessary clinical diagnostic laboratory tests that the CAH performs on specimens collected from patients in non-CAH locations. On the contrary, clinical diagnostic laboratory tests performed by CAHs on such specimens would be paid under the same conditions as would apply to such tests furnished by an independent laboratory. In such a case, a CAH would be providing independent laboratory services and generally would be paid under the laboratory fee schedule.

Regarding the concern about the difficulty of travel for some beneficiaries, we believe it is an incorrect assumption that beneficiaries in rural areas will not have specimens collected in their homes or other locations if the CAH is not paid on a cost basis for the collection and travel. If it is medically necessary for the specimen to be collected in the patient's home, the laboratory benefit under Medicare Part B will pay the specimen collection fee (currently $3 per specimen), plus a separate travel allowance (currently at least 75 cents per mile where the average round trip is more than 20 miles) for employees of independent, mobile or hospital-based laboratories to travel to the beneficiary's home. These payments are in addition to payment for performing the tests. (For further details on how specimen collection and travel fees are calculated, see CMS Transmittal AB–98–33, Change Request #526, dated July 1998; this transmittal is available on the CMS Web site at *www.cms.hhs.gov.*) In many cases, the laboratories collect blood specimens in batches or groups of beneficiaries residing in neighboring areas. This can make the technicians' trips to beneficiaries' residences more cost-effective.

In addition to laboratories, home health agencies that have laboratory provider numbers can perform blood draws at a beneficiary's residence and bill Medicare under the laboratory benefit, using the appropriate codes for specimen collection and travel. Agencies would be reimbursed the $3 specimen collection fee, plus travel costs determined by the Medicare contractor.

It is also important to note that home health agencies with laboratory provider numbers may conduct some of the less complex blood tests themselves, receive the collection and travel fee, and receive a fee through the laboratory benefit for performing the tests. These are called the Clinical Laboratory Improvement Amendments (CLIA)-waived tests, and, among others, include: glucose (blood sugar levels for diabetic patients), fructosamine (also checks blood sugar levels but over longer period of time), hemoglobin (tests hemoglobin levels for patients with anemia), urine dip stick (tests urine for a variety of diseases/infections), and cholesterol/triglyceride (checks for lipid levels for patients with cardiovascular disease) tests.

A variety of other providers can draw blood at a beneficiary's home, often in conjunction with other services necessitating the laboratory tests. For example, while a physician conducts a home visit for evaluation and management, the physician may also draw a blood specimen. If the physician meets applicable requirements under the laboratory benefit, he or she may receive an additional payment for the specimen collection.

The physician also can arrange for a nurse practitioner, physician assistant, or clinical nurse specialist to conduct a home visit and draw blood when they examine the beneficiary. These clinicians are reimbursed at a rate equal to 85 percent of the physician fee schedule for a home visit, and if all applicable billing requirements are met, they are also paid specimen collection and travel fees.

Regarding tests for nursing home patients, we note that if a CAH furnishes laboratory services to a beneficiary in an SNF stay covered by Part A, nonemergency diagnostic laboratory tests—regardless of whether furnished by the SNF directly or under an arrangement with the CAH—would be included within the SNF's bundled PPS per diem payment for the covered stay itself. If a CAH furnishes laboratory services to a beneficiary in an SNF stay not covered by Part A (for example, Part A benefits exhausted; no prior qualifying hospital stay; SNF level of care requirements not met), the SNF consolidated billing restrictions do not apply. However, if the SNF nonetheless elects to bill for such a beneficiary's laboratory services, section 1888(e)(9) of the Act provides that an SNF's Part B bills are to be paid in accordance with the fee schedule that applies to the particular item or service being billed.

In the case of beneficiaries in nursing homes, patients are already under the care of an institution staffed with registered nurses, licensed practical nurses, and nursing assistants, and other health care workers who are presumably well-trained in collecting specimens for analysis, and the nursing homes are already being paid, by Medicare, Medicaid, private insurers, or other means for caring for the patient. Under these circumstances, it would not seem unreasonable to expect the nursing home to take responsibility for collecting the specimens.

Because of the many ways in which specimen collection and travel are payable under Medicare, we do not expect beneficiaries to face reduced access to services under this proposal. We specifically reject the claims made by several commenters that beneficiaries would be able to obtain needed laboratory services only by traveling to the CAH to obtain them.

Comment: Some commenters took exception to the preamble statements that allowing cost reimbursement for laboratory tests on specimens obtained by CAH personnel in non-CAH settings would duplicate existing coverage, create confusion for beneficiaries, and add to the costs of care furnished to Medicare patients. Regarding the costs of care, the commenters stated that because clinical diagnostic laboratory tests are not subject to deductible or coinsurance liability under Medicare, there would be no increase in out-of-pocket costs for beneficiaries.

Response: Regarding duplication of coverage, we have explained in a response to an earlier comment the many ways in which Medicare now pays for specimen collection fees and

travel costs. Given this payment provision, adding another, more expensive payment option for the services would duplicate existing coverage without providing any benefit to anyone other than the operators of the CAHs. Despite the commenters' claims to the contrary, we continue to believe patients under the care of one provider (such as a SNF or RHC) might have questions as to why personnel from another provider are coming in to perform functions that could be performed by staff of the facility in which they are being treated. Finally, while there is no deductible or coinsurance liability associated with laboratory services, paying for services on a reasonable cost basis rather than on a fee schedule basis will ultimately drive up the cost of laboratory care provided under Medicare, increasing costs for taxpayers and contributing to general health care cost increases. To the extent Medicare Part B premiums will increase in the future because of current spending rises, we believe adopting the policy recommended by commenters would increase out-of-pocket costs for beneficiaries as well as for all other taxpayers.

Comment: One commenter asked whether the proposed clarification of our policy on payment for clinical diagnostic laboratory tests would be applied prospectively only, or also retroactively.

Response: Although this proposal represents a clarification of policy, we recognize that this policy has not been well understood in all areas. Therefore, we do not plan to direct Medicare contractors to routinely reopen and review past claims for compliance.

After full consideration of public comments on these issues as summarized above, we are adopting our proposed changes to § 413.70 as final without change.

E. Technical Change

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

We did not receive any comments on this proposal and, therefore, are adopting the proposed technical change as final.

VII. MedPAC Recommendations

We are required by section 1886(e)(4)(B) of the Act to respond to MedPAC's IPPS recommendations in our annual IPPS rules. We have reviewed MedPAC's March 1, 2003 ''Report to the Congress: Medicare Payment Policy'' and have given it careful consideration in conjunction with the policies set forth in this document. For further information relating specifically to the MedPAC report or to obtain a copy of the report, contact MedPAC at (202) 653–7220, or visit MedPAC's Web site at: *http://www.medpac.gov.*

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

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

Response: After reevaluation of this recommendation, in this final rule we are expanding the postacute care transfer policy to include 21 additional DRGs for FY 2004, although we are removing 2 DRGs from the current list. A thorough discussion of this provision, including a summary of MedPAC's analysis, can be found at section IV.A.3. of this preamble.

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

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

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

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

Response: We define the labor-related share to include costs that are likely related to, influenced by, or vary with local labor markets, even if they could be purchased in a national market. Since the implementation of the IPPS, the labor-related share has been determined by adding together the cost weights from categories in the hospital market basket that are influenced by local labor markets. When the hospital market basket weights are updated or rebased, the labor-related share is updated. The estimate of the labor-related share using the most recently revised and rebased hospital market basket (1997-based) is 72.495 percent.

In the August 1, 2002 IPPS final rule, we elected to continue to use 71.066 percent as the labor-related share applicable to the standardized amounts (67 FR 50041). At that time, we indicated that we would conduct further analysis to determine the most appropriate methodology for the labor-related share. Again, in the May 19, 2003 proposed rule, we did not propose to use the updated labor-related share for FY 2004 because we have not yet completed our research into the appropriateness of this updated measure. Specifically, we continue to review the labor-related share in two ways. First, we are performing

regression analysis with the expectation that it would help give an alternative indication of the labor-related share. Second, we continue to reevaluate the methodology we currently use for determining the labor-related share using the hospital market basket.

Our regression analysis is an attempt to explain the variation in operating cost per case for a given year using many different explanatory variables, such as case-mix, DSH status, and ownership type. We described this methodology and some of our initial results in the May 9, 2002 **Federal Register** (67 FR 31447–31479). However, the findings from the regressions continue to be both difficult to explain and inconsistent with the underlying cost data. Thus, we believe at this point that the regression results are not robust enough to support changing the current labor-related share measurement.

We also continue to explore all options for alternative data or methodology for determining the labor-related share using the hospital market basket. We have researched various alternative data sources for use in further breaking down the cost categories in the market basket and have evaluated alternative methodologies to determine the feasibility of separating the labor-related portion or the portion that varies with local labor markets from the portion that does not vary. While each of these alternatives has strengths and weaknesses, it is not clear at this point that any one alternative data source or methodology is superior to the current methodology. We will continue to research these alternatives.

Comment: Several commenters suggested the labor share should only be adjusted by those costs (wages and salaries and benefits) that are reflected in the wage index survey. Commenters suggested that CMS should consider reducing the labor-related share for rural hospitals or having different labor shares by geographic location.

Response: We define the labor-related share to include all costs that are likely related to, influenced by, or vary with local labor markets, even if they could be purchased in a national market. This differs from the hospital wage index survey, which only collects direct labor and patient-related contract costs. Using only those direct labor costs reflected in the wage index survey would mean redefining the term labor-related share and would likely leave out many of the other costs that do vary with the local labor market.

As indicated in prior rules, we continue to research alternative methodologies for determining the labor-related share, including reexamining the labor portion of each of the individual market basket categories. However, due to a lack of one definitive data source, our analysis is still preliminary and, therefore, we will continue to use 71.066 percent as the labor-related share applicable to the standardized amounts while we conduct further analysis to determine the most appropriate methodology for determining the labor-related share.

It is currently our policy to use a national labor-related share to apply to the national PPS standardized amounts. This policy has been in effect since the implementation of the IPPS in 1983. We will consider the commenters' recommended alternative approaches, such as different labor shares for urban and rural hospitals or labor shares that vary by more detailed geographic area, as part of our ongoing research efforts. However, until we have completed our research, we will continue to use only a national labor-related share, which is currently 71.066 percent and was calculated from the 1992-based market basket.

Comment: One commenter believed that we should examine each of the categories currently included in the labor share and determine which portion of that category was actually labor-related or varied with the local labor market.

Response: We agree with the commenter that it is important that the labor-related portion of the market basket include only those categories that are actually labor-related or vary with the local labor market. As we indicated in the May 19, 2003 rule, we are continuing to explore all options for accounting for the labor-related share, including reexamining each of the categories included in the current labor share (particularly professional fees, postage, and other labor-intensive services) to make sure the labor share represents only those costs that do vary with the local labor market. However, our preliminary research has indicated that much of the data needed to break out details from each of the current market basket categories into labor and nonlabor-related components are not readily available on a national basis. We will continue to research various data sources for this information and will update the labor share as needed once our research is complete.

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

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

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

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

VIII. Other Required Information

A. Requests for Data From the Public

In order to respond promptly to public requests for data related to the prospective payment system, we have established a process under which commenters can gain access to raw data on an expedited basis. Generally, the data are available in computer tape or cartridge format; however, some files are available on diskette as well as on the Internet at *http://www.hcfa.gov/stats/pufiles.htm.* In the May 19, 2003 proposed rule, we published a list of data files that are available for purchase from CMS or that may be downloaded from the Internet free of charge (68 FR 27226 through 27228).

B. Collection of Information Requirements

This final rule directly does not impose any collection and recordkeeping requirements. Consequently, it does not need to be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

List of Subjects

42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare,

Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 413

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

■ For the reasons stated in the preamble of this final rule, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as follows:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

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

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

■ 2. Section 412.4 is amended by—
■ A. Revising paragraphs (b), (c), and (d).
■ B. In paragraph (f)(1), revising the reference ''paragraph (b)(1) or (c)'' to read ''paragraph (b) or (c)''.

The revisions read as follows:

§ 412.4 Discharges and transfers.

* * * * *

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

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

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

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

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

(2) To a skilled nursing facility.

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

(d) *Qualifying DRGs.* For purposes of paragraph (c) of this section, the qualifying DRGs must meet the following criteria for both of the 2 most recent fiscal years for which data are available:

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

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

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

(4) If the DRG is one of a paired DRG based on the presence or absence of a comorbidity or complication, one of the DRGs meets the criteria under specified paragraphs (d)(1) through (d)(3) of this section.

(5) To initially qualify, the DRG meet the criteria specified in paragraphs (d)(1) through (d)(4) of this section and must have a decline in the geometric mean length of stay for the DRG during the most recent 5-year period of at least 7 percent. Once a DRG initially qualifies, the DRG is subject to the criteria specified under paragraphs (d)(1) through (d)(4) of this section for each subsequent fiscal year.

* * * * *

■ 3. Section 412.22 is amended by:
■ A. Republishing the introductory text of paragraph (e)(5) and revising the first sentence of paragraph (e)(5)(i).
■ B. Revising paragraph (f).

The revisions read as follows:

§ 412.22 Excluded hospitals and hospital units: General rules.

* * * * *

(e) * * *

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

(i) The hospital performs the basic functions specified in §§ 482.21 through 482.27, 482.30, 482.42, 482.43, and 482.45 of this chapter through the use of employees or under contracts or other agreements with entities other than the hospital occupying space in the same building or on the same campus, or a third entity that controls both hospitals.

* * *

(f) *Application for certain hospitals.* If a hospital was excluded from the prospective payment systems under the provisions of this section on or before September 30, 1995, and at that time occupied space in a building also used by another hospital, or in one or more buildings located on the same campus as buildings used by another hospital, the criteria in paragraph (e) of this section do not apply to the hospital as long as the hospital either—

(1) Continues to operate under the same terms and conditions, including the number of beds and square footage considered to be part of the hospital for purposes of Medicare participation and payment in effect on September 30, 1995; or

(2) In the case of a hospital that changes the terms and conditions under which it operates after September 30, 1995, but before October 1, 2003, continues to operate under the same terms and conditions, including the number of beds and square footage considered to be part of the hospital for purposes of Medicare participation and payment in effect on September 30, 2003.

* * * * *

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

§ 412.23 Excluded hospitals: Classifications.

* * * * *

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

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

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

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

* * * * *

§ 412.25 [Amended]

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

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

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

* * * * *

(a) *Eligibility criteria.* * * *

(3) The DRG prospective payment rate otherwise applicable to discharges

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

■ 7. Section 412.105 is amended by—

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

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

■ C. Revising paragraph (b).

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

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

■ F. Revising paragraph (f)(1)(x).

The revisions and additions read as follows:

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

* * * * *

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

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

(2) Beds in excluded distinct part hospital units;

(3) Beds otherwise countable under this section used for outpatient observation services, skilled nursing swing-bed services, or ancillary labor/delivery services;

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

(5) Custodial care beds;

* * * * *

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

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

* * * * *

(x) An urban hospital that establishes a new residency program (as defined in § 413.86(g)(13) of this subchapter), or has an existing residency program, with a rural track (or an integrated rural track) may include in its FTE count residents in those rural tracks in accordance with the applicable provisions of § 413.86(g)(12) of this subchapter.

* * * * *

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

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

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

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

(A) Beds in excluded distinct part hospital units;

(B) Beds otherwise countable under this section used for outpatient observation services, skilled nursing swing-bed services, or ancillary labor/delivery services; and

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

* * * * *

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

(4) *Second computation.* * * *

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

* * * * *

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

§ 412.112 Payments determined on a per case basis.

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

* * * * *

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

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

§ 412.116 Method of payment.

* * * * *

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

* * * * *

■ 10. Section 412.230 is amended by—

■ A. Republishing paragraph (e)(2) introductory text.

■ B. Revising paragraph (e)(2)(ii)(A).

The revisions read as follows:

§ 412.230 Criteria for an individual hospital seeking redesignation to another rural area or an urban area.

* * * * *

(e) *Use of urban or other rural area's wage index.* * * *

(2) *Appropriate wage data.* For a wage index change, the hospital must submit appropriate wage data as follows:

* * * * *

(ii) * * *

(A) For hospital-specific data, the hospital must provide a weighted 3-year average of its average hourly wages using data from the CMS hospital wage survey used to construct the wage index in effect for prospective payment purposes. However, for the limited purpose of qualifying for geographic reclassification based on wage data from cost reporting periods beginning prior to FY 2000, a hospital may request that its wage data be revised if the hospital is 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 its wage index.

* * * * *

■ 11. Section 412.278 is amended by revising paragraph (f)(2)(i) to read as follows:

§ 412.278 Administrator's review.

* * * * *

(f) * * *

(2) The Administrator issues a decision in writing to the party with a copy to CMS—

(i) Not later than 90 days following receipt of the party's request for review, except the Administrator may, at his or her discretion, for good cause shown, toll such 90 days; or

* * * * *

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; OPTIONAL PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

■ 1. The authority citation for part 413 is revised to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395hh, 1395rr, 1395tt, and 1395ww).

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

§ 413.70 Payment for services of a CAH.

* * * * *

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

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

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

* * * * *

■ 3. Section 413.85 is amended by—

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

■ B. Adding a new paragraph (g)(3).

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

The addition and revision read as follows.

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

* * * * *

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

* * * * *

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

* * * * *

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

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

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

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

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

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

* * * * *

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

* * * * *

■ 4. Section 413.86 is amended by—

■ A. Under paragraph (b)—

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

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

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

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

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

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

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

■ F. Revising paragraph (g)(4)(iv).

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

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

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

■ J. Revising paragraph (g)(7).

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

■ L. Revising paragraph (g)(12)(i).

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

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

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

■ P. Revising paragraph (g)(12)(iii).

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

■ R. Revising paragraph (g)(12)(iv)(A).
■ S. Revising paragraph (g)(12)(iv)(B)(*1*).
■ T. Redesignating paragraphs (i) and (j) as paragraphs (j) and (k), respectively, and adding a new paragraph (i).

The additions and revisions read as follows:

§ 413.86 Direct graduate medical education payments.

* * * * *

(b) *Definitions.* * * *

''Community support'' means funding that is provided by the community and generally includes all non-Medicare sources of funding (other than payments made for furnishing services to individual patients), including State and local government appropriations. Community support does not include grants, gifts, and endowments of the kind that are not to be offset in accordance with section 1134 of the Act.

* * * * *

''Medicare GME affiliated group'' means—

(1) Two or more hospitals that are located in the same urban or rural area (as those terms are defined in § 412.62(f) of this subchapter) or in a contiguous area and meet the rotation requirements in paragraph (g)(7)(ii) of this section.

(2) Two or more hospitals that are not located in the same or in a contiguous urban or rural area, but meet the rotation requirement in paragraph (g)(7)(ii) of this section, and are jointly listed—

(i) As the sponsor, primary clinical site or major participating institution for one or more programs as these terms are used in the most current publication of the *Graduate Medical Education Directory;* or

(ii) As the sponsor or is listed under ''affiliations and outside rotations'' for one or more programs in operation in *Opportunities, Directory of Osteopathic Postdoctoral Education Programs.*

(3) Two or more hospitals that are under common ownership and, effective for all Medicare GME affiliation agreements beginning July 1, 2003, meet the rotation requirement in paragraph (g)(7)(ii) of this section.

''Medicare GME affiliation agreement'' means a written, signed, and dated agreement by responsible representatives of each respective hospital in a Medicare GME affiliated group, as defined in this section, that specifies—

(1) The term of the Medicare GME affiliation agreement (which, at a minimum is one year), beginning on July 1 of a year;

(2) Each participating hospital's direct and indirect GME FTE caps in effect prior to the Medicare GME affiliation;

(3) The total adjustment to each hospital's FTE caps in each year that the Medicare GME affiliation agreement is in effect, for both direct GME and IME, that reflects a positive adjustment to one hospital's direct and indirect FTE caps that is offset by a negative adjustment to the other hospital's (or hospitals') direct and indirect FTE caps of at least the same amount;

(4) The adjustment to each participating hospital's FTE counts resulting from the FTE resident's (or residents'') participation in a shared rotational arrangement at each hospital participating in the Medicare GME affiliated group for each year the Medicare GME affiliation agreement is in effect. This adjustment to each participating hospital's FTE count is also reflected in the total adjustment to each hospital's FTE caps (in accordance with paragraph (3) of this definition); and

(5) The names of the participating hospitals and their Medicare provider numbers.

* * * * *

''Redistribution of costs'' occurs when a hospital counts FTE residents in medical residency programs and the costs of the program had previously been incurred by an educational institution.

* * * * *

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

* * * * *

(4) * * *

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

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

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

* * * * *

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

* * * * *

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

* * * * *

(vii) Subject to the provisions under paragraph (g)(12) of this section, effective for cost reporting periods beginning on or after April 1, 2000, FTE residents in a rural track program at an urban hospital are included in the urban hospital's rolling average calculation described in paragraph (g)(5) of this section.

* * * * *

(6) * * *

(i) * * *

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

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

* * * * *

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

(i) Each hospital in the Medicare GME affiliated group must submit the Medicare GME affiliation agreement, as defined under paragraph (b) of this section, to the CMS fiscal intermediary servicing the hospital and send a copy to CMS's Central Office no later than July 1 of the residency program year during which the Medicare GME affiliation agreement will be in effect.

(ii) Each hospital in the Medicare GME affiliated group must have a shared rotational arrangement, as defined in paragraph (b) of this section, with at least one other hospital within the Medicare GME affiliated group, and all of the hospitals within the Medicare GME affiliated group must be connected by a series of such shared rotational arrangements.

(iii) During the shared rotational arrangements under a Medicare GME affiliation agreement, as defined in paragraph (b) of this section, more than one of the hospitals in the Medicare GME affiliated group must count the proportionate amount of the time spent by the resident(s) in its FTE resident counts. No resident may be counted in the aggregate as more than one FTE.

(iv) The net effect of the adjustments (positive or negative) on the Medicare GME affiliated hospitals' aggregate FTE

cap for each Medicare GME affiliation agreement must not exceed zero.

(v) If the Medicare GME affiliation agreement terminates for any reason, the FTE cap of each hospital in the Medicare GME affiliated group will revert to the individual hospital's pre-affiliation FTE cap that is determined under the provisions of paragraph (g)(4) of this section.

* * * * *

(12) Subject to the provisions of (i) of this section, an urban hospital that establishes a new residency program, or has an existing residency program, with a rural track (or an integrated rural track) may include in its FTE count residents in those rural tracks, in addition to the residents subject to its FTE cap specified under paragraph (g)(4) of this section. An urban hospital with a rural track residency program may count residents in those rural tracks up to a rural track FTE limitation if the hospital complies with the conditions specified in paragraphs (g)(12)(i) through (g)(12)(vi) of this section.

(i) If an urban hospital rotates residents to a separately accredited rural track program at a rural hospital(s) for two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2000 and before October 1, 2003, or for more than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003, the urban hospital may include those residents in its FTE count for the time the rural track residents spend at the urban hospital. The urban hospital may include in its FTE count those residents in the rural track training at the urban hospital, not to exceed its rural track FTE limitation, determined as follows:

(A) For the first 3 years of the rural track's existence, the rural track FTE limitation for each urban hospital will be the actual number of FTE residents, subject to the rolling average at paragraph (g)(5)(vii) of this section, training in the rural track at the urban hospital.

(B) Beginning with the fourth year of the rural track's existence, the rural track FTE limitation is equal to the product of the highest number of residents, in any program year, who during the third year of the rural track's existence are training in the rural track at the urban hospital or the rural hospital(s) and are designated at the beginning of their training to be rotated to the rural hospital(s) for at least two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2000 and before October 1, 2002, or for more than one-half of the duration of the program effective for cost reporting periods beginning on or after October 1, 2003, and the number of years those residents are training at the urban hospital.

(ii) If an urban hospital rotates residents to a separately accredited rural track program at a rural nonhospital site(s) for two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2000 and before October 1, 2003, or for more than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003, the urban hospital may include those residents in its FTE count, subject to the requirements under paragraph (f)(4) of this section. The urban hospital may include in its FTE count those residents in the rural track, not to exceed its rural track FTE limitation, determined as follows:

(A) For the first 3 years of the rural track's existence, the rural track FTE limitation for each urban hospital will be the actual number of FTE residents, subject to the rolling average specified in paragraph (g)(5)(vii) of this section, training in the rural track at the urban hospital and the rural nonhospital site(s).

(B) * * *

(*1*) * * *

(*i*) The urban hospital and are designated at the beginning of their training to be rotated to a rural nonhospital site(s) for at least two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2000 and before October 1, 2003, or for more than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003; and

* * * * *

(iii) If an urban hospital rotates residents in the rural track program to a rural hospital(s) for less than two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2000 and before October 1, 2003, or for one-half or less than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003, the rural hospital may not include those residents in its FTE count (if the rural track is not a new program under paragraph (g)(6)(iii) of this section, or if the rural hospital's FTE count exceeds that hospital's FTE cap), nor may the urban hospital include those residents when calculating its rural track FTE limitation.

(iv) If an urban hospital rotates residents in the rural track program to a rural nonhospital site(s) for period of time is less than two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2000 and before October 1, 2003, or for one-half or less than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003, the urban hospital may include those residents in its FTE count, subject to the requirements under paragraph (f)(4) of this section. The urban hospital may include in its FTE count those residents in the rural track, not to exceed its rural track limitation, determined as follows:

(A) For the first 3 years of the rural track's existence, the rural track FTE limitation for the urban hospital will be the actual number of FTE residents, subject to the rolling average specified in paragraph (g)(5)(vii) of this section, training in the rural track at the rural nonhospital site(s).

(B) * * *

(*1*) The highest number of residents in any program year who, during the third year of the rural track's existence, are training in the rural track at the rural nonhospital site(s) or are designated at the beginning of their training to be rotated to the rural nonhospital site(s) for a period that is less than two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2002, and before October 1, 2003, or for one-half or less than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003; and

* * * * *

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

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

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

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

(2) *Application.* A hospital must continuously incur costs of direct graduate medical education of residents training in a particular program at a training site since the date the residents first began training in that program in order for the hospital to count the FTE

residents in accordance with the provisions of paragraphs (f) and (g)(4) through (g)(6) and (g)(12) of this section. This rule also applies to providers that are paid for direct GME in accordance with § 405.2468 of this chapter, § 422.270 of this subchapter, and § 413.70.

(3)(i) *Effective date.* Subject to the provisions of paragraph (i)(3)(ii) of this section, payments made in accordance with determinations made under the provisions of paragraphs (i)(1) and (i)(2) of this section will be effective for portions of cost reporting periods occurring on or after October 1, 2003.

(ii) *Applicability for certain hospitals.* With respect to an FTE resident who begins training in a residency program on or before October 1, 2003, and with respect to whom there has been a redistribution of costs or community support determined under the provisions of paragraphs (i)(1) and (i)(2) of this section, the hospital may continue to count the FTE resident until the resident has completed training in that program, or until 3 years after the date the resident began training in that program, whichever comes first.

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

Dated: July 23, 2003.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Dated: July 24, 2003.

Tommy G. Thompson,

Secretary.

[**Editorial Note:** The following Addendum and appendices will not appear in the Code of Federal Regulations.]

Addendum—Schedule of Standardized Amounts Effective With Discharges Occurring on or After October 1, 2003 and Update Factors and Rate-of-Increase Percentages Effective With Cost Reporting Periods Beginning on or After October 1, 2003

I. Summary and Background

In this Addendum, we are setting forth the amounts and factors for determining prospective payment rates for Medicare hospital inpatient operating costs and Medicare hospital inpatient capital-related costs. We are also setting forth rate-of-increase percentages for updating the target amounts for hospitals and hospital units excluded from the IPPS.

For discharges occurring on or after October 1, 2003, except for SCHs, MDHs, and hospitals located in Puerto Rico, each hospital's payment per discharge under the IPPS will be based on 100 percent of the Federal national rate, which will be based on the national adjusted standardized amount. This amount reflects the national average hospital costs per case from a base year, updated for inflation.

SCHs are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal national rate; the updated hospital-specific rate based on FY 1982 costs per discharge; the updated hospital-specific rate based on FY 1987 costs per discharge; or the updated hospital-specific rate based on FY 1996 costs per discharge.

Under section 1886(d)(5)(G) of the Act, MDHs are paid based on the Federal national rate or, if higher, the Federal national rate plus 50 percent of the difference between the Federal national rate and the updated hospital-specific rate based on FY 1982 or FY 1987 costs per discharge, whichever is higher. MDHs do not have the option to use their FY 1996 hospital-specific rate.

For hospitals in Puerto Rico, the payment per discharge is based on the sum of 50 percent of a Puerto Rico rate that reflects base year average costs per case of Puerto Rico hospitals and 50 percent of a blended Federal national rate (a discharge-weighted average of the national large urban and other areas standardized amounts). (See section II.D.3. of this Addendum for a complete description.)

As discussed below in section II. of this Addendum, we are making changes in the determination of the prospective payment rates for Medicare inpatient operating costs for FY 2004. The changes, to be applied prospectively effective with discharges occurring on or after October 1, 2003, affect the calculation of the Federal rates. In section III. of this Addendum, we discuss our changes for determining the prospective payment rates for Medicare inpatient capital-related costs for FY 2004. Section IV. of this Addendum sets forth our changes for determining the rate-of-increase limits for hospitals excluded from the IPPS for FY 2004. Section V. of this Addendum sets forth policies on payment for blood clotting factor administered to hemophilia patients. The tables to which we refer in the preamble of this final rule are presented in section VI. of this Addendum.

II. Changes to Prospective Payment Rates for Hospital Inpatient Operating Costs for FY 2004

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

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

- Updates of 3.4 percent for all areas (that is, the full market basket percentage increase of 3.4 percent);
- An adjustment to ensure the proposed DRG recalibration and wage index update and changes, as well as the add-on payments for new technology, are budget neutral, as provided for under sections 1886(d)(4)(C)(iii) and (d)(3)(E) of the Act, by applying new budget neutrality adjustment factors to the large urban and other standardized amounts;
- An adjustment to ensure the effects of geographic reclassification are budget neutral, as provided for in section 1886(d)(8)(D) of the Act, by removing the FY 2003 budget neutrality factor and applying a revised factor;
- An adjustment to apply the new outlier offset by removing the FY 2003 outlier offsets and applying a new offset.

A. Calculation of Adjusted Standardized Amounts

1. Standardization of Base-Year Costs or Target Amounts

The national standardized amounts are based on per discharge averages of adjusted hospital costs from a base period (section 1886(d)(2)(A) of the Act) or, for Puerto Rico, adjusted target amounts from a base period (section 1886(d)(9)(B)(i) of the Act), updated and otherwise adjusted in accordance with the provisions of section 1886(d) of the Act. The preamble to the September 1, 1983 interim final rule (48 FR 39763) contained a detailed explanation of how base-year cost data (from cost reporting periods ending during FY 1981) were established in the initial development of standardized amounts for the IPPS. The September 1, 1987 final rule (52 FR 33043, 33066) contains a detailed explanation of how the target amounts were determined, and how they are used in computing the Puerto Rico rates.

Sections 1886(d)(2)(B) and (d)(2)(C) of the Act require us to update base-year per discharge costs for FY 1984 and then standardize the cost data in order to remove the effects of certain sources of cost variations among hospitals. These effects include case-mix, differences in area wage levels, cost-of-living adjustments for Alaska and Hawaii, indirect medical education costs, and costs to hospitals serving a disproportionate share of low-income patients.

Under sections 1886(d)(2)(H) and (d)(3)(E) of the Act, in determining payments under the IPPS, the Secretary estimates from time to time the proportion of costs that are wages and wage-related costs. Based on the estimated labor-related share, the standardized amounts are divided into labor-related and nonlabor-related amounts. As discussed in section IV. of the preamble to the August 1, 2002 IPPS final rule, when we revised the market basket in FY 2003, we did not revise the labor share of the standardized amount (the proportion adjusted by the wage index). We consider 71.1 percent of costs to be labor-related for purposes of the IPPS. The average labor share in Puerto Rico is 71.3 percent.

2. Computing Large Urban and Other Area Average Standardized Amounts

Sections 1886(d)(2)(D) and (d)(3) of the Act require the Secretary to compute two average standardized amounts for discharges occurring in a fiscal year: one for hospitals located in large urban areas and one for hospitals located in other areas. In addition, under sections 1886(d)(9)(B)(iii) and (d)(9)(C)(i) of the Act, the average standardized amount per discharge must be determined for hospitals located in large urban and other areas in Puerto Rico. In

accordance with section 1886(b)(3)(B)(i) of the Act, the large urban average standardized amount is 1.6 percent higher than the other area average standardized amount.

Section 402(b) of Pub. L. 108–7 required that, effective for discharges occurring on or after April 1, 2003, and before October 1, 2003, the Federal rate for all IPPS hospitals would be based on the large urban standardized amount. However, for discharges occurring on or after October 1, 2003, the Federal rate will again be calculated based on separate average standardized amounts for hospitals in large urban areas and for hospitals in other areas.

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

As discussed previously, on June 6, 2003, OMB announced revised definitions of MSAs and new definitions of Micropolitan Statistical Areas and Combined Statistical Areas. In order to implement these changes for the IPPS, it is necessary to identify the new area designation for each county and hospital in the country. Because this process will have to be extensively reviewed and verified, we were unable to undertake it before publication of this final rule. Therefore, we are continuing to use MSAs based on OMB's definitions of MSAs prior to June 6, 2003. Based on those definitions, 63 areas meet the criteria to be defined as large urban areas for FY 2004. These areas are identified in Table 4A of section VI. of this Addendum.

3. Updating the Average Standardized Amounts

In accordance with section 1886(d)(3)(A)(iv) of the Act, we are updating the arge urban areas' and the other areas' average standardized amounts for FY 2004 by the full estimated market basket percentage increase for hospitals in all areas, as specified in section 1886(b)(3)(B)(i)(XIX) of the Act. The percentage change in the market basket reflects the average change in the price of goods and services purchased by hospitals to furnish inpatient care. The most recent forecast of the hospital market basket increase for FY 2004 is 3.4 percent. Thus, for FY 2004, the update to the average standardized amounts equals 3.4 percent for hospitals in all areas.

Although the update factors for FY 2004 are set by law, we are required by section 1886(e)(3) of the Act to report to the Congress our initial recommendation of update factors for FY 2004 for both IPPS hospitals and hospitals excluded from the IPPS. Our recommendation on the update factors (which is required by sections 1886(e)(4)(A) and (e)(5)(A) of the Act) is set forth as Appendix B of this final rule.

Comment: One commenter recommended an increase to the market basket that would account for large increases in the costs of malpractice, pensions, health benefits, pharmaceuticals, and new technology that hospitals are facing.

Response: The hospital market basket is structured to measure the change in prices for an exhaustive list of inputs used by hospitals in providing services. The index measures the ''pure'' price change of those inputs and appropriately does not measure changes in quantity or intensity. These nonprice factors include shifts in the skill mix of employees, increased amounts of labor purchased, increased malpractice coverage, the increased use of pharmaceuticals and technology in providing care, and movements toward more or less intensive pharmaceuticals and technology. Nonprice factors such as these may be contributing to the increases in cost that hospitals are currently facing.

In addition, the most recent data available are used to forecast the market basket price changes and are intended to reflect conditions that hospitals will face in the upcoming fiscal year. As it is intended, the hospital market basket measures the national average price increase and will not reflect geographic differences from one geographic area to another. In other words, while one area may see a large surge in the prices of inputs, another area may actually be experiencing much smaller increases in the prices of these inputs. This may also be contributing to the increased costs to which the commenter referred. Therefore, we believe that the market basket is an accurate representation of the national average price increase facing hospitals in providing services, and the 3.4 percent increase for FY 2004 provides an adequate update to hospitals to account for the inflationary increase in costs.

4. Other Adjustments to the Average Standardized Amounts

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

We do not remove the prior year's budget neutrality adjustments for reclassification and recalibration of the DRG weights and for updated wage data because, in accordance with section 1886(d)(4)(C)(iii) of the Act, estimated aggregate payments after the changes in the DRG relative weights and wage index should equal estimated aggregate payments prior to the changes. If we removed the prior year adjustment, we would not satisfy this condition.

Budget neutrality is determined by comparing aggregate IPPS payments before and after making the changes that are required to be budget neutral (for example, reclassifying and recalibrating the DRGs, updating the wage data, and geographic reclassifications). We include outlier payments in the payment simulations because outliers may be affected by changes in these payment parameters. Because the changes to the postacute care transfer policy discussed in section IV.A. of the preamble of this final rule are not budget neutral, we included the effects of expanding this policy to additional DRGs prior to estimating the payment effects of the DRG and wage data changes.

a. Recalibration of DRG Weights and Updated Wage Index—Budget Neutrality Adjustment.—Section 1886(d)(4)(C)(iii) of the Act specifies that, beginning in FY 1991, the annual DRG reclassification and recalibration of the relative weights must be made in a manner that ensures that aggregate payments to hospitals are not affected. As discussed in section II. of the preamble, we normalized the recalibrated DRG weights by an adjustment factor, so that the average case weight after recalibration is equal to the average case weight prior to recalibration. However, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payments to hospitals are affected by factors other than average case weight. Therefore, as we have done in past years, we are making a budget neutrality adjustment to ensure that the requirement of section 1886(d)(4)(C)(iii) of the Act is met.

Section 1886(d)(3)(E) of the Act requires us to update the hospital wage index on an annual basis beginning October 1, 1993. This provision also requires us to make any updates or adjustments to the wage index in a manner that ensures that aggregate payments to hospitals are not affected by the change in the wage index.

Section 4410 of Pub. L. 105–33 provides that, for discharges on or after October 1, 1997, the area wage index applicable to any hospital that is not located in a rural area may not be less than the area wage index applicable to hospitals located in rural areas in that State. This provision is required by section 4410(b) of Pub. L. 105–33 to be budget neutral. Therefore, we include the effects of this provision in our calculation of the wage update budget neutrality factor.

In addition, we are required to ensure that any add-on payments for new technology under section 1886(d)(5)(K) of the Act are budget neutral. As discussed in section II.E. of this final rule, we are approving two new technologies for add-on payments in FY 2004. We estimate that the total add-on payments for these new technologies will be $14.4 million for FY 2004.

To comply with the requirement that DRG reclassification and recalibration of the relative weights be budget neutral, and the requirement that the updated wage index be budget neutral, we used FY 2002 discharge data to simulate payments and compared aggregate payments using the FY 2003

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

Based on this comparison, we computed a budget neutrality adjustment factor equal to 1.005522. We also adjust the Puerto Rico-specific standardized amounts for the effect of DRG reclassification and recalibration. We computed a budget neutrality adjustment factor for Puerto Rico-specific standardized amounts equal to 1.001661. These budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the FY 2003 budget neutrality adjustments.

In addition, we are applying these same adjustment factors to the hospital-specific rates that are effective for cost reporting periods beginning on or after October 1, 2003. (See the discussion in the September 4, 1990 final rule (55 FR 36073).)

b. Reclassified Hospitals—Budget Neutrality Adjustment.—Section 1886(d)(8)(B) of the Act provides that, effective with discharges occurring on or after October 1, 1988, certain rural hospitals are deemed urban. In addition, section 1886(d)(10) of the Act provides for the reclassification of hospitals based on determinations by the MGCRB. Under section 1886(d)(10) of the Act, a hospital may be reclassified for purposes of the standardized amount or the wage index, or both.

Under section 1886(d)(8)(D) of the Act, the Secretary is required to adjust the standardized amounts so as to ensure that aggregate payments under the IPPS after implementation of the provisions of sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act are equal to the aggregate prospective payments that would have been made absent these provisions. To calculate this budget neutrality factor, we used FY 2002 discharge data to simulate payments, and compared total IPPS payments prior to any reclassifications to total IPPS payments after reclassifications. Based on these simulations, we are applying an adjustment factor of 0.992026 to ensure that the effects of reclassification are budget neutral.

The adjustment factor is applied to the standardized amounts after removing the effects of the FY 2003 budget neutrality adjustment factor. We note that the FY 2004 adjustment reflects FY 2004 wage index and standardized amount reclassifications approved by the MGCRB or the Administrator, and the effects of section 1886(d)(10)(D)(v) of the Act to extend wage index reclassifications for 3 years.

c. Outliers.—Section 1886(d)(5)(A) of the Act provides for payments in addition to the basic prospective payments, for ''outlier'' cases involving extraordinarily high costs. To qualify for outlier payments, a case must have costs above a fixed-loss cost threshold amount (a dollar amount by which the costs of a case must exceed payments in order to qualify for outlier payment). To determine whether the costs of a case exceed the fixed-loss threshold, a hospital's cost-to-charge ratio is applied to the total covered charges for the case to convert the charges to costs. Payments for eligible cases are then made based on a marginal cost factor, which is a percentage of the costs above the threshold.

Under section 1886(d)(5)(A)(iv) of the Act, outlier payments for any year must be projected to be not less than 5 percent nor more than 6 percent of total operating DRG payments plus outlier payments. Section 1886(d)(3)(B) of the Act requires the Secretary to reduce the average standardized amounts by a factor to account for the estimated proportion of total DRG payments made to outlier cases. Similarly, section 1886(d)(9)(B)(iv) of the Act requires the Secretary to reduce the average standardized amounts applicable to hospitals in Puerto Rico to account for the estimated proportion of total DRG payments made to outlier cases.

i. FY 2004 outlier fixed-loss cost threshold. In the August 1, 2002 IPPS final rule (67 FR 50124), we established a threshold for FY 2003 that was equal to the prospective payment rate for the DRG, plus any IME and DSH payments and any additional payments for new technology, plus $33,560. The marginal cost factor (the percent of costs paid after costs for the case exceed the threshold) was 80 percent.

In the May 19, 2003 proposed rule, we proposed to establish a fixed-loss cost outlier threshold equal to the prospective payment rate for the DRG plus any IME and DSH payments, and any add-on payments for new technology, plus $50,645. However, we also stated that the final FY 2004 threshold was likely to be different from that proposed threshold, as a result of any changes to outlier policy subsequent to a proposed rule published on March 5, 2003. Subsequently, we published three central changes to our outlier policy in a final rule on June 9, 2003.

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

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

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

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

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

We are continuing to use the 2-year average annual rate of change in charges per case to establish the FY 2004 threshold. The 2-year average annual rate of change in charges per case from FY 2000 to FY 2001, and from FY 2001 to FY 2002, was 12.5978 percent annually, or 26.8 percent over 2 years.

In the past, we used cost-to-charge ratios from the Provider Specific File, and multiplied these ratios by the charges for each case to estimate costs. After the changes in policy enacted by the final outlier rule this year, it is necessary to calculate more recent cost-to-charge ratios because fiscal intermediaries will now use the latest tentatively settled cost report instead of the latest settled cost report to determine a hospital's cost-to-charge ratio. Therefore, to approximate using the latest tentative settled cost reports in our estimate of the FY 2004 outlier threshold, we calculated updated cost-to-charge ratios using the following three steps: for each hospital, we matched charges-per-case to costs-per-case from the most recent cost reporting year; we then divided each hospital's costs by its charges to calculate the cost-to-charge ratio for each hospital; and we multiplied charges from each case in the FY 2002 MedPAR (inflated to FY 2004) by this cost-to-charge ratio to calculate the cost per case. The final outlier rule also established the policy that fiscal intermediaries are to reconcile outlier payments at the time of cost report final settlement if a hospital's actual operating or capital cost-to-charge ratios are found to be substantially different from the cost-to-charge ratios used during that time period to make outlier payments.

However, it is difficult to project which hospitals will be subject to reconciliation of their outlier payments using available data. For example, for most hospitals, the latest available cost data are from FY 2000. In addition, the amount of fiscal intermediary resources necessary to undertake reconciliation will ultimately influence the number of hospitals reconciled. Without actual experience with the reconciliation process, it is difficult to predict the number of hospitals that will be reconciled. However, as later data become available, particularly data reflecting hospital's latest tentative settled cost-to-charge ratios, we will be better able to assess the appropriate number of hospitals to be reconciled.

Based on our analysis of hospitals that have been consistently overpaid recently for outliers, we have identified approximately 50 hospitals we believe will be reconciled. Therefore, for these hospitals, to account for the fact that the reconciliation will result in

different outlier payments than predicted using the cost-to-charge ratios calculated as described above, we attempted to project each hospital's cost-to-charge ratio based on its rate of increase in charges per case based on FY 2002 charges, compared to costs (inflated to FY 2002 using actual market basket increases).

Using this methodology, we are establishing a fixed-loss cost outlier threshold equal to the prospective payment rate for the DRG, plus any IME and DSH payments, and any add-on payments for new technology, plus $31,000.

This single threshold will be applicable to qualify for both operating and capital outlier payments. We also are maintaining the marginal cost factor for cost outliers at 80 percent.

Comment: One commenter supported our changes to the outlier payment methodology but asked that we reconsider and revise the outlier threshold to at least a level of increase consistent with prior years. Other commenters asked that we lower the threshold to reflect the financial impact of the new outlier policies, to allow deserving hospitals to qualify for outlier payments and to ensure that hospitals receive the statutory mandated level of 5 to 6 percent of total DRG payments set aside for outliers. Another commenter reasoned that hospitals that have had their outlier payments dwindle to record low amounts will have no incentive to treat high-cost cases; therefore, the outlier threshold must be lowered. Another commenter noted that the current proposed threshold makes it almost impossible for hospitals to qualify for outlier payments and will cause hospitals to lose an extraordinary amount of money before additional outlier payments become available.

Other commenters indicated that they had conducted research, using the 2001 MedPAR file, which showed that the threshold required to spend 5.1 percent of total DRG payments decreased by 45 percent when the cost-to-charge ratios used to estimate costs were updated from the latest final settled to the latest tentatively settled cost report. Based on this finding, the commenters recommended a 45-percent reduction to the proposed outlier threshold, which would yield a threshold less than $28,000.

Some commenters believed that, in light of the changes adopted this year, it is appropriate that CMS revert to using changes in hospital costs to set the charge inflation factor rather than changes in hospital charges. The commenters explained that the combination of the changes made to the outlier policy and a return to using a cost inflation factor would lead to a more accurate and lower threshold. Another commenter noted the previous problems using changes in costs and recommended that CMS use a blend of the rates-of-increases for costs and charges to establish the charge inflation factor.

One commenter recommended that CMS keep the outlier threshold at $33,560 until CMS can determine the impact of using the most current cost-to-charge ratio during a full fiscal year. Other commenters also recommended that CMS eliminate any increase in the outlier threshold because the new outlier regulations will have a significant impact on Medicare outlier payments for FY 2004.

One commenter requested that CMS factor in the calculation of the threshold the fact that certain hospitals have distorted their charges significantly.

One commenter submitted a model of the outlier threshold for FY 2004 that incorporated the changes from the June 9, 2003 final rule. The commenter estimated the fixed-loss threshold to be $25,375 under these assumptions. The commenter also noted that the reconciliation process will reduce outlier payments and, accordingly, CMS should model a reduction in the outlier threshold to account for reconciliation, which would further lower the outlier threshold.

One commenter suggested that CMS lower the outlier threshold because independent studies strongly suggest that final FY 2003 outlier payments will fall short of the legislative mandate of 5 to 6 percent. Another commenter suggested that the outlier threshold remain at its current level because outlier payments for the first 3 months of FY 2003 represent 5.5 percent of total payments and, as a result, there does not seem to be any justification for such an increase. Another commenter explained that the transfer policy already reduces the payment to hospitals for short-stay cases and any increase in the outlier threshold will further penalize hospitals for treating high cost, medically complex cases.

Response: As described above, we are reflecting the changes made to outliers from the June 9, 2003 final rule. These changes have resulted in a substantial reduction in the outlier threshold from the proposed level. We estimate the outlier threshold would be approximately $50,200 without accounting for the effects of these changes. Therefore, the final threshold is 37 percent lower due to the changes described above. This reduction in the outlier threshold will allow hospitals that have been negatively impacted by the increase in the FY 2003 threshold due to those hospitals that maximized their outlier payments by dramatically increasing charges to qualify for higher outlier payments due to the lower threshold.

We are concerned that the outlier policy maintains its original intent to ensure hospitals are not significantly disadvantaged by unpredictable extraordinarily costly cases, and, therefore, we acted to close the loopholes in our prior policy through the final outlier rule. As a result of those changes, the threshold has fallen significantly from the proposed threshold.

Comment: Another commenter asked that any final outlier threshold included in the final rule be subject to a 60-day review and comment period.

Response: In the proposed rule, we noted that we would incorporate any final outlier policy changes in this final rule. We received many comments in response to the proposed rule, and we have considered them thoroughly in undertaking our analysis. Therefore, we do not believe there is any need for an additional public comment period on the changes. Accordingly, a fixed-loss threshold of $31,000 will be applied to calculate outlier payments for discharges occurring on or after October 1, 2003.

Comment: One commenter asked that CMS implement a transition period to protect those hospitals harmed by the significant changes in the June 9, 2003 final outlier rule. The commenter explained that a transition period is justified and would be consistent with previous transition methodologies employed for CMS changes, such as those proposed.

One commenter stated that any reconciliation would be inconsistent with the prospective nature of the IPPS.

Response: We responded to similar comments in the June 9, 2003 final rule on outliers (68 FR 34494). Therefore, we refer the commenters to that final rule.

Comment: Two commenters stated that the criterion in the final rule on outliers that specifically addressed our policy on reconciliation (that if a hospital's cost-to-charge ratio changed by 10 or more percentage points, a hospital would be subject to reconciliation) is flawed. The commenters believed that the criterion would tolerate vastly different rates of charge growth among hospitals, and hospitals with the lowest charges in relation to cost would be inappropriately subject to the greatest restriction in charge growth. The commenters provided an example where a hospital with a cost-to-charge ratio of .30 could mark up its charges by 50 percent in a 2-year period without triggering reconciliation, while another hospital with a cost-to-charge ratio of .80 would trigger reconciliation if charges grew by only 14 percent. The commenters recommended that, because of this inequity in this criterion, CMS modify the trigger for outlier reconciliation by promulgating a scale of cost-to-charge ratios rather than a constant amount. The scale could be based upon a rate of tolerable charge growth, which CMS would choose.

Response: We appreciate the suggestion by the commenters and will carefully evaluate the information provided by them. We note that fiscal intermediaries have discretion under the reconciliation policy to reconcile additional hospitals' cost reports based on analysis that indicates the outlier payments made to those hospitals are significantly inaccurate.

Comment: One commenter explained that one health care system agreed to accept reduced outlier payments during FY 2003. The commenter asked that this reduction be accounted for in the calculation of the threshold.

Response: Our calculation of the outlier threshold reflects the application of the outlier policies implemented by the June 9, 2003 final rule. The agreement referred to by the commenter was based upon the application of policies prior to that final rule. Therefore, it has no bearing on the calculation of the FY 2004 threshold described in this final rule.

Comment: One commenter noted that outlier payments are increasing because DRG payments are not keeping pace with the high cost of treatment. The commenter added that adjusting the outlier threshold will only add to the problem of underfunded health care and, because health care is not a priority,

there will always be a struggle to pay for it. The commenter noted that there needs to be a determination of what care will be paid for, and then hospitals need to decide if they will provide the noncovered services.

Another commenter believed that the final rule on outliers would affect hospitals that have applied outlier payments appropriately. The commenter also believed that Medicare beneficiaries would be impacted as community hospitals shift care to more costly tertiary care facilities due to concerns about underpayment for potentially complex patient cases. The commenter explained that it is concerned that claims processing errors in the application of the outlier provision may result in underreporting of services provided, which will perpetuate underpayments to hospitals and lead to long-term ramifications on the integrity of the data generated by the IPPS.

Response: As discussed above, we lowered the outlier threshold in response to the new provisions on outliers. We anticipate that, as a result of the changes implemented by our June 5, 2003 final rule, outlier payments will be better targeted to truly high-cost cases. This will help alleviate the commenters' concerns.

ii. Other changes concerning outliers. As stated in the September 1, 1993 final rule (58 FR 46348), we establish outlier thresholds that are applicable to both hospital inpatient operating costs and hospital inpatient capital-related costs. When we modeled the combined operating and capital outlier payments, we found that using a common set of thresholds resulted in a higher percentage of outlier payments for capital-related costs than for operating costs. We project that the thresholds for FY 2004 will result in outlier payments equal to 5.1 percent of operating DRG payments and 4.8 percent of capital payments based on the Federal rate.

In accordance with section 1886(d)(3)(B), we reduced the FY 2004 standardized amounts by the same percentage to account for the projected proportion of payments paid to outliers. The outlier adjustment factors to be applied to the standardized amounts for FY 2004 are as follows:

	Operating standardized amounts	Capital federal rate
National	0.949236	0.952050
Puerto Rico	0.976658	0.993231

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

To determine whether a case qualifies for outlier payments, we apply hospital-specific cost-to-charge ratios to the total covered charges for the case. Operating and capital costs for the case are calculated separately by applying separate operating and capital cost-to-charge ratios. These costs are then combined and compared with the fixed-loss outlier threshold.

The June 9, 2003 final rule eliminated the application of the statewide average for hospitals whose cost-to-charge ratios fall below 3 standard deviations from the national mean cost-to-charge ratio. However, for those hospitals for which the fiscal intermediary computes operating cost-to-charge ratios greater than 1.203 or capital cost-to-charge ratios greater than 0.163, or hospitals for whom the fiscal intermediary is unable to calculate a cost-to-charge ratio (as described at § 412.84(i)(3)), we are still using statewide average ratios to calculate costs to determine whether a hospital qualifies for outlier payments.[8] Table 8A in section VI. of this Addendum contains the statewide average operating cost-to-charge ratios for urban hospitals and for rural hospitals for which the fiscal intermediary is unable to compute a hospital-specific cost-to-charge ratio within the above range. These statewide average ratios would replace the ratios published in the August 1, 2002 IPPS final rule (67 FR 50263). Table 8B in section VI. of this Addendum contains the comparable statewide average capital cost-to-charge ratios. Again, the cost-to-charge ratios in Tables 8A and 8B will be used during FY 2004 when hospital-specific cost-to-charge ratios based on the latest settled cost report are either not available or are outside the range noted above. iii. FY 2002 and FY 2003 outlier payments.

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

Our current estimate, using available FY 2002 bills, is that actual outlier payments for FY 2002 were approximately 7.8 percent of actual total DRG payments. Thus, the data indicate that, for FY 2002, the percentage of actual outlier payments relative to actual total payments is higher than we projected before FY 2002 (and thus exceeds the percentage by which we reduced the standardized amounts for FY 2002). Nevertheless, consistent with the policy and statutory interpretation we have maintained since the inception of the IPPS, we do not plan to make retroactive adjustments to outlier payments to ensure that total outlier payments for FY 2002 are equal to 5.1 percent of total DRG payments.

We currently estimate that actual outlier payments for FY 2003 will be approximately 6.5 percent of actual total DRG payments, 1.4 percentage points higher than the 5.1 percent we projected in setting outlier policies for FY 2003. This estimate is based on simulations using the FY 2002 MedPAR file (discharge data for FY 2002 bills). We used these data to calculate an estimate of the actual outlier percentage for FY 2003 by applying FY 2003 rates and policies including an outlier threshold of $33,560 to available FY 2002 bills. This estimate does not reflect the outlier policy changes implemented in the June 9, 2003 final rule that will become effective on August 8, 2003. Due to the limited time remaining in FY 2003 during which these changes will be effective, we do not anticipate that these changes will substantially affect our estimate.

5. FY 2004 Standardized Amounts

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

The following table illustrates the changes from the FY 2003 national average standardized amounts. The first row in the table shows the updated (through FY 2003) average standardized amounts after restoring the FY 2003 offsets for outlier payments and geographic reclassification budget neutrality. The DRG reclassification and recalibration and wage index budget neutrality factor is cumulative. Therefore, the FY 2003 factor is not removed from the amounts in the table.

	Large urban	Other areas
FY 2003 Base Rate (after removing reclassification budget neutrality and outlier offset).	Labor: $3,213.66 Nonlabor: $1,306.26	Labor: $2,974.75 Nonlabor: $1,209.15
FY 2004 Update Factor	1.034	1.034
FY 2004 DRG Recalibrations and Wage Index Budget Neutrality Factor	1.005522	1.005522
FY 2004 Reclassification Budget Neutrality Factor	0.992026	0.992026
Adjusted for Blend of FY 2003 DRG Recalibration and Wage Index Budget Neutrality Factors (factor of 0.993209 effective October 1, 2002; factor of 0.993012 effective April 1, 2003).	Labor: $3,314.31 Nonlabor: $1,347.17	Labor: $3,261.83 Nonlabor: $1,325.84
FY 2004 Outlier Factor	0.949236	0.949236

[8] These figures represent 3.0 standard deviations from the mean of the log distribution of cost-to-charge ratios for all hospitals.

	Large urban	Other areas
Rate for FY 2004 (after multiplying FY 2003 base rate by above factors)	Labor: $3,146.06 ..... Nonlabor: $1,278.780	Labor: $3,096.25 Nonlabor: $1,258.54

Under section 1886(d)(9)(A)(ii) of the Act, the Federal portion of the Puerto Rico payment rate is based on the discharge-weighted average of the national large urban standardized amount and the national other standardized amount (as set forth in Table 1A). The labor and nonlabor portions of the national average standardized amounts for Puerto Rico hospitals are set forth in Table 1C of section VI. of this Addendum. This table also includes the Puerto Rico standardized amounts. The labor share applied to the Puerto Rico standardized amount is 71.3 percent.

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

Tables 1A and 1C, as set forth in section VI. of this Addendum, contain the labor-related and nonlabor-related shares that we used to calculate the prospective payment rates for hospitals located in the 50 States, the District of Columbia, and Puerto Rico. This section addresses two types of adjustments to the standardized amounts that are made in determining the prospective payment rates as described in this Addendum.

1. Adjustment for Area Wage Levels

Sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act require that we make an adjustment to the labor-related portion of the national and Puerto Rico prospective payment rates, respectively, to account for area differences in hospital wage levels. This adjustment is made by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. In section III. of the preamble to this final rule, we discuss the data and methodology for the FY 2004 wage index. The FY 2004 wage index is set forth in Tables 4A, 4B, 4C, and 4F of section VI. of this Addendum.

2. Adjustment for Cost-of-Living in Alaska and Hawaii

Section 1886(d)(5)(H) of the Act authorizes an adjustment to take into account the unique circumstances of hospitals in Alaska and Hawaii. Higher labor-related costs for these two States are taken into account in the adjustment for area wages described above. For FY 2004, we are adjusting the payments for hospitals in Alaska and Hawaii by multiplying the nonlabor portion of the standardized amounts by the appropriate adjustment factor contained in the table below.

Area	Cost of living adjustment factor
Alaska: All areas	1.25
Hawaii:	
County of Honolulu	1.25
County of Hawaii	1.165
County of Kauai	1.2325
County of Maui	1.2375
County of Kalawao	1.2375

(The above factors are based on data obtained from the U.S. Office of Personnel Management.)

C. DRG Relative Weights

As discussed in section II. of the preamble, we have developed a classification system for all hospital discharges, assigning them into DRGs, and have developed relative weights for each DRG that reflect the resource utilization of cases in each DRG relative to Medicare cases in other DRGs. Table 5 of section VI. of this Addendum contains the relative weights that we are using for discharges occurring in FY 2004. These factors have been recalibrated as explained in section II. of the preamble of this final rule.

D. Calculation of Prospective Payment Rates for FY 2004

General Formula for Calculation of Prospective Payment Rates for FY 2004

The operating prospective payment rate for all hospitals paid under the IPPS located outside of Puerto Rico, except SCHs and MDHs, equals the Federal rate based on the amounts in Table 1A in section VI. of this Addendum.

The prospective payment rate for SCHs equals the higher of the applicable Federal rate from Table 1A or the hospital-specific rate as described below. The prospective payment rate for MDHs equals the higher of the Federal rate, or the Federal rate plus 50 percent of the difference between the Federal rate and the hospital-specific rate as described below. The prospective payment rate for Puerto Rico equals 50 percent of the Puerto Rico rate plus 50 percent of the national rate from Table 1C in section VI. of this Addendum.

1. Federal Rate

For discharges occurring on or after October 1, 2003 and before October 1, 2004, except for SCHs, MDHs, and hospitals in Puerto Rico, payment under the IPPS is based exclusively on the Federal rate.

The Federal rate is determined as follows:

Step 1—Select the appropriate average standardized amount considering the location of the hospital (large urban or other) (see Table 1A in section VI. of this Addendum).

Step 2—Multiply the labor-related portion of the standardized amount by the applicable wage index for the geographic area in which the hospital is located or the area to which the hospital is reclassified (see Tables 4A, 4B, and 4C of section VI. of this Addendum).

Step 3—For hospitals in Alaska and Hawaii, multiply the nonlabor-related portion of the standardized amount by the appropriate cost-of-living adjustment factor.

Step 4—Add the amount from Step 2 and the nonlabor-related portion of the standardized amount (adjusted, if appropriate, under Step 3).

Step 5—Multiply the final amount from Step 4 by the relative weight corresponding to the appropriate DRG (see Table 5 of section VI. of this Addendum).

The Federal rate as determined in Step 5 may then be further adjusted if the hospital qualifies for either the IME or DSH adjustment.

2. Hospital-Specific Rate (Applicable Only to SCHs and MDHs)

a. Calculation of Hospital-Specific Rate

Section 1886(b)(3)(C) of the Act provides that SCHs are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal rate; the updated hospital-specific rate based on FY 1982 costs per discharge; the updated hospital-specific rate based on FY 1987 costs per discharge; or the updated hospital-specific rate based on FY 1996 costs per discharge.

Section 1886(d)(5)(G) of the Act provides that MDHs are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal rate or the Federal rate plus 50 percent of the difference between the Federal rate and the greater of the updated hospital-specific rates based on either FY 1982 or FY 1987 costs per discharge. MDHs do not have the option to use their FY 1996 hospital-specific rate.

Hospital-specific rates have been determined for each of these hospitals based on either the FY 1982 costs per discharge, the FY 1987 costs per discharge or, for SCHs, the FY 1996 costs per discharge. For a more detailed discussion of the calculation of the hospital-specific rates, we refer the reader to the September 1, 1983 interim final rule (48 FR 39772); the April 20, 1990 final rule with comment (55 FR 15150); the September 4, 1990 final rule (55 FR 35994); and the August 1, 2000 final rule (65 FR 47082). In addition, for both SCHs and MDHs, the hospital-specific rate is adjusted by the budget neutrality adjustment factor (that is, by 1.005522) as discussed in section II.A.4.a. of this Addendum. The resulting rate was used in determining the payment rate an SCH or MDH will receive for its discharges beginning on or after October 1, 2003.

b. Updating the FY 1982, FY 1987, and FY 1996 Hospital-Specific Rates for FY 2004

We are increasing the hospital-specific rates by 3.4 percent (the hospital market basket percentage) for SCHs and MDHs for FY 2004. Section 1886(b)(3)(C)(iv) of the Act provides that the update factor applicable to the hospital-specific rates for SCHs is equal to the update factor provided under section 1886(b)(3)(B)(iv) of the Act, which, for SCHs in FY 2004, is the market basket rate of increase. Section 1886(b)(3)(D) of the Act

provides that the update factor applicable to the hospital-specific rates for MDHs also equals the update factor provided under section 1886(b)(3)(B)(iv) of the Act, which, for FY 2004, is the market basket rate.

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

a. Puerto Rico Rate

The Puerto Rico prospective payment rate is determined as follows:

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

Step 2—Multiply the labor-related portion of the standardized amount by the appropriate Puerto Rico-specific wage index (see Table 4F of section VI. of the Addendum).

Step 3—Add the amount from Step 2 and the nonlabor-related portion of the standardized amount.

Step 4—Multiply the result in Step 3 by 50 percent.

Step 5—Multiply the amount from Step 4 by the appropriate DRG relative weight (see Table 5 of section VI. of the Addendum).

b. National Rate

The national prospective payment rate is determined as follows:

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

Step 2—Add the amount from Step 1 and the nonlabor-related portion of the national average standardized amount.

Step 3—Multiply the result in Step 2 by 50 percent.

Step 4—Multiply the amount from Step 3 by the appropriate DRG relative weight (see Table 5 of section VI. of the Addendum).

The sum of the Puerto Rico rate and the national rate computed above equals the prospective payment for a given discharge for a hospital located in Puerto Rico. This rate may then be further adjusted if the hospital qualifies for either the IME or DSH adjustment.

III. Changes to Payment Rates for Acute Care Hospital Inpatient Capital-Related Costs for FY 2004

The PPS for acute care hospital inpatient capital-related costs was implemented for cost reporting periods beginning on or after October 1, 1991. Effective with that cost reporting period and during a 10-year transition period extending through FY 2001, acute care hospital inpatient capital-related costs were paid on the basis of an increasing proportion of the capital PPS Federal rate and a decreasing proportion of a hospital's historical costs for capital.

The basic methodology for determining Federal capital prospective rates is set forth in regulations at §§ 412.308 through 412.352. Below we discuss the factors that we used to determine the capital Federal rate for FY 2004, which will be effective for discharges occurring on or after October 1, 2003. The 10-year transition period ended with hospital cost reporting periods beginning on or after October 1, 2001 (FY 2002). Therefore, for cost reporting periods beginning in FY 2002, all hospitals (except ''new'' hospitals under §§ 412.304(c)(2) and 412.324(b)) are paid based on 100 percent of the capital Federal rate.

For FY 1992, we computed the standard Federal payment rate for capital-related costs under the IPPS by updating the FY 1989 Medicare inpatient capital cost per case by an actuarial estimate of the increase in Medicare inpatient capital costs per case. Each year after FY 1992, we update the capital standard Federal rate, as provided in § 412.308(c)(1), to account for capital input price increases and other factors. Section 412.308(c)(2) provides that the capital Federal rate is adjusted annually by a factor equal to the estimated proportion of outlier payments under the capital Federal rate to total capital payments under the capital Federal rate. In addition, § 412.308(c)(3) requires that the capital Federal rate be reduced by an adjustment factor equal to the estimated proportion of payments for (regular and special) exception under § 412.348. Section 412.308(c)(4)(ii) requires that the capital standard Federal rate be adjusted so that the annual DRG reclassification and the recalibration of DRG weights and changes in the geographic adjustment factor are budget neutral.

For FYs 1992 through 1995, § 412.352 required that the capital Federal rate also be adjusted by a budget neutrality factor so that aggregate payments for inpatient hospital capital costs were projected to equal 90 percent of the payments that would have been made for capital-related costs on a reasonable cost basis during the fiscal year. That provision expired in FY 1996. Section 412.308(b)(2) describes the 7.4 percent reduction to the capital rate that was made in FY 1994, and § 412.308(b)(3) describes the 0.28 percent reduction to the capital rate made in FY 1996 as a result of the revised policy of paying for transfers. In FY 1998, we implemented section 4402 of Pub. L. 105–33, which requires that, for discharges occurring on or after October 1, 1997, and before October 1, 2002, the unadjusted capital standard Federal rate is reduced by 17.78 percent. As we discussed in the August 1, 2002 IPPS final rule (67 FR 50102) and implemented in § 412.308(b)(6)), a small part of that reduction was restored effective October 1, 2002.

To determine the appropriate budget neutrality adjustment factor and the regular exceptions payment adjustment during the 10-year transition period, we developed a dynamic model of Medicare inpatient capital-related costs, that is, a model that projected changes in Medicare inpatient capital-related costs over time. With the expiration of the budget neutrality provision, the capital cost model was only used to estimate the regular exceptions payment adjustment and other factors during the transition period. As we explained in the August 1, 2001 IPPS final rule (66 FR 39911), beginning in FY 2003, an adjustment for regular exception payments is no longer necessary because regular exception payments were only made for cost reporting periods beginning on or after October 1, 1991, and before October 1, 2001 (see § 412.348(b)). Since payments are no longer being made under the regular exception policy in FY 2003 and after, we no longer use the capital cost model. The capital cost model and its application during the transition period are described in Appendix B of the August 1, 2001 IPPS final rule (66 FR 40099).

In accordance with section 1886(d)(9)(A) of the Act, under the IPPS for acute care hospital operating costs, hospitals located in Puerto Rico are paid for operating costs under a special payment formula. Prior to FY 1998, hospitals in Puerto Rico were paid a blended capital rate that consisted of 75 percent of the applicable standardized amount specific to Puerto Rico hospitals and 25 percent of the applicable national average standardized amount. However, effective October 1, 1997, as a result of section 4406 of Pub. L. 105–33, operating payments to hospitals in Puerto Rico are based on a blend of 50 percent of the applicable standardized amount specific to Puerto Rico hospitals and 50 percent of the applicable national average standardized amount. In conjunction with this change to the operating blend percentage, effective with discharges on or after October 1, 1997, we compute capital payments to hospitals in Puerto Rico based on a blend of 50 percent of the Puerto Rico capital rate and 50 percent of the capital Federal rate.

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

A. Determination of Federal Hospital Inpatient Capital-Related Prospective Payment Rate Update

In the final IPPS rule published in the **Federal Register** on August 1, 2002 (67 FR 50127), we established a capital Federal rate of $407.01 for FY 2003. Section 402(b) of Pub. L. 108–7 requires that, effective for discharges occurring on or after April 1, 2003, and before October 1, 2003, the capital Federal rate for operating costs for all IPPS hospitals is based on the large urban standardized amount. However, under current law for discharges occurring on or after October 1, 2003, the capital Federal rate will again be calculated based on separate average standardized amounts for hospitals in large urban areas and for hospitals in other areas. In addition, a correction notice to the FY 2003 final IPPS rule issued in the **Federal Register** on April 25, 2003 (68 FR 22272) contains corrections and revisions to the wage index and geographic adjustment factor (GAF). In conjunction with the change to the operating PPS standardized amounts made by Pub. L. 108–7 and the wage index and GAF corrections, we have established a capital PPS standard Federal rate of $406.93

effective for discharges occurring on or after April 1, 2003 through September 30, 2003. As we discussed in the May 19, 2003 proposed rule (68 FR 27238), the capital rates effective for discharges occurring on or after April 1, 2003 through September 30, 2003, were used in determining the final FY 2004 capital rates. As a result of the changes to the factors used to establish the capital Federal rate that are explained in this Addendum, the FY 2004 capital standard Federal rate is $415.47.

In the discussion that follows, we explain the factors that were used to determine the FY 2004 capital Federal rate. In particular, we explain why the FY 2004 capital Federal rate has increased 2.10 percent compared to the FY 2003 capital Federal rate (effective for discharges occurring on or after April 1, 2003 through September 30, 2003). We also estimate aggregate capital payments will increase by 1.4 percent during this same period. This increase is primarily due to the increase in the number of hospital admissions and the increase in case-mix. This increase in capital payments is slightly less than last year (5.81 percent), mostly due to the restoration of the 2.1 percent reduction to the capital Federal rate in FY 2003 (§ 412.308(b)(6)) and the projected decrease in outlier payments as a result of the IPPS outlier policy established in the June 9, 2003 high-cost outlier final rule (68 FR 34494).

Total payments to hospitals under the IPPS are relatively unaffected by changes in the capital prospective payments. Since capital payments constitute about 10 percent of hospital payments, a 1-percent change in the capital Federal rate yields only about 0.1 percent change in actual payments to hospitals. Aggregate payments under the capital PPS are estimated to increase in FY 2004 compared to FY 2003.

1. Capital Standard Federal Rate Update

a. Description of the Update Framework

Under § 412.308(c)(1), the capital standard Federal rate is updated on the basis of an analytical framework that takes into account changes in a capital input price index (CIPI) and several other policy adjustment factors. Specifically, we have adjusted the projected CIPI rate of increase as appropriate each year for case-mix index-related changes, for intensity, and for errors in previous CIPI forecasts. In the May 19, 2003 proposed rule (68 FR 27239), we proposed an update factor of 0.7 for FY 2004 under that framework based on the best data available at that time. Under that same update framework based on more recent data, the final update factor for FY 2004 is 0.7 percent. This final update factor is based on a 0.7 percent increase in the CIPI, a 0.0 percent adjustment for intensity, a 0.0 percent adjustment for case-mix, a 0.0 percent adjustment for the FY 2002 DRG reclassification and recalibration, and a forecast error correction of 0.0 percent. We explain the basis for the FY 2004 CIPI projection in section III.C. of this Addendum. Below we describe the policy adjustments that have been applied.

The case-mix index is the measure of the average DRG weight for cases paid under the IPPS. Because the DRG weight determines the prospective payment for each case, any percentage increase in the case-mix index corresponds to an equal percentage increase in hospital payments.

The case-mix index can change for any of several reasons:

- The average resource use of Medicare patients changes (''real'' case-mix change);
- Changes in hospital coding of patient records result in higher weight DRG assignments (''coding effects''); and
- The annual DRG reclassification and recalibration changes may not be budget neutral (''reclassification effect'').

We define real case-mix change as actual changes in the mix (and resource requirements) of Medicare patients as opposed to changes in coding behavior that result in assignment of cases to higher weighted DRGs but do not reflect higher resource requirements. In the update framework for the PPS for operating costs, we adjust the update upwards to allow for real case-mix change, but remove the effects of coding changes on the case-mix index. We also remove the effect on total payments of prior year changes to the DRG classifications and relative weights, in order to retain budget neutrality for all case-mix index-related changes other than patient severity. (For example, we adjusted for the effects of the FY 2002 DRG reclassification and recalibration as part of our update for FY 2004.) We have adopted this case-mix index adjustment in the capital update framework as well.

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

We estimate that FY 2002 DRG reclassification and recalibration will result in a 0.0 percent change in the case-mix when compared with the case-mix index that would have resulted if we had not made the reclassification and recalibration changes to the DRGs. Therefore, we are making a 0.0 percent adjustment for DRG reclassification and recalibration in the update for FY 2004 to maintain budget neutrality.

The capital update framework contains an adjustment for forecast error. The input price index forecast is based on historical trends and relationships ascertainable at the time the update factor is established for the upcoming year. In any given year, there may be unanticipated price fluctuations that may result in differences between the actual increase in prices and the forecast used in calculating the update factors. In setting a prospective payment rate under the framework, we make an adjustment for forecast error only if our estimate of the change in the capital input price index for any year is off by 0.25 percentage points or more. There is a 2-year lag between the forecast and the measurement of the forecast error. A forecast error of 0.2 percentage points was calculated for the FY 2002 update. That is, current historical data indicate that the forecasted FY 2002 CIPI used in calculating the FY 2002 update factor (0.7 percent) overstated the actual realized price increases (0.5 percent) by 0.2 percentage points. This slight overprediction was mostly due to an underestimation of the interest rate cuts by the Federal Reserve Board in 2002, which impacted the interest component of the CIPI. However, since this estimation of the change in the CIPI is less than 0.25 percentage points, it is not reflected in the update recommended under this framework. Therefore, we are making a 0.0 percent adjustment for forecast error in the update for FY 2004.

Under the capital PPS system framework, we also make an adjustment for changes in intensity. We calculate this adjustment using the same methodology and data that are used in the framework for the operating PPS. The intensity factor for the operating update framework reflects how hospital services are utilized to produce the final product, that is, the discharge. This component accounts for changes in the use of quality-enhancing services, for changes in within-DRG severity, and for expected modification of practice patterns to remove noncost-effective services.

We calculate case-mix constant intensity as the change in total charges per admission, adjusted for price level changes (the CPI for hospital and related services) and changes in real case-mix. The use of total charges in the calculation of the intensity factor makes it a total intensity factor, that is, charges for capital services are already built into the calculation of the factor. Therefore, we have incorporated the intensity adjustment from the operating update framework into the capital update framework. Without reliable estimates of the proportions of the overall annual intensity increases that are due, respectively, to ineffective practice patterns and to the combination of quality-enhancing new technologies and within-DRG complexity, we assume, as in the operating update framework, that one-half of the annual increase is due to each of these factors. The capital update framework thus provides an add-on to the input price index rate of increase of one-half of the estimated annual increase in intensity, to allow for within-DRG severity increases and the adoption of quality-enhancing technology.

As we discussed in the May 19, 2003 proposed rule (68 FR 27239), we have developed a Medicare-specific intensity measure based on a 5-year average. Past studies of case-mix change by the RAND Corporation (''Has DRG Creep Crept Up? Decomposing the Case Mix Index Change Between 1987 and 1988'' by G. M. Carter, J. P. Newhouse, and D. A. Relles, R–4098–HCFA/ProPAC (1991)) suggest that real case-mix change was not dependent on total change, but was usually a fairly steady 1.0 to 1.4 percent per year. We use 1.4 percent as the upper bound because the RAND study did not take into account that hospitals may have induced doctors to document medical records more completely in order to improve payment.

We calculate case-mix constant intensity as the change in total charges per admission, adjusted for price level changes (the CPI for hospital and related services), and changes in real case-mix. As we noted above, in accordance with § 412.308(c)(1)(ii), we began updating the capital standard Federal rate in FY 1996 using an update framework that takes into account, among other things, allowable changes in the intensity of hospital

services. For FYs 1996 through 2001, we found that case-mix constant intensity was declining and we established a 0.0 percent adjustment for intensity in each of those years. For FYs 2001 and 2002, we found that case-mix constant intensity was increasing and we established a 0.3 percent adjustment and 1.0 percent adjustment for intensity, respectively.

Using the methodology described above, as we discussed in the May 19, 2003 proposed rule (68 FR 27239), for FY 2004 we examined the change in total charges per admission, adjusted for price level changes (the CPI for hospital and related services), and changes in real case-mix for FYs 1998 though 2002. We found that, over this period and in particular the last 3 years of this period (FYs 2000 through 2002), the charge data appear to be skewed. More specifically, we found a dramatic increase in hospital charges for FYs 2000 through 2002 without a corresponding increase in hospital case-mix index. If hospitals were treating new or different types of cases, which would result in an appropriate increase in charges per discharge, then we would expect hospitals' case-mix to increase proportionally.

The timing of this increase in charge growth is consistent with the dramatic increase in charges that we discussed in the June 9, 2003 high-cost outlier final rule (68 FR 34494). As we discussed in that final rule, because hospitals have the ability to increase their outlier payments through dramatic charge increases, we have made several changes in our high-cost outlier policy at §§ 412.84(i) and (m) in order to prevent hospitals from taking advantage of our current outlier policy.

As discussed above, our intensity calculation relies heavily upon charge data and we believe that this charge data may be inappropriately skewed. Therefore, in the May 19, 2003 proposed rule (68 FR 22739), we proposed a 0.0 percent adjustment for intensity for FY 2004. As we explained in that same proposed rule, in past FYs (1996 through 2000) when we found intensity to be declining, we believed a zero (rather then negative) intensity adjustment was appropriate. Similarly, we believe that it is appropriate to apply a zero intensity adjustment for FY 2004 until we believe that any increase in charges can be tied to intensity rather then to attempts to maximize outlier payments. We received no comments on our proposed 0.0 percent adjustment for intensity. Therefore, in this final rule, we are making a 0.0 percent adjustment for intensity in the update for FY 2004.

Above we described the basis of the components used to develop the 0.7 percent final capital update factor for FY 2004 as shown in the table below.

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

Capital Input Price Index	0.7
Intensity:	0.0
Case-Mix Adjustment Factors:	.....
Projected Case-Mix Change	−1.0
Real Across DRG Change	1.0
Subtotal	0.0
Effect of FY 2002 Reclassification and Recalibration	0.0
Forecast Error Correction	0.0
Total Update	0.7

b. Comparison of CMS and MedPAC Update Recommendation

In the past, MedPAC has included update recommendations for capital PPS in a Report to Congress. As we discussed in the May 19, 2003 proposed rule (68 FR 27240), in its March 2003 Report to Congress, MedPAC did not make an update recommendation for capital PPS payments. However, in that same report, MedPAC made an update recommendation for hospital inpatient and outpatient services (page 4). MedPAC stated that hospital inpatient and outpatient services should be considered together because they are so closely interrelated. Their recommendation is based on an assessment of whether payments are adequate to cover the costs of efficient providers, an estimate of input price inflation (measured by the market basket index), and an adjustment for technological charges, which is offset by reasonable expectations in productivity gains.

2. Outlier Payment Adjustment Factor

Section 412.312(c) establishes a unified outlier methodology for inpatient operating and inpatient capital-related costs. A single set of thresholds is used to identify outlier cases for both inpatient operating and inpatient capital-related payments. Section 412.308(c)(2) provides that the standard Federal rate for inpatient capital-related costs be reduced by an adjustment factor equal to the estimated proportion of capital related outlier payments to total inpatient capital-related PPS payments. The outlier thresholds are set so that operating outlier payments are projected to be 5.1 percent of total operating DRG payments.

In the August 1, 2002 IPPS final rule (67 FR 50129), we estimated that outlier payments for capital in FY 2003 would equal 5.31 percent of inpatient capital-related payments based on the FY 2003 capital Federal rate. Accordingly, we applied an outlier adjustment factor of 0.9469 to the FY 2003 capital Federal rate. Based on the thresholds as set forth in section II.A.4.c. of this Addendum, we estimate that outlier payments for capital will equal 4.79 percent of inpatient capital-related payments based on the capital Federal rate in FY 2004. Therefore, we are establishing an outlier adjustment factor of 0.9521 to the capital Federal rate. Thus, the percentage of capital outlier payments to total capital standard payments for FY 2004 is lower than the percentage for FY 2003. This projected decrease in capital outlier payments is mostly due to the changes in the IPPS outlier policy established in the June 9, 2003 high-cost outlier final rule (68 FR 34494).

The outlier reduction factors are not built permanently into the capital rates; that is, they are not applied cumulatively in determining the capital Federal rate. Therefore, the net change in the outlier adjustment to the capital Federal rate for FY 2004 is 1.0055 (0.9521/0.9469). The outlier adjustment increases the FY 2004 capital Federal rate by 0.55 percent compared with the FY 2003 outlier adjustment.

3. Budget Neutrality Adjustment Factor for Changes in DRG Classifications and Weights and the Geographic Adjustment Factor

Section 412.308(c)(4)(ii) requires that the capital Federal rate be adjusted so that aggregate payments for the fiscal year based on the capital Federal rate after any changes resulting from the annual DRG reclassification and recalibration and changes in the geographic adjustment factor (GAF) are projected to equal aggregate payments that would have been made on the basis of the capital Federal rate without such changes.

Since we implemented a separate geographic adjustment factor for Puerto Rico, we apply separate budget neutrality adjustments for the national geographic adjustment factor and the Puerto Rico geographic adjustment factor. We apply the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. Separate adjustments were unnecessary for FY 1998 and earlier since the geographic adjustment factor for Puerto Rico was implemented in FY 1998.

In the past, we used the actuarial capital cost model (described in Appendix B of the August 1, 2001 IPPS final rule (66 FR 40099)) to estimate the aggregate payments that would have been made on the basis of the capital Federal rate with and without changes in the DRG classifications and weights and in the GAF to compute the adjustment required to maintain budget neutrality for changes in DRG weights and in the GAF. During the transition period, the capital cost model was also used to estimate the regular exception payment adjustment factor. As we explain in section III.A.4. of this Addendum, beginning in FY 2003 an adjustment for regular exception payments is no longer necessary. Therefore, we are no longer using the capital cost model. Instead, we are using historical data based on hospitals' actual cost experiences to determine the exceptions payment adjustment factor for special exceptions payments.

To determine the factors for FY 2004, we compared (separately for the national capital rate and the Puerto Rico capital rate) estimated aggregate capital Federal rate payments based on the FY 2003 DRG relative weights and the FY 2003 GAF to estimated aggregate capital Federal rate payments based on the FY 2004 relative weights and the FY 2004 GAF. In the August 1, 2002 IPPS final rule (67 FR 50129) for FY 2003, the budget neutrality adjustment factors were 0.9885 for the national capital rate and 0.9963 for the Puerto Rico capital rate. As a result of the revisions to the GAF effective for discharges occurring on or after April 1, 2003 through September 30, 2003, the budget neutrality adjustment factor is 0.9983 for the national capital rate for discharges occurring on or before April 1, 2003 through September 30, 2003. The budget neutrality adjustment factor for the Puerto Rico capital rate remained

unchanged (0.9963). As we noted above, the capital rates effective for discharges occurring on or after April 1, 2003 through September 30, 2003 were used in determining the FY 2004 capital rates. In making the comparison, we set the regular and special exceptions reduction factors to 1.00.

To achieve budget neutrality for the changes in the national GAF, based on calculations using updated data, we are applying an incremental budget neutrality adjustment of 1.0051 for FY 2004 to the previous cumulative FY 2003 adjustment (0.9883), yielding a cumulative adjustment of 0.9933 through FY 2004. For the Puerto Rico GAF, we are applying an incremental budget neutrality adjustment of 1.0002 for FY 2004 to the previous cumulative FY 2003 adjustment (0.9963), yielding a cumulative adjustment of 0.9965 through FY 2004.

We then compared estimated aggregate capital Federal rate payments based on the FY 2003 DRG relative weights and the FY 2003 GAF to estimated aggregate capital Federal rate payments based on the FY 2004 DRG relative weights and the FY 2004 GAF. The incremental adjustment for DRG classifications and changes in relative weights is 1.0008 both nationally and for Puerto Rico. The cumulative adjustments for DRG classifications and changes in relative weights and for changes in the GAF through FY 2004 are 0.9941 nationally and 0.9973 for Puerto Rico. The following table summarizes the adjustment factors for each fiscal year:

BUDGET NEUTRALITY ADJUSTMENT FOR DRG RECLASSIFICATIONS AND RECALIBRATION AND THE GEOGRAPHIC ADJUSTMENT FACTORS

Fiscal year	National				Puerto Rico			
	Incremental adjustment			Cumulative	Incremental adjustment			Cumulative
	Geographic adjustment factor	DRG reclassifications and recalibration	Combined		Geographic adjustment factor	DRG Reclassifications and Recalibration	Combined	
1992	—	—	1.00000	—	—	—	—	—
1993	—	—	0.99800	0.99800	—	—	—	—
1994	—	—	1.00531	1.00330	—	—	—	—
1995	—	—	0.99980	1.00310	—	—	—	—
1996	—	—	0.99940	1.00250	—	—	—	
1997	—	—	0.99873	1.00123	—	—	—	—
1998	—	—	0.99892	1.00015	—	—	—	1.00000
1999	0.99944	1.00335	1.00279	1.00294	0.99898	1.00335	1.00233	1.00233
2000	0.99857	0.99991	0.99848	1.00142	0.99910	0.99991	0.99901	1.00134
2001[1]	0.99782	1.00009	0.99791	0.99933	1.00365	1.00009	1.00374	1.00508
2001[2]	[3]0.99771	[3]1.00009	[3]0.99780	0.99922	[3]1.00365	[3]1.00009	[3]1.00374	1.00508
2002	[4]0.99666	[4]0.99668	[4]0.99335	0.99268	[4]0.98991	[4]0.99668	[4]0.99662	0.99164
2003[5]	0.99915	0.99662	0.99577	0.98848	1.00809	0.99662	1.00468	0.99628
2003[6]	[7]0.99896	[7]0.99662	[7]0.99558	0.98830	[7]1.00809	[7]0.99662	[7]1.00468	[7]0.99628
2004	[8]1.00510	1.00081	[8]1.00591	0.99414	[8]1.00023	[8]1.00081	[8]1.00104	0.99731

[1] Factors effective for the first half of FY 2001 (October 2000 through March 2001).
[2] Factors effective for the second half of FY 2001 (April 2001 through September 2001).
[3] Incremental factors are applied to FY 2000 cumulative factors.
[4] Incremental factors are applied to the cumulative factors for the first half of FY 2001.
[5] Factors effective for the first half of FY 2003 (October 2002 through March 2003).
[6] Factors effective for the second half of FY 2003 (April 2003 through September 2003).
[7] Incremental factors are applied to FY 2002 cumulative factors.
[8] Incremental factors are applied to the cumulative factors for the second half of FY 2003.

The methodology used to determine the recalibration and geographic (DRG/GAF) budget neutrality adjustment factor for FY 2004 is similar to that used in establishing budget neutrality adjustments under the PPS for operating costs. One difference is that, under the operating PPS, the budget neutrality adjustments for the effect of geographic reclassifications are determined separately from the effects of other changes in the hospital wage index and the DRG relative weights. Under the capital PPS, there is a single DRG/GAF budget neutrality adjustment factor (the national capital rate and the Puerto Rico capital rate are determined separately) for changes in the GAF (including geographic reclassification) and the DRG relative weights. In addition, there is no adjustment for the effects that geographic reclassification has on the other payment parameters, such as the payments for serving low-income patients, indirect medical education payments, or the large urban add-on payments.

In the August 1, 2002 IPPS final rule (67 FR 50129), we calculated a GAF/DRG budget neutrality factor of 0.9957 for FY 2003. As we noted above, as a result of the revisions to the GAF effective for discharges occurring on or after April 1, 2003 through September 30, 2003 published in the **Federal Register** on April 25, 2003 (68 FR 22272), we calculated a GAF/DRG budget neutrality factor of 0.9956 for discharges occurring on or after April 1, 2003 through September 30, 2003. Furthermore, as noted above, the capital rates effective for discharges occurring on or after April 1, 2003 through September 30, 2003 were used in determining the FY 2004 capital rates.

In the May 19, 2003 proposed rule (68 FR 27241), for FY 2004 we calculated a GAF/DRG budget neutrality factor of 1.0038. For this final rule, based on updated data, we are establishing a GAF/DRG budget neutrality factor of 1.0059 for FY 2004. The GAF/DRG budget neutrality factors are built permanently into the capital rates; that is, they are applied cumulatively in determining the capital Federal rate. This follows from the requirement that estimated aggregate payments each year be no more or less than they would have been in the absence of the annual DRG reclassification and recalibration and changes in the GAF. The incremental change in the adjustment from FY 2003 to FY 2004 is 1.0059. The cumulative change in the capital Federal rate due to this adjustment is 0.9941 (the product of the incremental factors for FY 1993, FY 1994, FY 1995, FY 1996, FY 1997, FY 1998, FY 1999, FY 2000, FY 2001, FY 2002, FY 2003, and the incremental factor for FY 2004: $0.9980 \times 1.0053 \times 0.9998 \times 0.9994 \times 0.9987 \times 0.9989 \times 1.0028 \times 0.9985 \times 0.9979 \times 0.9934 \times 0.9956 \times 1.0059 = 0.9941$).

This factor accounts for DRG reclassifications and recalibration and for changes in the GAF. It also incorporates the effects on the GAF of FY 2004 geographic reclassification decisions made by the MGCRB compared to FY 2003 decisions. However, it does not account for changes in payments due to changes in the DSH and IME adjustment factors or in the large urban add-on.

4. Exceptions Payment Adjustment Factor

Section 412.308(c)(3) requires that the capital standard Federal rate be reduced by an adjustment factor equal to the estimated proportion of additional payments for both regular exceptions and special exceptions under § 412.348 relative to total capital PPS payments. In estimating the proportion of regular exception payments to total capital PPS payments during the transition period, we used the actuarial capital cost model originally developed for determining budget neutrality (described in Appendix B of the August 1, 2001 IPPS final rule (66 FR 40099)) to determine the exceptions payment adjustment factor, which was applied to both the Federal and hospital-specific capital rates.

An adjustment for regular exception payments is no longer necessary in determining the FY 2004 capital Federal rate because, in accordance with § 412.348(b), regular exception payments were only made for cost reporting periods beginning on or after October 1, 1991 and before October 1, 2001. Accordingly, as we explained in the August 1, 2001 IPPS final rule (66 FR 39949), in FY 2003 and subsequent fiscal years, no payments will be made under the regular exceptions provision. However, in accordance with § 412.308(c), we still need to compute a budget neutrality adjustment for special exception payments under § 412.348(g). We describe our methodology for determining the special exceptions adjustment used in calculating the FY 2004 capital Federal rate below.

Under the special exceptions provision specified at § 412.348(g)(1), eligible hospitals include SCHs, urban hospitals with at least 100 beds that have a disproportionate share percentage of at least 20.2 percent or qualify for DSH payments under § 412.106(c)(2), and hospitals with a combined Medicare and Medicaid inpatient utilization of at least 70 percent. An eligible hospital may receive special exceptions payments if it meets (1) a project need requirement as described at § 412.348(g)(2), which, in the case of certain urban hospitals, includes an excess capacity test as described at § 412.348(g)(4); (2) an age of assets test as described at § 412.348(g)(3); and (3) a project size requirement as described at § 412.348(g)(5).

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

For the hospitals remaining in the potential universe, we estimated project-size by using the fixed capital acquisitions shown on Worksheet A7 from the following HCRIS cost reports updated through March 2003.

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

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

Because we estimate that so few hospitals will qualify for special exceptions, projecting costs, payments, and margins would result in high statistical variance. Consequently, we decided to model the effects of special exceptions using historical data based on hospitals' actual cost experiences. If we determined that a hospital may qualify for special exceptions, we modeled special exceptions payments from the project start date through the last available cost report (FY 2001). While we have not yet received all of the FY 2001 cost reports, we do have a sufficient number of FY 2001 cost reports to model a preliminary estimate of special exception payments for FY 2004. For purposes of modeling, we used the cost and payment data on the cost reports from HCRIS assuming that special exceptions would begin at the start of the qualifying project. In other words, when modeling costs and payment data, we ignored any regular exception payments that these hospitals may otherwise have received as if there had not been regular exception provision during the transition period. In projecting an eligible hospital's special exception payment, we applied the 70-percent minimum payment level, the cumulative comparison of current year capital PPS payments and costs, and the cumulative operating margin offset (excluding 75 percent of operating DSH payments).

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

Cost report	Number of hospitals eligible for special exceptions	Special exceptions as a fraction of capital payments to all hospitals
PPS IX	—	—
PPS X	—	—
PPS XI	2	—
PPS XII	5	—
PPS XIII	7	—
PPS XIV	13	0.0001
PPS XV	17	0.0001
PPS XVI	24	0.0001
PPS XVII	26	0.0001
PPS XVIII	29	*0.0004

*Preliminary estimate based on submission of cost reports available as of March 2003.

We note that hospitals must complete their projects by the end of PPS XVIII in order to be eligible for special exceptions payments. With complete submission of the PPS XVIII (FY 2001) cost reports, we estimate that about 30 hospitals may qualify for special exceptions payments. Thus, we project that special exception payments as a fraction of capital payments to all hospitals to be approximately 0.0005.

Because special exceptions are budget neutral, in the May 19, 2003 proposed rule, we proposed to offset the capital Federal rate by 0.05 percent for special exceptions payments for FY 2004. For this final rule, based on updated data, we are offsetting the capital Federal rate by 0.05 percent for special exceptions payments for FY 2004. Therefore, the exceptions adjustment factor is equal to 0.9995 (1 − 0.0005) to account for special exceptions payments in FY 2004.

In the August 1, 2002 IPPS final rule (67 FR 50131) for FY 2003, we estimated that total (special) exceptions payments would equal 0.30 percent of aggregate payments based on the capital Federal rate. Therefore, we applied an exceptions reduction factor of 0.9970 (1 − 0.0030) in determining the FY 2003 capital Federal rate. As we stated above, we estimate that exceptions payments in FY 2004 will equal 0.05 percent of aggregate payments based on the FY 2004 capital Federal rate. Therefore, we are applying an exceptions payment adjustment factor of 0.9995 (1 − 0.0005) to the capital Federal rate for FY 2004. The exceptions adjustment factor for FY 2004 is 0.25 percent higher than the factor for FY 2003 published in the

August 1, 2002 IPPS final rule (67 FR 50131). This increase is primarily due to a refined analysis of more recent data.

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

5. Capital Standard Federal Rate for FY 2004

In the August 1, 2002 IPPS final rule (67 FR 50131) we established a capital Federal rate of $407.01 for FY 2003. As we noted above, as a result of the revisions to the GAF effective for discharges occurring on or after April 1, 2003 through September 30, 2003 published August 25, 2003 in the **Federal Register** (68 FR 22272), we have established a capital Federal rate of $406.93 for discharges occurring on or after April 1, 2003 through September 30, 2003. The capital rates effective for discharges occurring on or after April 1, 2003 through September 30, 2003, were used in determining the FY 2004 capital rates. In this final rule, we are establishing a capital Federal rate of $415.47 for FY 2004. The capital Federal rate for FY 2004 was calculated as follows:

- The FY 2004 update factor is 1.0070; that is, the update is 0.70 percent.
- The FY 2004 budget neutrality adjustment factor that is applied to the capital standard Federal payment rate for changes in the DRG relative weights and in the GAF is 1.0059.
- The FY 2004 outlier adjustment factor is 0.9521.
- The FY 2004 (special) exceptions payment adjustment factor is 0.9995.

Since the capital Federal rate has already been adjusted for differences in case-mix, wages, cost-of-living, indirect medical education costs, and payments to hospitals serving a disproportionate share of low-income patients, we are making no additional adjustments in the capital standard Federal rate for these factors, other than the budget neutrality factor for changes in the DRG relative weights and the GAF.

We are providing a chart that shows how each of the factors and adjustments for FY 2004 affected the computation of the FY 2004 capital Federal rate in comparison to the FY 2003 capital Federal rate. The FY 2004 update factor has the effect of increasing the capital Federal rate by 0.70 percent compared to the FY 2003 capital Federal rate, while the GAF/DRG budget neutrality factor has the effect of increasing the capital Federal rate by 0.59 percent. The FY 2004 outlier adjustment factor has the effect of increasing the capital Federal rate by 0.55 percent compared to the FY 2003 capital Federal rate. The FY 2004 exceptions payment adjustment factor has the effect of increasing the capital Federal rate by 0.25 percent compared to the exceptions payment adjustment factor for capital FY 2003. The combined effect of all the changes is to increase the capital Federal rate by 2.10 percent compared to the FY 2003 capital Federal rate.

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

	FY 2003	FY 2004	Change	Percent change
Update factor[1]	1.0110	1.0070	1.0070	0.70
GAF/DRG Adjustment Factor[1]	0.9957	1.0059	1.0059	0.59
Outlier Adjustment Factor[2]	0.9469	0.9521	1.0055	0.55
Exceptions Adjustment Factor[2]	0.9970	0.9995	1.0025	0.25
Capital Federal Rate	$406.93	$415.47	[3]1.0210	[3]2.10

[1] The update factor and the GAF/DRG budget neutrality factors are built permanently into the capital rates. Thus, for example, the incremental change from FY 2003 to FY 2004 resulting from the application of the 1.0059 GAF/DRG budget neutrality factor for FY 2004 is 1.0059.

[2] The outlier reduction factor and the exceptions adjustment factor are not built permanently into the capital rates; that is, these factors are not applied cumulatively in determining the capital rates. Thus, for example, the net change resulting from the application of the FY 2004 outlier adjustment factor is 0.9521/0.9469, or 1.0055.

[3] The percent change in factors and adjustments may not sum due to rounding.

We are also providing a chart that shows how the final FY 2004 capital Federal rate differs from the proposed FY 2004 capital Federal rate.

COMPARISON OF FACTORS AND ADJUSTMENTS: FY 2004 PROPOSED CAPITAL FEDERAL RATE AND FY 2004 FINAL CAPITAL FEDERAL RATE

	Proposed FY 2004	Final FY 2004	Change	Percent change
Update factor	1.0070	1.0070	1.0000	0.00
GAF/DRG Adjustment Factor	1.0038	1.0059	1.0021	0.21
Outlier Adjustment Factor	0.9455	0.9521	1.0070	0.70
Exceptions Adjustment Factor	0.9995	0.9995	1.0000	0.00
Capital Federal Rate	$411.72	$415.47	1.0091	0.91

6. Special Capital Rate for Puerto Rico Hospitals

As explained at the beginning of section II.D. of this Addendum, hospitals in Puerto Rico are paid based on 50 percent of the Puerto Rico capital rate and 50 percent of the capital Federal rate. The Puerto Rico capital rate is derived from the costs of Puerto Rico hospitals only, while the capital Federal rate is derived from the costs of all acute care hospitals participating in the PPS (including Puerto Rico). To adjust hospitals' capital payments for geographic variations in capital costs, we apply a GAF to both portions of the blended capital rate. The GAF is calculated using the operating PPS wage index and varies, depending on the MSA or rural area in which the hospital is located. We use the Puerto Rico wage index to determine the GAF for the Puerto Rico part of the capital-blended rate and the national wage index to determine the GAF for the national part of the blended capital rate.

Because we implemented a separate GAF for Puerto Rico in FY 1998, we also apply separate budget neutrality adjustments for the national GAF and for the Puerto Rico GAF. However, we apply the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. As we stated in section III.A.4. of this Addendum, for Puerto Rico the GAF budget neutrality factor is 1.0002, while the DRG adjustment is 1.0008, for a combined cumulative adjustment of 0.9973.

In computing the payment for a particular Puerto Rico hospital, the Puerto Rico portion of the capital rate (50 percent) is multiplied by the Puerto Rico-specific GAF for the MSA in which the hospital is located, and the national portion of the capital rate (50 percent) is multiplied by the national GAF for the MSA in which the hospital is located (which is computed from national data for all hospitals in the United States and Puerto

Rico). In FY 1998, we implemented a 17.78 percent reduction to the Puerto Rico capital rate as a result of Pub. L. 105–33. In FY 2003, a small part of that reduction was restored.

For FY 2003, before application of the GAF, the special capital rate for Puerto Rico hospitals was $198.29. With the changes we proposed to the factors used to determine the capital rate, the proposed FY 2004 special capital rate for Puerto Rico was $201.26. For this final rule, based on the final factors, the FY 2004 capital rate for Puerto Rico is $203.15.

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

With the end of the capital PPS transition period in FY 2001, all hospitals (except ''new'' hospitals under § 412.324(b) and under § 412.304(c)(2)) are paid based on 100 percent of the capital Federal rate in FY 2004. The applicable capital Federal rate was determined by making adjustments as follows:

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

For purposes of calculating payments for each discharge during FY 2004, the capital standard Federal rate is adjusted as follows: (Standard Federal Rate) × (DRG weight) × (GAF) × (Large Urban Add-on, if applicable) × (COLA adjustment for hospitals located in Alaska and Hawaii) × (1 + Disproportionate Share Adjustment Factor + IME Adjustment Factor, if applicable). The result is the adjusted capital Federal rate.

Hospitals also may receive outlier payments for those cases that qualify under the thresholds established for each fiscal year. Section 412.312(c) provides for a single set of thresholds to identify outlier cases for both inpatient operating and inpatient capital-related payments. The outlier thresholds for FY 2004 are in section II.A.4.c. of this Addendum. For FY 2004, a case qualifies as a cost outlier if the cost for the case plus the IME and DSH payments is greater than the prospective payment rate for the DRG plus $31,000.

An eligible hospital may also qualify for a special exceptions payment under § 412.348(g) for up through the 10th year beyond the end of the capital transition period if it meets: (1) a project need requirement described at § 412.348(g)(2), which in the case of certain urban hospitals includes an excess capacity test as described at § 412.348(g)(4); and (2) a project size requirement as described at § 412.348(g)(5). Eligible hospitals include sole community hospitals, urban hospitals with at least 100 beds that have a DSH patient percentage of at least 20.2 percent or qualify for DSH payments under § 412.106(c)(2), and hospitals that have a combined Medicare and Medicaid inpatient utilization of at least 70 percent. Under § 412.348(g)(8), the amount of a special exceptions payment is determined by comparing the cumulative payments made to the hospital under the capital PPS to the cumulative minimum payment level. This amount is offset by: (1) any amount by which a hospital's cumulative capital payments exceed its cumulative minimum payment levels applicable under the regular exceptions process for cost reporting periods beginning during which the hospital has been subject to the capital PPS; and (2) any amount by which a hospital's current year operating and capital payments (excluding 75 percent of operating DSH payments) exceed its operating and capital costs. Under § 412.348(g)(6), the minimum payment level is 70 percent for all eligible hospitals.

During the transition period, new hospitals (as defined under § 412.300) were exempt from the capital PPS for their first 2 years of operation and were paid 85 percent of their reasonable costs during that period. Effective with the third year of operation through the remainder of the transition period, under § 412.324(b) we paid the hospital under the appropriate transition methodology. If the hold-harmless methodology was applicable, the hold-harmless payment for assets in use during the base period would extend for 8 years, even if the hold-harmless payments extend beyond the normal transition period. As discussed in section VI.A. of the preamble of this final rule, under § 412.304(c)(2), for cost reporting periods beginning on or after October 1, 2002, we pay a new hospital 85 percent of their reasonable costs during the first 2 years of operation unless it elects to receive payment based on 100 percent of the capital Federal rate. Effective with the third year of operation, we pay the hospital based on 100 percent of the capital Federal rate (that is, the same methodology used to pay all other hospitals subject to the capital PPS).

C. Capital Input Price Index

1. Background

Like the operating input price index, the capital input price index (CIPI) is a fixed-weight price index that measures the price changes associated with capital costs during a given year. The CIPI differs from the operating input price index in one important aspect—the CIPI reflects the vintage nature of capital, which is the acquisition and use of capital over time. Capital expenses in any given year are determined by the stock of capital in that year (that is, capital that remains on hand from all current and prior capital acquisitions). An index measuring capital price changes needs to reflect this vintage nature of capital. Therefore, the CIPI was developed to capture the vintage nature of capital by using a weighted-average of past capital purchase prices up to and including the current year.

We periodically update the base year for the operating and capital input prices to reflect the changing composition of inputs for operating and capital expenses. The CIPI was last rebased to FY 1997 in the August 1, 2002 final rule (67 FR 50044).

2. Forecast of the CIPI for Federal Fiscal Year 2004

Based on historical data available through the second quarter of 2003, we forecast the CIPI to increase 0.7 percent in FY 2004. This reflects a projected 1.2 percent increase in vintage-weighted depreciation prices (building and fixed equipment, and movable equipment) and a 3.8 percent increase in other capital expense prices in FY 2004, partially offset by a 2.6 percent decline in vintage-weighted interest expenses in FY 2004. The weighted average of these three factors produces the 0.7 percent increase for the CIPI as a whole in FY 2004.

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

As discussed in section VI. of the preamble of this final rule, in accordance with section 1886(b)(3)(H)(i) of the Act and effective for cost reporting periods beginning on or after October 1, 2002, payments to existing psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals excluded from the IPPS are no longer subject to limits on a hospital-specific target amount (expressed in terms of the inpatient operating cost per discharge) that are set for each hospital, based on the hospital's own historical cost experience trended forward by the applicable rate-of-increase percentages (update factors).

Effective for cost reporting periods beginning on or after October 1, 2002, rehabilitation hospitals and units are no longer paid on a reasonable cost basis but are paid under the 100 percent of IRF PPS Federal rate. Effective for cost reporting periods beginning on or after October 1, 2002, LTCHs also are no longer paid on a reasonable cost basis but are paid under a LTCH DRG-based PPS. As part of the payment process for LTCHs, we established a 5-year transition period from reasonable cost-based reimbursement to a fully Federal PPS. However, a LTCH that is subject to the blend methodology may elect to be paid based on a 100 percent of the Federal prospective rate.

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

Section 1886(b)(7) of the Act had established a payment limitation for new hospitals and units excluded from the IPPS. While both rehabilitation hospitals and units and LTCHs are now paid under a PPS, psychiatric hospitals and units continue to be subject to the payment limitation. A discussion of how the payment limitation was calculated can be found in the August 29, 1997 final rule with comment period (62 FR 46019); the May 12, 1998 final rule (63 FR 26344); the July 31, 1998 final rule (63 FR 41000); and the July 30, 1999 final rule (64 FR 41529).

The amount of payment for a ''new'' psychiatric hospital or unit would be determined as follows:

- Under existing § 413.40(f)(2)(ii), for cost reporting periods beginning on or after October 1, 1997, the amount of payment for a new hospital or unit that was not paid as

an excluded hospital or unit before October 1, 1997, is the lower of: (1) the hospital's net inpatient operating costs per case; or (2) 110 percent of the national median of the target amounts for the same class of excluded hospitals and units, adjusted for differences in wage levels and updated to the first cost reporting period in which the hospital receives payment. The second cost reporting period is subject to the same target amount applied to the first cost reporting period.

• In the case of a hospital that received payments under § 413.40(f)(2)(ii) as a newly created hospital or unit, to determine the hospital's or unit's target amount for the hospital's or unit's third 12-month cost reporting period, the payment amount determined under § 413.40(f)(2)(ii)(A) for the preceding cost reporting period is updated to the third cost reporting period.

The amounts included in the following table reflect the updated 110 percent of the national median target amounts of new excluded psychiatric hospitals and units for cost reporting periods beginning during FY 2004. These figures are updated with the most recent data available to reflect the market basket increase percentage of 3.4 percent. This percentage change in the market basket reflects the average change in the price of goods and services purchased by hospitals to furnish inpatient hospital services (as projected by CMS' Office of the Actuary based on its historical experience with the IPPS). For a new provider, the labor-related share of the target amount is multiplied by the appropriate geographic area wage index, without regard to IPPS reclassifications, and added to the nonlabor-related share in order to determine the per case limit on payment under the statutory payment methodology for new providers.

Class of excluded hospital or unit	FY 2004 labor-related share	FY 2004 nonlabor-related share
Psychiatric	$7,294	$2,899

Effective for cost reporting periods beginning on or after October 1, 2002, this payment limitation is no longer applicable to new LTCHs since they will be paid 100 percent of the Federal rate. A new LTCH is a provider of inpatient hospital services that meets the qualifying criteria for LTCHs specified under § 412.23(e)(1) and (e)(2) and whose first cost reporting period as a LTCH begins on or after October 1, 2002 (§ 412.23(e)(4)). Under the LTCH PPS, new LTCHs are paid based on 100 percent of the fully Federal prospective rate (they may not participate in the 5-year transition from cost-based reimbursement to prospective payment). In contrast, those ''new'' LTCHs that meet the definition of ''new'' under § 413.40(f)(2)(ii) and that have their first cost reporting periods beginning on or after October 1, 1997, and before October 1, 2002, may be paid under the LTCH PPS transition methodology. Since those hospitals by definition would have been considered new before October 1, 2002, they would have been subject to the updated payment limitation on new hospitals that was published in the FY 2003 IPPS final rule (67 FR 50103). Under existing regulations at § 413.40(f)(2)(ii), the ''new'' hospital would be subject to the same cap in its second cost reporting period; this cap would not be updated for the new hospital's second cost reporting year. Thus, since the same cap is to be used for the ''new'' LTCH's first two cost reporting periods, it is no longer necessary to publish an updated cap.

We are in the process of developing a proposed rule that would establish a per diem PPS for inpatient psychiatric facilities (IPFs) (previously referred to as psychiatric hospitals and units) that is required under the provisions of section 124 of Pub. L. 106–113.

V. Payment for Blood Clotting Factor Administered to Hemophilia Inpatients

In December 2002, the Department implemented a policy that established the Single Drug Pricer (SDP) to correct identified discrepancies, further the legislative goal of establishing a uniform payment allowance as a reflection of the average wholesale price (AWP), and otherwise apply the existing stature and regulation more accurately and efficiently (CMS Program Memorandum AB–02–174, December 3, 2002, which can be accessed at: *http://www.cms.hhs.gov/manuals*). Under the SDP, CMS will establish prices centrally, thereby resulting in greater consistency in drug pricing nationally. The SDP instruction applies to blood clotting factors furnished to hospital inpatients. The payment allowance for the single national drug price for each Medicare covered drug is based on 95 percent of the AWP, except for drugs billed to durable medical equipment regional carriers (DMERCs) and hospital outpatient drugs billed to fiscal intermediaries. We are publishing this notice here because we previously have addressed the add-on payment for the costs of administering blood clotting factor in the IPPS annual rule (see the August 1, 2000 IPPS final rule (65 FR 47116).

On a quarterly basis, CMS will furnish three SDP files to all fiscal intermediaries. Each fiscal intermediary must accept the SDP files and process claims for any drug identified on the files on the basis of the price shown on the applicable file. Previously, the fiscal intermediary performed annual update calculations based on the most recent AWP data available to the carrier. The fiscal intermediary should use the SDP to price the blood clotting factors.

VI. Tables

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

Table 1A.—National Adjusted Operating Standardized Amounts, Labor/Nonlabor
Table 1C.—Adjusted Operating Standardized Amounts for Puerto Rico, Labor/Nonlabor
Table 1D.—Capital Standard Federal Payment Rate
Table 2.—Hospital Average Hourly Wage for Federal Fiscal Years 2002 (1998 Wage Data), 2003 (1999 Wage Data), and 2004 (2000 Wage Data) Wage Indexes and 3-Year Average of Hospital Average Hourly Wages
Table 3A.—3-Year Average Hourly Wage for Urban Areas
Table 3B.—3-Year Average Hourly Wage for Rural Areas
Table 4A.—Wage Index and Capital Geographic Adjustment Factor (GAF) for Urban Areas
Table 4B.—Wage Index and Capital Geographic Adjustment Factor (GAF) for Rural Areas
Table 4C.—Wage Index and Capital Geographic Adjustment Factor (GAF) for Hospitals That Are Reclassified
Table 4F.—Puerto Rico Wage Index and Capital Geographic Adjustment Factor (GAF)
Table 4G.—Pre-Reclassified Wage Index for Urban Areas
Table 4H.—Pre-Reclassified Wage Index for Rural Areas
Table 5.—List of Diagnosis Related Groups (DRGs), Relative Weighting Factors, Geometric and Arithmetic Mean Length of Stay
Table 6A.—New Diagnosis Codes
Table 6B.—New Procedure Codes
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Table 6D.—Invalid Procedure Codes
Table 6E.—vised Diagnosis Code Titles
Table 6F.—Revised Procedure Code Titles
Table 6G.—Additions to the CC Exclusions List
Table 6H.—Deletions from the CC Exclusions List
Table 7A.—Medicare Prospective Payment System Selected Percentile Lengths of Stay
FY 2002 MedPAR Update March 2003 GROUPER V20.0
Table 7B.—Medicare Prospective Payment System Selected Percentile Lengths of Stay
FY 2002 MedPAR Update March 2003 GROUPER V21.0
Table 8A.—Statewide Average Operating Cost-to-Charge Ratios—July 2003
Table 8B.—Statewide Average Capital Cost-to-Charge Ratios—July 2003
Table 9.—Hospital Reclassifications and Redesignations—FY 2004
Table 10.—Mean and .75 Standard Deviation by Diagnosis-Related Groups (DRGs)-July 2003
Table 11.—LTC-DRGs Relative Weights and Geometric and Five-Sixth of the Average Length of Stay-FY 2004

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

Large urban areas		Other areas	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$3,145.06	$1,278.78	$3,095.27	$1,258.54

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

	Large urban areas		Other areas	
	Labor	Nonlabor	Labor	Nonlabor
National	$3,119.61	$1,268.03	$3,119.61	$1,268.03
Puerto Rico	1,510.12	607.86	1,486.22	598.24

TABLE 1D.—CAPITAL STANDARD FEDERAL PAYMENT RATE

	Rate
National	$415.47
Puerto Rico	203.15

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
010001	17.4467	17.9841	19.4061	18.2955
010004	19.0010	20.1613	22.2673	20.4948
010005	18.6554	19.9733	19.6063	19.4156
010006	17.6115	18.3931	19.0976	18.4162
010007	15.6788	16.0781	17.5462	16.4299
010008	17.4728	19.0182	19.6573	18.7416
010009	18.4979	19.7272	20.4309	19.5485
010010	16.4664	17.7348	19.2644	17.7722
010011	22.4292	24.8922	25.8231	24.3180
010012	15.8686	20.3376	20.0896	18.5710
010015	19.1178	19.8205	18.8890	19.2826
010016	20.2198	20.3175	21.7918	20.8284
010018	18.9388	19.5519	19.2071	19.2353
010019	17.0856	17.6414	18.9177	17.8535
010021	15.1241	25.3335	17.7595	18.4456
010022	17.6435	22.1250	22.2266	20.3667
010023	16.3209	18.4567	20.4900	18.3307
010024	15.9034	17.3746	18.5942	17.2467
010025	15.1548	17.4702	19.3649	17.3268
010027	16.8595	16.5157	14.0974	15.7259
010029	18.3605	19.3393	20.9868	19.6276
010031	18.6402	19.2612	21.0176	19.6504
010032	15.3590	16.3967	16.4712	16.0937
010033	21.2986	21.9828	24.5088	22.5487
010034	15.3639	14.9379	14.9333	15.0828
010035	15.9439	20.7808	21.6182	19.2869
010036	17.7166	18.7158	19.2501	18.5418
010038	19.6098	19.6887	18.6578	19.2855
010039	20.3406	21.3550	23.0339	21.6158
010040	20.0983	20.4486	20.7779	20.4475
010043	18.6640	17.3567	19.9012	18.6528
010044	24.0265	23.4575	25.8561	24.4502
010045	17.0417	18.7569	22.7713	19.2947
010046	18.9737	18.8741	19.6754	19.1973
010047	15.4190	13.4130	16.1695	14.9341
010049	15.5246	16.3349	16.2973	16.0600
010050	17.9830	20.3028	20.7398	19.6262
010051	11.8108	12.3280	14.3007	12.8040

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

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
010052	18.0653	19.8289	11.9019	15.6329
010053	15.5649	15.4156	17.3238	16.1023
010054	19.4955	20.9656	20.6382	20.3799
010055	18.8590	19.5667	18.9664	19.1295
010056	19.6577	20.5645	21.1104	20.4208
010058	16.9715	16.1265	17.7800	16.9302
010059	18.8020	19.1270	20.5534	19.4928
010061	14.5003	18.5320	17.0447	16.6905
010062	12.3259	16.9721	17.1786	15.3820
010064	19.5256	20.5650	22.2280	20.6930
010065	16.8752	17.0557	17.2698	17.0733
010066	13.1559	14.8904	14.8696	14.3351
010068	18.6925	23.4322	18.3308	20.2712
010069	14.7211	15.4497	17.0957	15.7416
010072	16.2339	16.5652	18.8807	17.1920
010073	14.1273	13.5594	14.9826	14.2068
010078	18.1363	18.5127	20.1447	18.9315
010079	17.0648	17.1612	20.7401	18.2252
010081	17.2996	*	*	17.2996
010083	18.0312	18.4282	19.8525	18.7454
010084	18.7769	19.8773	21.6522	20.1274
010085	19.9023	21.5860	22.5282	21.3942
010086	16.5711	16.8886	18.0122	17.1417
010087	18.0567	18.7915	19.7620	18.8065
010089	17.7800	19.5241	19.5783	18.9652
010090	18.9445	19.5635	20.0287	19.5086
010091	17.0799	17.1775	17.4672	17.2432
010092	17.8144	18.5478	19.9351	18.7658
010095	12.2597	12.3064	12.5243	12.3676
010097	12.7286	14.2675	15.1593	14.0568
010098	14.0300	15.5763	15.1629	14.9158
010099	15.5619	15.9232	16.3307	15.9423
010100	17.9430	18.3755	19.8146	18.7658
010101	14.4625	18.9525	19.0718	17.2612
010102	13.8136	15.7777	16.4636	15.3148
010103	17.7242	22.0802	22.5709	20.6405
010104	16.8457	21.9457	20.9391	19.7211
010108	19.4617	19.1596	20.7787	19.7956
010109	14.6752	15.9627	18.2235	16.2157
010110	15.8283	15.5817	16.0015	15.8256
010112	16.8271	15.6041	17.9243	16.7545
010113	16.8936	18.2774	19.4106	18.1836
010114	17.0760	19.3772	20.1763	18.8237
010115	14.2261	15.3510	15.7873	15.0923
010118	17.0834	17.4620	19.5302	17.9294
010119	19.3942	19.5163	20.5245	19.8190
010120	18.2567	18.9975	19.4369	18.8719
010121	14.5262	15.2345	17.1640	15.7079
010123	19.2140	*	*	19.2141
010124	16.7465	*	*	16.7465
010125	16.0136	16.5117	16.8622	16.4618
010126	19.1065	19.5933	19.9647	19.5751
010127	18.2786	*	*	18.2786
010128	14.4322	16.6899	14.7646	15.2637
010129	16.1733	16.7609	16.4904	16.4644
010130	19.5573	17.4614	18.7190	18.5367
010131	20.1883	19.0492	22.9969	20.8110
010134	19.9856	18.5179	17.7717	18.7919
010137	20.5828	21.3573	28.9402	23.2122
010138	14.5254	14.1369	14.2024	14.2898
010139	20.4331	20.5708	22.8390	21.2553
010143	17.6212	18.9084	20.5639	19.0433
010144	18.2040	18.8272	19.1497	18.7345
010145	20.5895	20.8157	22.1394	21.2084

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
010146	19.1415	18.3666	21.3083	19.5948
010148	15.8349	18.4591	17.6830	17.3825
010149	18.0156	19.0199	21.0086	19.3661
010150	18.9359	19.4819	21.2360	19.9132
010152	18.7677	19.8990	21.6038	20.0519
010155	15.0689	13.6136	*	14.4394
010157	*	17.7372	19.6977	18.7304
010158	18.3957	18.6052	18.5464	18.5206
010159	*	19.3950	*	19.3950
020001	28.0394	28.6530	30.1452	28.9867
020002	25.1987	28.2759	*	26.6688
020004	25.4679	29.2351	27.3516	27.2833
020005	29.2378	35.0860	32.7936	32.3866
020006	28.1417	33.0843	31.2673	30.7745
020007	32.3852	27.7269	*	29.7080
020008	30.8691	31.8878	33.4543	32.1364
020009	18.4660	18.5594	*	18.5119
020010	22.7559	23.7275	20.7928	22.3051
020011	28.0658	27.5062	*	27.7745
020012	25.5320	26.7586	27.9955	26.7886
020013	28.1557	29.5646	30.6424	29.4993
020014	24.5875	27.7870	29.6806	27.4656
020017	28.0572	28.8752	30.3017	29.1234
020024	25.3205	25.5933	28.0930	26.3977
020025	20.2583	29.4375	*	24.0587
030001	21.7869	22.8996	25.7513	23.3305
030002	21.8375	23.1450	25.6038	23.5516
030003	22.6804	23.9849	22.1436	22.9249
030004	15.5478	13.8452	*	14.6087
030006	20.0273	20.5019	23.2881	21.1483
030007	21.5169	22.2473	26.1551	23.4298
030008	22.2190	*	*	22.2190
030009	18.7557	19.1258	19.9131	19.2261
030010	19.5123	19.8496	20.7204	20.0003
030011	19.4310	19.8141	21.0028	20.0690
030012	20.6585	21.1099	24.2366	22.1509
030013	20.0535	19.9517	21.9766	20.7166
030014	19.7966	20.3017	23.3663	21.1589
030016	19.4785	22.2526	24.3380	22.1886
030017	21.7938	23.1702	21.8792	22.2509
030018	20.8980	21.8067	24.9216	22.5811
030019	21.2540	22.0341	23.2973	22.2278
030022	19.5794	22.3351	24.9941	22.3479
030023	24.1678	25.4626	28.6628	26.2700
030024	23.6009	23.7663	26.7641	24.7020
030025	11.9894	20.2690	*	15.6341
030027	17.6555	18.5500	19.4583	18.5927
030030	21.6932	23.1280	25.2425	23.1970
030033	20.2820	20.3034	26.3814	22.2735
030034	20.8689	19.5578	*	20.1515
030035	20.0226	20.5339	*	20.2741
030036	21.6371	22.2690	24.9432	23.0233
030037	23.7615	23.7325	23.0542	23.5162
030038	22.9822	23.4477	25.2632	23.9087
030040	19.7636	19.3706	21.2717	20.1331
030041	18.8717	18.4750	*	18.6831
030043	20.5598	20.5653	23.5172	21.6042
030044	17.6575	18.6781	21.9503	19.2464
030047	21.4412	22.7385	*	22.1035
030049	19.3580	19.7315	*	19.5288
030054	15.0657	15.7973	*	15.4443
030055	20.2991	20.8373	22.8612	21.3919
030059	22.6279	27.3929	*	24.8227
030060	18.6313	19.5021	21.7685	19.9508

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
030061	19.9047	21.1013	22.9706	21.3676
030062	18.7172	19.2670	21.1639	19.7478
030064	20.3837	21.6435	22.8009	21.6120
030065	20.7838	22.2846	24.6064	22.6068
030067	17.2778	17.6414	18.4004	17.7581
030068	17.7208	18.9718	19.7097	18.8803
030069	21.0936	23.4902	24.5432	23.0752
030080	20.6581	21.2299	22.8953	21.6643
030083	23.5229	23.5049	24.3273	23.8162
030085	20.8690	21.6542	21.8196	21.4875
030087	21.9465	23.1339	25.6351	23.5333
030088	20.5340	21.4491	23.5761	21.9185
030089	20.9516	22.0850	24.5055	22.5911
030092	21.8308	19.6625	24.0515	21.9130
030093	20.4314	21.7195	23.2485	21.9062
030094	22.8123	21.8049	24.5992	23.0301
030095	13.7664	20.5222	*	16.1313
030099	18.2263	19.8092	20.3310	19.5882
030100	23.7609	23.5868	27.6299	25.3037
030101	19.2547	21.1029	23.7661	21.3217
030102	18.2413	21.5405	27.9419	22.5589
030103	*	28.9308	29.1105	29.0254
030104	*	32.8668	34.6026	33.8315
040001	16.9178	16.3882	18.7141	17.4255
040002	15.1107	16.1353	18.0776	16.4361
040003	15.5740	15.5186	16.3918	15.8349
040004	17.9034	19.0105	21.2335	19.4115
040005	11.1318	16.5465	*	13.6054
040007	18.6998	22.5319	23.3992	21.2518
040008	14.7985	20.2121	*	17.4031
040010	19.4913	19.8251	20.7114	20.0272
040011	16.0995	17.1337	18.8346	17.5256
040014	18.1434	19.3996	22.4970	19.9652
040015	15.5207	17.9602	18.8513	17.4824
040016	20.2321	19.8087	21.2198	20.4114
040017	15.4736	16.5648	17.7545	16.6023
040018	18.7463	18.8203	22.0408	19.7570
040019	23.4163	21.0465	21.1711	21.7572
040020	18.9844	17.6056	18.6419	18.3851
040021	19.6835	21.3321	23.5620	21.5681
040022	20.8281	19.2393	21.4194	20.3876
040024	17.6607	17.1507	17.5750	17.4623
040025	13.4705	14.8071	*	14.1228
040026	19.7924	21.0143	22.7699	21.2074
040027	17.4431	17.7161	19.3388	18.1973
040028	13.9946	15.2850	*	14.6625
040029	21.1370	22.5094	22.1882	21.9489
040030	11.2402	16.5488	*	13.2353
040032	13.2872	13.8013	16.2781	14.3506
040035	10.9569	11.0611	11.8237	11.2698
040036	20.2012	21.1066	21.6742	21.0202
040037	14.0941	15.4984	*	14.7246
040039	14.7177	15.2811	15.9673	15.3471
040040	19.1984	19.6704	*	19.4380
040041	16.4624	17.7783	20.4646	18.2091
040042	15.2057	16.6875	16.2285	16.0552
040044	13.3501	17.1869	*	15.1931
040045	16.2469	16.6648	19.5573	17.3603
040047	17.5336	18.6295	21.6323	19.2840
040050	14.0036	14.2087	15.1428	14.4627
040051	16.6039	18.2152	17.6964	17.5006
040053	15.0219	14.1508	19.2586	15.8377
040054	14.2577	16.5217	16.5573	15.7676
040055	18.0414	17.4236	19.7335	18.3506

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
040058	16.4278	19.3124	*	17.6419
040060	17.9805	15.4220	*	16.5871
040062	17.8902	19.4255	21.9336	19.7228
040064	11.5029	13.3479	*	12.3898
040066	19.7144	19.5619	21.7766	20.3116
040067	14.4741	15.0081	16.0516	15.1736
040069	17.0026	18.9754	20.5968	18.8667
040070	16.9700	18.6066	*	17.8568
040071	17.6144	18.4956	19.4324	18.4911
040072	17.4960	21.3320	19.3079	19.3210
040074	18.7542	20.8465	22.0800	20.5126
040075	14.0975	14.6681	15.7875	14.8313
040076	20.5840	21.8010	23.5948	21.9901
040077	13.9114	14.7230	16.7832	15.1038
040078	18.5821	19.6363	21.4854	19.9519
040080	19.3707	22.8153	18.4470	20.0143
040081	11.1332	12.4796	13.2797	12.2892
040082	15.1331	16.4840	*	15.7978
040084	17.7295	18.3410	20.1163	18.7753
040085	16.5216	14.1782	15.5811	15.3778
040088	17.1624	18.3159	20.0032	18.4492
040090	19.0824	16.6619	*	17.8591
040091	20.1378	20.2904	20.6688	20.3813
040093	13.9741	14.7132	*	14.3380
040100	15.6833	17.0271	17.8889	16.9700
040105	14.3896	14.8936	15.4697	14.9508
040106	18.1341	19.0936	*	18.6698
040107	17.8628	20.6852	17.6695	18.7676
040109	16.6278	16.2496	17.1706	16.6926
040114	21.1231	21.3826	21.6849	21.4003
040118	18.2123	19.6248	21.7913	19.9047
040119	16.9407	18.6028	19.9013	18.5380
040124	19.2889	*	*	19.2889
040126	11.6517	16.3391	13.3832	13.6732
040132	10.3875	24.6941	29.2337	17.5163
040134	19.0185	22.1291	24.4646	22.0021
040135	23.0084	*	*	23.0082
040136	*	21.4139	*	21.4138
040137	*	*	24.7813	24.7813
040138	*	*	22.3523	22.3523
050002	36.9630	30.2629	30.9729	32.2632
050006	18.2061	22.4890	25.4604	22.0357
050007	30.8676	31.6270	34.1406	32.1656
050008	26.3682	28.2021	32.4067	28.7024
050009	28.4734	28.3021	30.2740	29.0378
050013	28.0569	27.2552	29.8401	28.3575
050014	23.6745	25.1664	27.7646	25.5586
050015	27.7731	28.2204	27.5652	27.8552
050016	21.2045	22.7014	25.5508	23.2128
050017	25.6178	25.7403	28.4911	26.6066
050018	15.2903	16.5909	17.9621	16.7254
050022	24.5254	26.2574	28.1312	26.3930
050024	22.4274	21.5230	25.1425	23.0352
050025	24.8245	26.0161	29.8262	26.8932
050026	23.1904	23.4651	24.2564	23.6605
050028	17.6138	17.9421	18.7866	18.1131
050029	24.6839	26.6783	30.2538	27.1782
050030	21.5621	21.8639	21.9251	21.7896
050032	24.3598	24.4176	28.8046	25.7369
050033	32.0179	31.1768	*	31.6954
050036	21.8239	24.8017	25.3885	24.0459
050038	29.9698	32.1757	36.1619	32.5954
050039	22.8288	23.8478	26.8993	24.5711
050040	30.2607	30.1153	30.7426	30.3810

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
050042	24.5260	25.4903	27.6765	25.9508
050043	33.8255	38.8988	37.3217	36.6008
050045	21.1474	21.0356	22.1691	21.4359
050046	25.2005	25.3067	25.5490	25.3505
050047	29.9580	31.6959	34.4427	32.0849
050051	18.7809	17.9266	*	18.3161
050054	22.0982	19.2395	21.3495	20.8463
050055	29.2730	32.0923	36.1182	32.3322
050056	23.8396	24.7994	27.1458	25.3250
050057	20.7420	22.2584	24.2758	22.4840
050058	23.3009	24.8366	25.9389	24.7179
050060	20.5450	21.9971	22.9491	22.0213
050061	24.5488	23.9906	25.3042	24.6040
050063	25.7593	25.5798	28.6093	26.6450
050065	24.6290	27.6677	28.8369	27.0472
050066	16.1649	26.3920	*	19.8363
050067	25.8857	22.1250	27.8867	24.8006
050068	19.3615	19.2325	21.9031	19.5920
050069	24.6153	25.8560	27.2744	25.8994
050070	34.0721	36.4136	39.5178	36.7625
050071	34.4367	36.4834	40.1344	37.0182
050072	39.7321	36.1146	39.2529	38.3306
050073	32.8555	36.1054	38.6763	35.9238
050075	33.7160	37.8104	40.2265	37.4233
050076	33.9752	37.0415	40.8075	37.1398
050077	24.1404	25.3481	27.1234	25.5664
050078	24.3150	23.0613	24.1091	23.8126
050079	30.0167	36.5455	38.8981	35.1106
050082	23.7617	23.7718	27.5022	24.9190
050084	25.4517	25.1155	26.0607	25.5652
050088	24.9641	25.2282	27.1103	25.7384
050089	22.8450	23.4120	24.7857	23.6599
050090	24.6070	25.4545	27.4193	25.8348
050091	23.7713	26.6463	29.2522	26.4442
050092	17.1211	17.1883	*	17.1549
050093	25.6647	27.2048	29.2642	27.4393
050095	30.4847	29.2226	*	29.7245
050096	22.7394	22.5034	23.0526	22.7555
050097	22.5991	24.2548	24.6726	23.8591
050099	25.3722	26.2363	27.1282	26.2763
050100	25.2031	23.9877	25.6798	24.9469
050101	31.8957	33.1232	32.9866	32.6718
050102	24.0014	22.6741	25.5763	24.0204
050103	25.4133	23.5946	27.8079	25.5235
050104	26.9726	27.3260	26.1592	26.8000
050107	22.2019	22.2746	22.6900	22.4227
050108	25.1758	25.6983	28.5244	26.4357
050110	19.9589	21.3399	21.9296	21.1132
050111	20.7897	21.0813	23.7715	21.9292
050112	26.8182	29.1268	31.9797	29.3043
050113	28.5224	32.4493	32.6932	31.3678
050114	26.6757	27.6486	28.1938	27.5328
050115	23.0182	24.3748	24.1481	23.8529
050116	24.9196	27.0331	28.2924	26.6320
050117	22.2123	23.0697	24.7555	23.3917
050118	23.7129	24.9094	28.9358	25.8815
050121	18.7272	18.8430	25.0858	20.5240
050122	26.9546	26.9048	29.1534	27.6723
050124	24.5069	23.9379	23.0843	23.8087
050125	32.0230	33.3290	35.6572	33.6339
050126	24.6752	26.9718	27.7126	26.4996
050127	20.9027	20.5928	21.8719	21.1212
050128	26.6132	26.2519	28.7668	27.1805
050129	24.0108	23.7432	25.2780	24.3452

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

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
050131	32.5462	33.0980	37.7844	34.4656
050132	24.0173	24.1583	27.8805	25.3842
050133	23.2093	23.9479	25.1948	24.1576
050135	24.7157	23.2750	*	23.9658
050136	24.7280	28.0754	31.6146	27.9406
050137	32.9192	33.7489	35.0503	33.8818
050138	38.1584	40.8912	43.0858	40.6538
050139	31.4984	35.1492	33.8749	33.3407
050140	32.7609	36.7096	36.1708	35.1295
050144	27.4069	29.8983	30.3678	29.2851
050145	34.5185	37.5003	37.5722	36.5610
050148	20.0971	21.1622	17.3908	19.5271
050149	26.8674	25.8880	28.0501	26.8823
050150	24.6596	25.9494	26.7728	25.8255
050152	33.3305	34.5096	34.5694	34.1486
050153	32.3389	33.3333	34.5870	33.4428
050155	25.3354	23.2118	21.2069	23.1002
050158	28.6071	28.9764	30.6598	29.4328
050159	22.5313	26.6139	27.4051	24.9053
050167	21.8796	21.9596	23.2022	22.3516
050168	25.1937	27.1971	27.5313	26.5678
050169	24.8407	24.7737	25.6896	25.1108
050170	24.3654	27.7693	29.4075	26.9505
050172	19.6120	22.0400	24.5849	22.0737
050173	24.8694	*	27.7070	26.3141
050174	30.2775	31.6888	33.5204	31.9008
050175	24.7548	26.0146	26.9627	25.9076
050177	21.1396	22.5039	23.1575	22.2317
050179	23.8868	22.8941	23.0583	23.2574
050180	33.3257	34.0900	36.9905	34.8613
050186	23.6288	25.0791	27.6638	25.5202
050188	28.2364	30.6007	34.1503	31.0517
050189	27.4071	28.3295	32.3514	29.2097
050191	25.3516	29.4162	28.1689	27.6587
050192	14.1996	19.0400	19.5327	17.3659
050193	24.9444	25.5294	24.6307	25.0325
050194	29.5678	28.5389	28.1413	28.7132
050195	36.9068	39.1617	42.1735	39.4471
050196	18.2411	19.4304	20.7257	19.5002
050197	32.4030	34.6878	*	33.4489
050204	22.7099	23.0192	24.9458	23.5600
050205	24.1691	24.1275	25.2841	24.5169
050207	22.9941	23.7774	25.1863	23.9991
050211	31.7280	33.2481	34.3396	33.0898
050213	21.4951	*	*	21.4951
050214	24.0276	21.1480	22.4773	22.4934
050215	35.0459	31.6895	36.6063	34.4197
050217	20.2042	21.3026	22.2055	21.2565
050219	21.2458	21.7637	21.8649	21.6598
050222	23.3563	23.0670	25.2922	23.9448
050224	23.5101	24.8431	26.2108	24.9081
050225	21.6820	22.0981	25.0218	22.9304
050226	24.4443	26.1959	26.0826	25.7144
050228	34.2596	36.0632	38.6751	36.2629
050230	26.6291	26.7963	30.0380	27.8217
050231	26.7321	27.4697	27.8896	27.3721
050232	24.5245	25.8640	25.3439	25.2423
050234	24.6126	25.0104	24.0754	24.5126
050235	27.0922	26.0323	27.2838	26.7962
050236	25.9458	27.7406	27.0687	26.9151
050238	24.5823	25.1796	26.0312	25.2541
050239	23.2711	24.9469	27.0866	25.1260
050240	26.7620	28.8910	32.8542	29.7204
050241	29.8345	*	*	29.8345

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.