B. Collection of Information Requirements

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

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

In the May 18, 2004 proposed rule, we solicited public comments on each of these issues for the information collection requirements in the proposed rule discussed below under which associated burdens are subject to the PRA.

§412.22 Excluded hospitals and hospital units: General rules.

In summary, this section outlines the requirements for excluded hospitals and hospital units. This section states that a LTCH that occupies space in a building used by another hospital, or in one or more separate buildings located on the same campus as

buildings used by another hospital must notify its fiscal intermediary and CMS in writing of its co-location.

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

§412.25 Excluded hospital units: Common requirements.

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

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

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

In summary, this section outlines the requirements and process for determining the adjustment of the wage index to account for the commuting patterns of hospital workers. This section states that a hospital may waive the application of the wage index

adjustment by notifying CMS in writing within 45 days after the publication of the annual notice of proposed rulemaking for the IPPS.

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

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

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

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

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

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

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

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

In the May 18, 2004 proposed rule, we proposed to revise this section. However, the collection requirement remains the same. While this requirement is subject to the PRA, this requirement is currently approved in OMB No. 0938-0573, with a current expiration date of October 31, 2005.

§412.211 Puerto Rico rates for Federal fiscal year 2004 and subsequent fiscal years.

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

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

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

§412.234 Criteria for all hospitals in an urban county seeking redesignation to another urban area.

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

In the May 18, 2004 proposed rule, we proposed to revise this section. However, the collection requirement remains the same. While this requirement is subject to the PRA, this requirement is currently approved in OMB No. 0938-0907, with a current expiration date of December 31, 2005.

§413.70 Payment for services of a CAH.

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

In the May 18, 2004 proposed rule, we proposed to revise this section. However, the collection requirement remains the same. While this requirement is subject to the PRA, this requirement is currently approved in OMB No. 0938-0050, with a current expiration date of November 30, 2005.

§413.78 Direct GME payments: Determinations of the total number of FTE residents.

In summary, this section outlines the requirements for the determination of the total number of FTE residents in determining direct GME payments to hospitals. Currently, this section states that, for residents who spend time in nonprovider settings, there must be a written agreement between the hospital and the outside entity that states that the resident's compensation for training time spent outside of the hospital setting is to be paid by the hospital. In the May 18, 2004 proposed rule, we proposed to remove the written agreement requirement from this section.

This requirement is exempt from the PRA in accordance with Pub. L. 99-272 or Pub. L. 108-173, or both.

§413.79 Direct GME payments: Determination of the weighted number of FTE residents.

In summary, this section outlines the requirements for the determination of the weighted number of FTE residents for direct GME payments to hospitals. Under this section in the May 18, 2004 proposed rule, we proposed that a hospital seeking an adjustment to the limit on its unweighted resident count under section 422 of Pub. L. 108-173 must provide documentation justifying the adjustment. In addition, the section states that a hospital wishing to receive a temporary adjustment to its FTE resident cap because it is participating in a Medicare GME affiliated group must submit the Medicare GME affiliation agreement to the CMS fiscal intermediary and to CMS's Central Office. This section specifies the information that a request must contain.

These requirements are exempt from the PRA in accordance with Pub. L. 99-272 or Pub. L. 108-173, or both.

§413.80 Direct GME payments: Determination of weighting factors for foreign medical graduates.

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

This requirement is exempt from the PRA in accordance with Pub. L. 99-272 or Pub. L. 108-173, or both.

§413.83 Direct GME payments: Adjustment of a hospital's target amount or prospective payment hospital-specific rate.

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

This requirement is exempt from the PRA in accordance with Pub. L. 99-272 or Pub. L. 108-173, or both.

§480.106 Exceptions to QIO notice requirements.

In summary, in the May 18, 2004 proposed rule, we proposed to revise this section to add exceptions to the notice requirements for disclosure of QIO information to any person, agency, or organization. The notice requirements do not apply if the

institution or practitioner has requested, in writing, that the QIO make the disclosure; the institution or practitioner has provided, in writing, consent for the disclosure; or the information is public information.

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

We believe the collection requirements are exempt as defined in 5 CFR 1320.3(c)(4) because we believe this would affect less than 10 persons.

§480.133 Disclosure of information about practitioners, reviewers, and institutions.

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

We believe the collection requirements are exempt as defined in 5 CFR 1320.3(c)(4) because we believe this would affect less than 10 persons.

§480.140 Disclosure of quality review study information.

In summary, this section outlines the requirements concerning the disclosure of quality review study information. This section states that a QIO may disclose quality review study information with identifiers of particular practitioners or institutions, or both, at the written request of, or with the written consent of, the identified practitioner(s)

or institution(s). The consent or request must specify the information that is to be disclosed and the intended recipient of the information. The recipient would be subject to the same rights and responsibilities on redisclosure as the requesting or consenting practitioner or institution.

We believe the collection requirements to be exempt as defined in 5 CFR 1320.3(c)(4) because we believe this would affect less than 10 persons.

§482.43 Condition of participation: Discharge planning.

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

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

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

We did not receive any comments on the proposed information collection and recordkeeping requirements.

The new information collection and recordkeeping requirements, described above, have been submitted to the OMB for review under the authority of the PRA. These requirements will not be effective until they have been approved by OMB.

C. Waiver of Proposed Rulemaking for Technical Correction to LTCH Regulations

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** to provide a period for public comment before the provisions of a notice take effect. However, we can waive this procedure if we find good cause that notice and comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporate a statement of the findings and the reasons for it into the notice issued.

In section VI.A.6 of the preamble of this final rule, we discuss a technical correction that we are making to the regulations to reinstate §412.22(h)(6) to the regulations governing payments to LTCHs under the LTCH PPS. We find it unnecessary to undertake notice and comment rulemaking with respect to the addition of §412.22(h)(6) to the regulation text because this correction merely reinstates a paragraph of regulation text implemented in one final rule and inadvertently erroneously removed by another final rule. We also note that the policy codified in §412.22(h)(6) underwent notice and comment rulemaking before being finalized. Thus, because the public has already had the opportunity to comment on this policy, additional comment would be unnecessary.

Crosswalk of Contents of §413.86

Existing Section	New Section
§413.86(a)	§413.75(a)
§413.86(a)(1)	§413.75(a)(1)
§413.86(a)(2)	§413.75(a)(2)

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

Existing Section	New Section
§413.86(e)(4)(ii), introductory text	§413.77(d)(2), introductory text--**NEW**
§413.86(e)(4)(ii)(A)	§413.77(d)(2)(i)
§413.86(e)(4)(ii)(B)	§413.77(d)(2)(ii)
§413.86(e)(4)(ii)(C), introductory text	§413.77(d)(2)(iii), introductory text
§413.86(e)(4)(ii)(C)(1)	§413.77(d)(2)(iii)(A)
§413.86(e)(4)(ii)(C)(1)(i)	§413.77(d)(2)(iii)(A)(1)
§413.86(e)(4)(ii)(C)(1)(ii)	§413.77(d)(2)(iii)(A)(2)
§413.86(e)(4)(ii)(C)(1)(iii)	§413.77(d)(2)(iii)(A)(3)
§413.86(e)(4)(ii)(C)(2), introductory text	§413.77(d)(2)(iii)(B), introductory text--**NEW**
§413.86(e)(4)(ii)(C)(2)(i)	§413.77(d)(2)(iii)(B)(1)
§413.86(e)(4)(ii)(C)(2)(ii)	§413.77(d)(2)(iii)(B)(2)
§413.86(e)(4)(ii)(C)(2)(iii)	§413.77(d)(2)(iii)(B)(3)--**NEW**
§413.86(e)(4)(ii)(C)(2)(iv)	§413.77(d)(2)(iii)(B)(4)--**NEW**
--	§413.77(d)(2)(iiii)(B)(5)--**NEW**
§413.86(e)(4)(ii)(C)(3)	§413.77(d)(2)(iii)(C)--**NEW**
§413.86(e)(5)	§413.77(e)
§413.86(e)(5)(i)	§413.77(e)(1)
§413.86(e)(5)(i)(A)	§413.77(e)(1)(i)
§413.86(e)(5)(i)(B), introductory text	§413.77(e)(1)(ii), introductory text
§413.86(e)(5)(i)(B)(1)	§413.77(e)(1)(ii)(A)
§413.86(e)(5)(i)(B)(2)	§413.77(e)(1)(ii)(B)
§413.86(e)(5)(i)(C)	§413.77(e)(1)(iii)
§413.86(e)(5)(ii)	§413.77(e)(2)
§413.86(e)(5)(iii)	§413.77(e)(3)
--	§413.77(f)--**NEW**
--	§413.77(g)--**NEW**
§413.86(f)	§413.78
§413.86(f), introductory text	§413.78, introductory text
§413.86(f)(1)	§413.78(a)
§413.86(f)(2)	§413.78(b)
§413.86(f)(3), introductory text	§413.78(c), introductory text
§413.86(f)(3)(i)	§413.78(c)(1)
§413.86(f)(3)(ii)	§413.78(c)(2)
§413.86(f)(4), introductory text	§413.78(d), introductory text
§413.86(f)(4)(i)	§413.78(d)(1)
§413.86(f)(4)(ii)	§413.78(d)(2)
§413.86(f)(4)(iii)	§413.78(d)(3)
§413.86(f)(4)(iv)	§413.78(d)(4)
--	§413.78(e), introductory text--**NEW**
--	§413.78(e)(1)--**NEW**

Existing Section	New Section
--	§413.78(e)(2)--**NEW**
--	§413.78(e)(3)--**NEW**
§413.86(g), introductory text	§413.79
§413.86(g), introductory text	§413.79, introductory text
§413.86(g)(1)	§413.79(a)
§413.86(g)(1)	§413.79(a) introductory text--**NEW**
§413.86(g)(1)	§413.79(a)(1)--**NEW**
§413.86(g)(1)	§413.79(a)(2)--**NEW**
§413.86(g)(1)	§413.79(a)(3)--**NEW**
§413.86(g)(1)	§413.79(a)(4)--**NEW**
§413.86(g)(1)	§413.79(a)(5)--**NEW**
§413.86(g)(1)(i)	§413.79(a)(6)
§413.86(g)(1)(ii)	§413.79(a)(7)
§413.86(g)(1)(iii), introductory text	§413.79(a)(8), introductory text
§413.86(g)(1)(iii)(A)	§413.79(a)(8)(i)
§413.86(g)(1)(iii)(B)	§413.79(a)(8)(ii)
§413.86(g)(1)(iv)	§413.79(a)(9)
--	§413.79(a)(10)--**NEW**
§413.86(g)(2)	§413.79(b)(1)
§413.86(g)(3)	§413.79(b)(2)
--	§413.79(c)(1), introductory text--**NEW**
--	§413.79(c)(1)(i) through (iii)--**NEW**
§413.86(g)(4), introductory text	§413.79(c)(2), introductory text
§413.86(g)(4)(i)	§413.79(c)(2)(i)
§413.86(g)(4)(ii)	§413.79(c)(2)(ii)
§413.86(g)(4)(iii)	§413.79(c)(2)(iii)
§413.86(g)(4)(iv)	§413.79(c)(2)(iv)
§413.86(g)(4)(v)	§413.79(c)(2)(v)
--	§413.79(c)(3)(i) through (ii)--**NEW**
--	§413.79(c)(4)--**NEW**
	§413.79(c)(5)--**NEW**
§413.86(g)(5), introductory text	§413.79(d), introductory text
§413.86(g)(5)(i)	§413.79(d)(1)
§413.86(g)(5)(ii)	§413.79(d)(2)
§413.86(g)(5)(iii)	§413.79(d)(3)
§413.86(g)(5)(iv)	§413.79(d)(4)
§413.86(g)(5)(v)	§413.79(d)(5)
§413.86(g)(5)(vi)	§413.79(d)(6)
§413.86(g)(5)(vii)	§413.79(d)(7)
§413.86(g)(6), introductory text	§413.79(e), introductory text
§413.86(g)(6)(i)	§413.79(e)(1)
§413.86(g)(6)(i)(A)	§413.79(e)(1)(i)

Existing Section	New Section
§413.86(g)(6)(i)(B)	§413.79(e)(1)(ii)
§413.86(g)(6)(i)(C)	§413.79(e)(1)(iii)
§413.86(g)(6)(i)(D)	§413.79(e)(1)(iv)
§413.86(g)(6)(i)(E)	§413.79(e)(1)(v)
§413.86(g)(6)(ii), introductory text	§413.79(e)(2), introductory text
§413.86(g)(6)(ii)(A)	§413.79(e)(2)(i)
§413.86(g)(6)(ii)(B)	§413.79(e)(2)(ii)
§413.86(g)(6)(iii)	§413.79(e)(3)
§413.86(g)(6)(iv)	§413.79(e)(4)
§413.86(g)(7)	§413.79(f)
§413.86(g)(7)(i)	§413.79(f)(1)
§413.86(g)(7)(ii)	§413.79(f)(2)
§413.86(g)(7)(iii)	§413.79(f)(3)
§413.86(g)(7)(iv)	§413.79(f)(4)
§413.86(g)(7)(v)	§413.79(f)(5)
§413.86(g)(8), introductory text	§413.79(g), introductory text
§413.86(g)(8)(i), introductory text	§413.79(g)(1), introductory text
§413.86(g)(8)(i)(A)	§413.79(g)(1)(i)
§413.86(g)(8)(i)(B)	§413.79(g)(1)(ii)
§413.86(g)(8)(ii)	§413.79(g)(2)
§413.86(g)(8)(iii)	§413.79(g)(3)
§413.86(g)(8)(iv)	§413.79(g)(4)
§413.86(g)(8)(v)	§413.79(g)(5)
§413.86(g)(9)	§413.79(h)
§413.86(g)(9)(i), introductory text	§413.79(h)(1), introductory text
§413.86(g)(9)(i)(A)	§413.79(h)(1)(i)
§413.86(g)(9)(i)(B)	§413.79(h)(1)(ii)
§413.86(g)(9)(ii), introductory text	§413.79(h)(2), introductory text
§413.86(g)(9)(ii)(A)	§413.79(h)(2)(i)
§413.86(g)(9)(ii)(B)	§413.79(h)(2)(ii)
§413.86(g)(9)(iii), introductory text	§413.79(h)(3), introductory text
§413.86(g)(9)(iii)(A), introductory text	§413.79(h)(3)(i), introductory text
§413.86(g)(9)(iii)(A)(1)	§413.79(h)(3)(i)(A)
§413.86(g)(9)(iii)(A)(2)	§413.79(h)(3)(i)(B)
§413.86(g)(9)(iii)(B), introductory text	§413.79(h)(3)(ii), introductory text
§413.86(g)(9)(iii)(B)(1)	§413.79(h)(3)(ii)(A)
§413.86(g)(9)(iii)(B)(2)	§413.79(h)(3)(ii)(B)
§413.86(g)(10), introductory text	§413.79(i), introductory text
§413.86(g)(10)(i)	§413.79(i)(1)
§413.86(g)(10)(ii)	§413.79(i)(2)
§413.86(g)(10)(iii)	§413.79(i)(3)
§413.86(g)(11), introductory text	§413.79(j), introductory text

Existing Section	New Section
§413.86(g)(11)(i)	§413.79(j)(1)
§413.86(g)(11)(ii)	§413.79(j)(2)
§413.86(g)(11)(iii)	§413.79(j)(3)
§413.86(g)(12), introductory text	§413.79(k), introductory text
§413.86(g)(12)(i), introductory text	§413.79(k)(1), introductory text
§413.86(g)(12)(i)(A)	§413.79(k)(1)(i)
§413.86(g)(12)(i)(B)	§413.79(k)(1)(ii)
§413.86(g)(12)(ii), introductory text	§413.79(k)(2), introductory text
§413.86(g)(12)(ii)(A)	§413.79(k)(2)(i)
§413.86(g)(12)(ii)(B), introductory text	§413.79(k)(2)(ii), introductory text
§413.86(g)(12)(ii)(B)(1), introductory text	§413.79(k)(2)(ii)(A), introductory text
§413.86(g)(12)(ii)(B)(1)(i)	§413.79(k)(2)(ii)(A)(1)
§413.86(g)(12)(ii)(B)(1)(ii)	§413.79(k)(2)(ii)(A)(2)
§413.86(g)(12)(ii)(B)(2)	§413.79(k)(2)(ii)(B)
§413.86(g)(12)(iii)	§413.79(k)(3)
§413.86(g)(12)(iv), introductory text	§413.79(k)(4), introductory text
§413.86(g)(12)(iv)(A)	§413.79(k)(4)(i)
§413.86(g)(12)(iv)(B), introductory text	§413.79(k)(4)(ii), introductory text
§413.86(g)(12)(iv)(B)(1)	§413.79(k)(4)(ii)(A)
§413.86(g)(12)(iv)(B)(2)	§413.79(k)(4)(ii)(B)
§413.86(g)(12)(v), introductory text	§413.79(k)(5), introductory text
§413.86(g)(12)(v)(A)	§413.79(k)(5)(i)
§413.86(g)(12)(v)(B)	§413.79(k)(5)(ii)
§413.86(g)(12)(v)(C)	§413.79(k)(5)(iii)
§413.86(g)(12)(vi)	§413.79(k)(6)
§413.86(g)(13)	§413.79(l)
§413.86(h)	§413.80
§413.86(h)(1), introductory text	§413.80(a), introductory text
§413.86(h)(1)(i)	§413.80(a)(1)
§413.86(h)(1)(ii)	§413.80(a)(2)
§413.86(h)(2)	§413.80(b)
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§413.86(h)(4)	§413.80(d)
§413.86(h)(5)	§413.80(e)
§413.86(h)(6)	§413.80(f)
§413.86(i)	§413.81
§413.86(i)(1), introductory text	§413.81(a), introductory text
§413.86(i)(1)(i)	§413.81(a)(1)
§413.86(i)(1)(ii)	§413.81(a)(2)
§413.86(i)(2)	§413.81(b)
§413.86(i)(3)(i)	§413.81(c)(1)
§413.86(i)(3)(ii)	§413.81(c)(2)

Existing Section	New Section
§413.86(j), introductory text	§413.75(d), introductory text
§413.86(j)(1)	§413.75(d)(1)
§413.86(j)(2)	§413.75(d)(2)
§413.86(j)(3)	§413.75(d)(3)
§413.86(j)(4)	§413.75(d)(4)
§413.86(j)(5)	§413.75(d)(5)
§413.86(j)(6)	§413.75(d)(6)
§413.86(j)(7)	§413.75(d)(7)
§413.86(k)	§413.82
§413.86(k)(1)	§413.82(a)
§413.86(k)(2)	§413.82(b)
§413.86(k)(3)	§413.82(c)
§413.86(l)	§413.83
§413.86(l)(1)	§413.83(a)
§413.86(l)(1)(i)	§413.83(a)(1)
§413.86(l)(1)(ii)	§413.83(a)(2)
§413.86(l)(2)(iii)	§413.83(a)(3)
§413.86(l)(2)	§413.83(b)
§413.86(l)(2)(i)	§413.83(b)(1)
§413.86(l)(2)(ii)	§413.83(b)(2)
§413.86(l)(2)(iii)	§413.83(b)(3)

Note to Readers: Redesignated §§413.77, 413.78 and 413.79 were the only three sections of the redesignated §§413.75 through 413.83 that contain proposed policy changes in the May 18, 2004 proposed rule:

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

These policy changes, any public comments we received, our responses to these comments and any further changes we have made in response to these comments are discussed in section IV. O. of the preamble of this final rule.

The remaining portions of the redesignated §§413.75 through 413.83 contain only coding, cross-reference, and conforming redesignation changes. In the May 18, 2004 proposed rule, we solicited comments on redesignation, coding, and cross-reference changes.

We were notified of one error in our proposed redesignation of the contents of §413.86. We erroneously redesignated the contents of §413.86(j) and (j)(1) through (j)(7) as paragraphs (g) and (g)(1) through (g)(7) under §413.80 which relates to determination of weighting factors for foreign medical graduates. The contents of §413.86(j) and (j)(1) through (j)(7) are general GME requirements relating to the information that a hospital must furnish to include a resident in the FTE count for a particular cost reporting period. Therefore, in this final rule, we have correctly redesignated §413.86(j) and (j)(1) through (j)(7) as paragraphs (d) and (d)(1) through (d)(7) under §413.75.

List of Subjects

42 CFR Part 403

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

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.

42 CFR Part 418

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

42 CFR Part 460

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

42 CFR Part 480

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

42 CFR Part 482

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

42 CFR Part 483

Grant program-health, Health facilities, Health professions, Health records, Medicaid, Medicare, Nursing homes, Nutrition, Reporting and recordkeeping requirements, Safety.

42 CFR Part 485

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

42 CFR Part 489

Health facilities, Medicare, Reporting and record keeping requirements.

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

A. Part 403 is amended as follows:

PART 403—SPECIAL PROGRAMS AND PROJECTS

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

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

2. Section 403.744 is amended by--

A. Revising paragraph (a).

B. Revising paragraph (c).

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

The revision reads as follows:

§403.744 Condition of Participation: Life safety from fire.

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

(1) Except as otherwise provided in this section--

(i) The RNHCI must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101® 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to:

http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the **Federal Register** to announce the changes.

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

* * * * *

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

B. Part 412 is amended as follows:

PART 412--PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

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

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

2. Section 412.2 is amended by adding a new paragraph (b)(3) to read as follows:

§412.2 Basis for payment.

* * * * *

(b) Payment in full. * * *

(3) If a patient is admitted to an acute care hospital and then the acute care hospital meets the criteria at §412.23(e) to be paid as a LTCH, during the course of the

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

* * * * *

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

§412.4 Discharges and transfers.

* * * * *

(d) Qualifying DRGs.

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

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

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

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

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

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

(2) For purposes of paragraph (c), a discharge is also considered to be a transfer if it meets the following conditions:

(i) The discharge is assigned to a DRG that contains only cases that were assigned to a DRG that qualified under this paragraph within the previous 2 years; and

(ii) The latter DRG was split or otherwise modified within the previous 2 fiscal years.

* * * * *

4. Section 412.22 is amended by--

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

B. Revising paragraph (e).

C. Adding a new paragraph (h)(6).

The additions and revision read as follows:

§412.22 Excluded hospitals and hospital units: General rules.

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

* * * * *

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

(1) Except as specified in paragraph (e)(2) of this section, for cost reporting periods beginning on or after October 1, 1987, and before October 1, 2004--

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

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

(iii) Separate medical staff. The hospital has a medical staff that is separate from the medical staff of the hospital occupying space in the same building or on the same

campus. The hospital's medical staff is directly accountable to the governing body for the quality of medical care provided in the hospital, and adopts and enforces by-laws governing medical staff activities, including criteria and procedures for recommending to the governing body the privileges to be granted to individual practitioners.

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

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

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

(B) For the same period of at least 6 months used to determine compliance with the criterion regarding the age of patients in §412.23(d)(2) or the length-of-stay criterion in §412.23(e)(2), or for hospitals other than children's or long-term care hospitals, for a

period of at least 6 months immediately preceding the first cost reporting period for which exclusion is sought, the cost of the services that the hospital obtains under contracts or other agreements with the hospital occupying space in the same building or on the same campus, or with a third entity that controls both hospitals, is mo more than 15 percent of the hospital's total inpatient operating costs, as defined in §412.2(c). For purposes of this paragraph (e)(1)(v)(B), however, the costs of preadmission services are those specified under §413.40(c)(2) rather than those specified under §412.2(c)(5).

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

(2) Effective for long-term care hospitals-within-hospitals for cost reporting periods beginning on or after October 1, 2004, the hospital must meet the governance and control requirements at paragraphs (e)(1)(i) through (e)(1)(iv) of this section.

(3) Notification of co-located status. A long-term care hospital that occupies space in a building used by another hospital, or in one or more separate buildings located on the same campus as buildings used by another hospital that meets the criteria of (e)(1) or (e)(2) of this section must notify its fiscal intermediary and CMS in writing of its

co-location within 60 days of its first cost reporting period that begins on or after October 1, 2002.

* * * * *

(h) Satellite facilities. * * *

(6) The provisions of paragraph (h)(2)(i) of this section do not apply to any long-term care hospital that is subject to the long-term care hospital prospective payment system under Subpart O of this subpart, effective for cost reporting periods occurring on or after October 1, 2002, and that elects to be paid bases on 100 percent of the Federal prospective payment rate as specified in §412.533(c), beginning with the first cost reporting period following that election, or when the LTCH is fully transitioned to 100 percent of the Federal prospective rate, or to a new long-term care hospital, as defined in §412.23(e)(4).

* * * * *

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

§412.25 Excluded hospital units: Common requirements.

* * * * *

(g) CAH units not meeting applicable requirements. If a psychiatric or rehabilitation unit of a CAH does not meet the requirements of §485.647 with respect to a cost reporting period, no payment may be made to the CAH for services furnished in that unit for that period. Payment to the CAH for services in the unit may resume only after the start of the first cost reporting period beginning after the unit has demonstrated to CMS that the unit meets the requirements of §485.647.

6. Section 412.63 is amended by--

A. Revising the heading of the section.

B. Revising paragraph (a).

C. Adding introductory text to paragraph (b).

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

E. Revising paragraph (u).

The revisions and addition read as follow:

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

(a) General rule.

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

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

* * * * *

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

* * * * *

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

* * * * *

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

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

* * * * *

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

* * * * *

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

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

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

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

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

(ii) The term urban area means--

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

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

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

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

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

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

(4) For purposes of this section, any change in an MSA designation is recognized on October 1 following the effective date of the change. Such a change in MSA

designation may occur as a result of redesignation of an MSA by the Executive Office of Management and Budget.

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

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

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

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

(e) Maintaining budget neutrality.

(1) CMS makes an adjustment to the standardized amount to ensure that--

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

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

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

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

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

(h) Adjusting for different area wage levels. CMS adjusts the proportion of the Federal rate for inpatient operating costs that are attributable to wages and labor-related

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

(1) The wage index is updated annually.

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

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

(4) For discharges on or after October 1, 2004 and before September 30, 2007, CMS establishes a minimum wage index for each all-urban State, as defined in paragraph (h)(5) of this section. This minimum wage index value is computed using the following methodology:

(i) CMS computes the ratio of the lowest-to-highest wage index for each all-urban State;

(ii) CMS computes the average of the ratios of the lowest-to-highest wage indexes of all the all-urban States;

(iii) For each all-urban State, CMS determines the higher of the State's own lowest-to-highest rate (as determined under paragraph (h)(4)(i) of this section) or the average lowest-to-highest rate (as determined under paragraph (h)(4)(ii) of this section);

(iv) For each State, CMS multiplies the rate determined under paragraph (h)(4)(iii) of this section by the highest wage index value in the State;

(v) The product determined under paragraph (h)(4)(iv) of this section is the minimum wage index value for the State.

(5) An all-urban State is a State with no rural areas, as defined in this section, or a State in which there are no hospitals classified as rural. A State with rural areas and with hospitals reclassified as rural under §412.103 in not an all-urban State.

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

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

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

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

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

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

(3) Process for determining the adjustment.

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

(ii) CMS will include, in its annual proposed and final notices of updates to the hospital inpatient prospective payment system, a listing of qualifying counties and the

hospitals that are eligible to receive the adjustment to their wage indexes for commuting hospital employees, and the wage index increase applicable to each qualifying county.

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

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

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

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

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

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

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

MGCRB in FY 2004. The wage index assignment is applicable for discharges occurring during the 3-year period beginning October 1, 2004 and ending September 30, 2007.

(k) Midyear corrections to the wage index.

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

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

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

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

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

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

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

* * * * *

(b) Eligibility criteria. * * *

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

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

§412.88 [Amended]

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

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

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

(a) General considerations.

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

(2) In order to qualify for this adjustment, a hospital must have less than 200 discharges during the fiscal year, as reflected in its cost report specified in paragraph (a)(3) of this section, and be located more than 25 road miles from the nearest subsection (d) hospital.

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

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

(b) Determination of the adjustment amount. The low-volume adjustment for hospitals that qualify under paragraph (a) of this section is 25 percent for each Medicare discharge.

(c) Eligibility of new hospitals for the adjustment. A new hospital will be eligible for a low-volume adjustment under this section once it has submitted a cost report for a cost reporting period that indicates that it meets the number of discharge requirement during the fiscal year and has provided its fiscal intermediary with sufficient evidence that it meets the distance requirement, as specified under paragraph (a)(2) of this section.

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

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

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

* * * * *

12. Section 412.103 is amended by--

A. Revising paragraph (a) introductory text.

B. Adding a new paragraph (a)(4).

The revision and addition read as follows:

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

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

* * * * *

(4) For any period after September 30, 2004 and before January 1, 2004, a CAH in a county that, in FY 2004, was not part of a MSA as defined by the Office of Management and Budget, but as of FY 2005 was included as part of an MSA as a result

of the most recent census data and implementation of the new MSA definitions announced by OMB on June 6, 2003, may be reclassified as being located in a rural area for purposes of meeting the rural location requirement in §485.610(b) of this chapter if it meets any of the requirements in paragraphs (a)(1), (a)(2), or (a)(3) of this section.

* * * * *

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

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

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

* * * * *

14. Section 412.105 is amended by--

A. Revising paragraph (b).

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

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

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

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

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

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

Cross-Reference Changes

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

Section	Remove Cross-Reference	Add Cross-Reference
412.105(a)(1), introductory text	paragraph (f) and (h) of this section	paragraph (f) of this section
412.105(f)(1)(i)(A)	§415.200(a)	§415.152
412.105(f)(1)(ii)(C)	§413.86(f)(3) or §413.86(f)(4)	§413.78(c) or §413.78(d)
412.105(f)(1)(vi)	§413.86(b)	§413.75(b)
412.105(f)(1)(vi)	§413.86(g)(7)	§413.79(f)
412.105(f)(1)(vii)	§413.86(g)(13)	§413.79(l)
412.105(f)(1)(vii)	§§413.86(g)(6)(i) through (iv)	§§413.79(e)(1) through (e)(4)
412.105(f)(1)(viii)	§413.86(g)(8)	§413.79(g)
412.105(f)(1)(ix)	§§413.86(g)(9)(i) and (g)(9)(ii)	§§ 413.79(h)(1) and (h)(2)
412.105(f)(1)(ix)	§§413.86(g)(9)(i) and (g)(9)(iii)(B)	§§413.79(h)(1) and (h)(3)(ii)
412.105(f)(1)(ix)	§§413.86(g)(9)(i) and (g)(9)(iii)(A)	§§413.79(h)(1) and (h)(3)(i)
412.105(f)(1)(x)	§413.86(g)(13)	§413.79(l)
412.105(f)(1)(x)	§413.86(g)(12)	§413.79(k)
412.105(f)(1)(xi)	§413.86(g)(10)	§413.79(i)
412.105(f)(1)(xii)	§413.86(g)(11)	§413.79(j)
412.105(g)	§§413.86(d)(3)(i) through (d)(3)(v)	§§413.76(c)(1) through (c)(5)

The revisions and additions read as follows:

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

* * * * *

(b) Determination of the 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 a unit or ward that is not occupied to provide a level of care that would be payable under the acute care hospital inpatient prospective payment system at any time during the 3 preceding months (the beds in the unit or ward are to be excluded from the determination of available bed days during the current month);

(2) Beds in a unit or ward that is otherwise occupied (to provide a level of care that would be payable under the acute care hospital inpatient prospective payment system) that could not be made available for inpatient occupancy within 24 hours for 30 consecutive days;

(3) Beds in excluded distinct part hospital units;

(4) Beds otherwise countable under this section used for outpatient observation services, skilled nursing swing-bed services, or ancillary labor/delivery services. This exclusion would not apply if a patient treated in an observation bed is ultimately admitted for acute inpatient care, in which case the beds and days would be included in those counts;

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

(6) Custodial care beds.

* * * * *

(d) Determination of education adjustment factor.

* * * * *

(3) Step three. * * *

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

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

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

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

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

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

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

(e) Determination of payment amount.

(1) * * *

(2) For discharges occurring on or after July 1, 2005, a hospital that counts additional residents as a result of an increase in its FTE resident cap under paragraph

(f)(1)(iv)(C) of this section will receive indirect medical education payments based on the sum of the following two indirect medical education adjustment factors:

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

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

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

(1) * * *

(iv) (A) * * *

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

(C) Effective for portions of cost reporting periods beginning on or after July 1, 2005, a hospital may qualify to receive an increase in its otherwise applicable FTE

resident cap (up to 25 additional FTEs) if the criteria specified in §413.79(c)(4) of this subchapter are met.

* * * * *

15. Section 412.106 is amended by--

A. Revising paragraphs (a)(1)(ii)(B) and (a)(1)(ii)(C).

B. Adding a new paragraph (a)(1)(ii)(D).

C. Revising paragraph (b)(2)(i).

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

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

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

(a) General considerations.

(1) * * *

(ii) * * *

(B) Beds otherwise countable under this section used for outpatient observation services, skilled nursing swing-bed services, or ancillary labor/delivery services. This exclusion would not apply if a patient treated in an observation bed is ultimately admitted for acute inpatient care, in which case the beds and days would be included in those counts;

(C) Beds in a unit or ward that is not occupied to provide a level of care that would be payable under the acute care hospital inpatient prospective payment system at

any time during the 3 preceding months (the beds in the unit or ward are to be excluded from the determination of available bed days during the current month); and

(D) Beds in a unit or ward that is otherwise occupied (to provide a level of care that would be payable under the acute care hospital inpatient prospective payment system) that could not be made available for inpatient occupancy within 24 hours for 30 consecutive days.

* * * * *

(b) * * *

(2) * * *

(i) Determines the number of patient days that-- * * *

(d) Payment adjustment factor.

* * * * *

(2) Payment adjustment factors.

* * * * *

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) 10 percent; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

* * * * *

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

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

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

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

* * * * *

17. Section 412.204 is amended by--

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

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

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

The revision and addition read as follows:

§412.204 Payment to hospitals in Puerto Rico.

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

* * * * *

(b) FY 1998 through March 31, 2004. For discharges occurring on or after October 1, 1997 and before April 1, 2004, payments for inpatient operating costs to hospitals located in Puerto Rico that are paid under the prospective payment system are equal to the sum of--

* * * * *

(c) Period of April 1, 2004 through September 31, 2004. For discharges occurring on or after April 1, 2004 and before October 1, 2004, payment for inpatient operating costs to hospitals located in Puerto Rico that are paid under the prospective payment system are equal to the sum of--

(1) 37.5 percent of the Puerto Rico prospective payment rate for inpatient operating costs, as determined under §412.208 or §412.210; and

(2) 62.5 percent of the national prospective payment rate for inpatient operating costs, as determined under §412.212.

(d) FY 2005 and thereafter. For discharges occurring on or after October 1, 2004, payments for inpatient operating costs to hospitals located in Puerto Rico that are paid under the prospective payment system are equal to the sum of--

(1) 25 percent of the Puerto Rico prospective payment rate for inpatient operating costs, as determined under §412.208 or §412.211; and

(2) 75 percent of a national prospective payment rate for inpatient operating costs, as determined under§412.212.

18. Section 412.210 is amended by--

A. Revising the title of the section.

B. Revising paragraph (a)(1).

§412.210 Puerto Rico rates for Federal fiscal years 1989 through 2003.

(a) General rule. (1) CMS determines the Puerto Rico adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge occurring in Federal fiscal years 1989 through 2003 that involves inpatient hospital services of a hospital in Puerto Rico subject to the prospective payment system for which payment may be made under Medicare Part A.

* * * * *

19. New §412.211 is added to read as follows:

§412.211 Puerto Rico rates for Federal fiscal year 2004 and subsequent fiscal years.

(a) General rule. CMS determines the Puerto Rico adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge occurring in Federal fiscal year 2004 and subsequent fiscal years that involves inpatient hospital services of a hospital in Puerto Rico subject to the prospective payment system for which payment may be made under Medicare Part A.

(b) Geographic classifications.

(1) For purposes of this section, the following definitions apply

(i) The term urban area means a Metropolitan Statistical Area (MSA) as defined by the Executive Office of Management and Budget.

(ii) The term rural area means any area outside of an urban area.

(2) For discharges occurring on or after October 1, 2004, a hospital located in a rural county adjacent to one or more urban areas is deemed to be located in an urban area

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

(c) Computing the standardized amount. CMS computes a Puerto Rico standardized amount that is applicable to all hospitals located in all areas, increased by the applicable percentage change specified in §412.64(d)(1).

(d) Computing Puerto Rico Federal rates for inpatient operating costs for hospitals located in all areas. For each discharge classified within a DRG, CMS establishes for the fiscal year a Puerto Rico prospective payment rate for inpatient operating costs equal to the product of--

(1) The average standardized amount for the fiscal year for hospitals located in all areas; and

(2) The weighting factor determined under §412.60(b) for that DRG.

(e) Adjusting for different area wage levels. CMS adjusts the proportion of the Puerto Rico rate for inpatient operating costs that are attributable to wages and labor-

related costs for area differences in hospital wage levels by a factor (established by CMS based on survey data) reflecting the relative level of hospital wages and wage-related costs in the geographic area (that is, urban or rural area as determined under the provisions of paragraph (b) of this section) of the hospital compared to the Puerto Rico average level of hospital wages and wage-related costs. The adjustment specified in this paragraph (e) also takes into account the earnings and paid hours of employment by occupational category.

(1) The wage index is updated annually.

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

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

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

(1) General criteria. For discharges occurring on or after October 1, 2004, CMS adjusts the hospital wage index for hospitals located in qualifying areas to recognize the

commuting patterns of hospital employees. A qualifying area is an area that meets all of the following criteria:

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

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

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

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

(3) Process for determining the adjustment.

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

(ii) CMS will include, in its annual proposed and final notices of updates to the hospital inpatient prospective payment system, a listing of qualifying areas and the

hospitals that are eligible to receive the adjustment to their wage indexes for commuting hospital employees, and the wage index increase applicable to each qualifying area.

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

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

20. Section 412.212 is amended by revising paragraph (b) to read as follows:

§412.212 National rate.

* * * * *

(b) Computing Puerto Rico standardized amounts. (1) For Federal fiscal years before FY 2004, CMS computes a discharge-weighted average of the--

(i) National urban adjusted standardized amount determined under §412.63(j)(1); and

(ii) National rural adjusted average standardized amount determined under §412.63(j)(2)(i).

(2) For fiscal years 2004 and subsequent fiscal years, CMS computes a discharge-weighted average of the national adjusted standardized amount determined under §412.64(e).

* * * * *

21. Section 412.230 is amended by--

A. Revising paragraph (a)(1).

B. Revising paragraph (a)(4).

C. Removing paragraph (a)(5)(ii) and redesignating paragraphs (a)(5)(iii), (a)(5)(iv), and (a)(5)(v) as paragraphs (a)(5)(ii), (a)(5)(iii), and (a)(5)(iv), respectively.

D. Removing paragraph (d).

E. Removing paragraph (e)(2)(i)(C).

F. Redesignating paragraph (e) as paragraph (d).

G. In redesignated paragraph (d)(1), removing the cross-reference "paragraphs (e)(3) and (e)(4)" and adding in its place "paragraphs (d)(3) and (d)(4)".

H. In redesignated paragraph (d)(2)(iii), removing the cross-reference "paragraph (e)(2)" and adding in its place "paragraph (d)(2)".

I. Revising redesignated paragraphs (d)(3)(i), (d)(3)(ii), and adding (d)(3)(iii)(C).

J. In redesignated paragraph (d)(4), removing the cross-reference "paragraphs (e)(1)(i) and (e)(1)(iii)" and adding in its place "paragraph (d)(1)(i) and (d)(1)(iii)".

K. In redesignated paragraph (d)(4)(iii), removing the cross-reference "paragraph (e)" and adding in its place "paragraph (d)".

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

(a) General. (1) Purposes. Except as specified in paragraph (a)(5)--

(i) For fiscal years prior to fiscal year 2005, an individual hospital may be redesignated from a rural area to an urban area, from a rural area to another rural area, or from a rural area to another urban area for the purposes of using the other area's standardized amount for inpatient operating costs, the wage index value, or both.

(ii) Effective for fiscal year 2005 and subsequent fiscal years, an individual hospital may be redesignated from a rural area to an urban area, from a rural area to another rural area, or from a rural area to another urban area for the purposes of using the other area's wage index value.

* * * * *

(4) Application of criteria. In applying the numeric criteria contained in paragraphs (b)(1), (b)(2), (d)(1)(iii), (d)(1)(iv)(A), and (d)(1)(iv)(B) of this section, rounding of numbers to meet the mileage or qualifying percentage standards is not permitted.

* * * * *

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

* * * * *

(3) Rural referral center exceptions.

(i) If a hospital was ever a rural referral center, it does not have to demonstrate that it meets the criterion set forth in paragraph (d)(1)(iii) of this section concerning its average hourly wage.

(ii) If a hospital was ever a rural referral center, it is required to meet only the criterion that applies to rural hospitals under paragraph (d)(1)(iv) of this section, whether or not it is actually located in an urban or rural area.

(iii) * * *

(C) With respect to redesignations for Federal fiscal year 2006 and later years, the hospital's average hourly wage is, in the case of a hospital located in a rural area, at least 106 percent, and, in the case of a hospital located in an urban area, 108 percent of the average hourly wage of all other hospitals in the area in which the hospital is located.

* * * * *

22. Section 412.232 is amended by--

A. Revising paragraph (a)(1).

B. Revising paragraph (a)(4).

C. Revising paragraph (b).

§412.232 Criteria for all hospitals in a rural county seeking urban redesignation.

(a) Criteria. * * *

(1) The county in which the hospitals are located--

(i) For fiscal years prior to fiscal year 2005, must be adjacent to the MSA or NECMA to which they seek redesignation.

(ii) For fiscal years beginning with fiscal years 2005, must be adjacent to the MSA to which they seek redesignation.

* * * * *

(4) The hospital may be redesignated only if one of the following conditions is met:

(i) The prereclassified average hourly wage for the area to which they seek redesignation is higher than the prereclassified average hourly wage for the area in which they are currently located.

(ii) For fiscal years prior to fiscal year 2005, the standardized amount for the area to which they seek redesignation is higher than the standardized amount for the area in which they are located.

(b) Metropolitan character.

(1) For fiscal years prior to FY 2005, the group of hospitals must demonstrate that the county in which the hospitals are located meets the standards for redesignation to an MSA or an NECMA as an outlying county that were published in the **Federal Register** on March 30, 1990 (55 FR 12154) using Bureau of the Census data or Bureau of Census estimates made after 1990.

(2) For fiscal years beginning with FY 2005, the group of hospitals must demonstrate that the county in which the hospitals are located meets the standards for redesignation to an MSA as an outlying county that were published in the **Federal Register** on December 27, 2000 (65 FR 82228) using Census Bureau data or Census Bureau estimates made after 2000.

* * * * *

23. Section 412.234 is amended by--

A. Revising paragraph (a)(3).

B. Revising paragraph (a)(4)

C. Removing paragraph (c).

D. Redesignating paragraph (d) as paragraph (c) and revising the redesignated paragraph (c).

The revisions read as follows.

§412.234 Criteria for all hospitals in an urban county seeking redesignation to another urban area.

(a) General criteria. * * *

(3) (i) For Federal fiscal years before fiscal year 2006, the counties in which the hospitals are located must be part of the Consolidated Metropolitan Statistical Area (CMSA) that includes the urban area to which they seek redesignation.

(ii) For fiscal years 2006 and thereafter, hospitals located in counties that are in the same Consolidated Statistical Area (CSA) (under the MSA definitions announced by the OMB on June 6, 2003) as the urban area to which they seek redesignation; or in the same Consolidated Metropolitan Statistical Area (CMSA) (under the standards published by the OMB on March 30, 1990) as the urban area to which they seek redesignation qualify as meeting the proximity requirement for reclassification to the urban area to which they seek redesignation.

(4) The hospital may be redesignated only if one of the following conditions is met:

(i) The prereclassified average hourly wage for the area to which they seek redesignation is higher than the prereclassified average hourly wage for the area in which they are currently located.

(ii) For fiscal years prior to fiscal year 2005, the standardized amount for the area to which they seek redesignation is higher than the standardized amount for the area in which they are located.

* * * * *

(c) Appropriate wage data. The hospitals must submit appropriate wage data as provided for in §412.230(d)(2).

§412.236 [Removed]

24. Section 412.236 is removed.

§412.252 [Amended]

25. In §412.252, paragraph (b), the phrase "or in a NECMA" is removed.

26. Section 412.274 is amended by revising paragraph (b)(1) to read as follows:

§412.274 Scope and effect of an MGCRB decision.

* * * * *

(b) Effective date and term of the decision.

(1) For reclassifications prior to fiscal year 2005, a standardized amount classification change is effective for 1 year beginning with discharges occurring on the first day (October 1) of the second Federal fiscal year following the Federal fiscal year in which the complete application is filed and ending effective at the end of that Federal fiscal year (the end of the next September 30).

* * * * *

27. Section 412.312 is amended by --

A. Revising paragraph (b)(2)(ii).

B. Revising paragraph (e).

The revisions read as follows.

§412.312 Payment based on the Federal rate.

(b) Payment adjustment. * * *

(2) Geographic adjustment factor. * * *

(ii) Large urban add-on. An additional adjustment is made for hospitals located in a large urban area to reflect the higher costs incurred by hospitals located in those areas. For purposes of the payment adjustment under this paragraph, the definition of large urban area set forth at §412.63(c)(6) continues to be in effect for discharges occurring on or after September 30, 2004.

* * * * *

(e) Payment for extraordinary circumstances. For cost reporting periods beginning on or after October 1, 2001--

(1) Payment for extraordinary circumstances is made as provided for in §412.348(f).

(2) Although no longer independently in effect, the minimum payment levels established under §412.348(c) continue to be used in the calculation of exception payments for extraordinary circumstances, according to the formula in §412.348(f).

(3) Although no longer independently in effect, the offsetting amounts established under §412.348(c) continue to be used in the calculation of exception payments for extraordinary circumstances. However, for cost reporting periods beginning during FY 2005 and subsequent fiscal years, the offsetting amounts in §412.348(c) are determined based on the lesser of--

(i) The preceding 10-year period; or

(ii) The period of time under which the hospital is subject to the prospective payment system for capital-related costs.

* * * * *

26. Section 412.316 is amended by revising paragraph (b) to read as follows:

§412.316 Geographic adjustment factors.

* * * * *

(b) Large urban location. CMS provides an additional payment to a hospital located in a large urban area equal to 3.0 percent of what would otherwise be payable to the hospital based on the Federal rate.

(1) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital's location for the purpose of receiving payment under §412.63(a). The term "large urban area" is defined under §412.63(c)(6).

(2) For discharges occurring on or after October 1, 2004, the definition of large urban area under §412.63(c)(6) continues to be in effect for purposes of the payment adjustment under this section, based on the geographic classification under §412.64.

* * * * *

27. Section 412.320 is amended by revising paragraph (a)(1) to read as follows:

§412.320 Disproportionate share adjustment factor.

(a) Criteria for classification.

* * * * *

(1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with §412.105(b), and serves low-income patients as determined under §412.106(b).

(i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital's location, for the purpose of receiving payment, under §412.63(a).

(ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under §412.64.

* * * * *

28. Section 412.374 is amended by--

A. Revising paragraph (a).

B. Redesignating paragraphs (b) and (c) as paragraphs (c) and (d), respectively.

C. Adding a new paragraph (b).

The revisions and addition read as follows:

§412.374 Payments to hospitals located in Puerto Rico.

(a) FY 1998 through FY 2004. Payments for capital-related costs to hospitals located in Puerto Rico that are paid under the prospective payment system are equal to the sum of the following:

(1) 50 percent of the Puerto Rico capital rate based on data from Puerto Rico hospitals only, which is determined in accordance with procedures for developing the Federal rate; and

(2) 50 percent of the Federal rate, as determined under §412.308.

(b) FY 2005 and FYs thereafter. For discharges occurring on or after October 1, 2004, payments for capital-related costs to hospitals located in Puerto Rico that are paid under the prospective payment system are equal to the sum of the following:

(1) 25 percent of the Puerto Rico capital rate based on data from Puerto Rico hospitals only, which is determined in accordance with procedures for developing the Federal rate; and

(2) 75 percent of the Federal rate, as determined under §412.308.

* * * * *

29. Section 412.521 is amended by adding a new paragraph (e) to read as follows:

§412.521 Basis for payment.

* * * * *

(e) Special payment provisions for patients in acute care hospitals that change classification status to LTCH status during a patient stay. (1) If a patient is admitted to an acute care hospital and then the acute care hospital meets the criteria at §412.23(e) to be paid as a LTCH during the course of the patient's hospitalization, Medicare considers all the days of the patient stay in the facility (days prior to and after the designation of LTCH status) to be a single episode of LTCH care. Payment for the entire patient stay (days prior to and after the designation of LTCH status) will include the day and cost data for that patient at both the acute care hospital and the LTCH in determining the payment to the LTCH under this subpart. The requirements of this paragraph (e)(1) apply only to a patient stay in which a patient is in an acute care hospital and that hospital is designated as a LTCH on or after October 1, 2004.

(2) The days of the patient's stay prior to and after the hospital's designation as a LTCH as specified in paragraph (e)(1) of this section are included for purposes of determining the beneficiary's length of stay.

30. Section 412.534 is added to read as follows:

§413.534. Special payment provisions for long-term care hospitals within hospitals and satellites of long-term care hospitals.

(a) Scope. The policies set forth in this section apply to discharges occurring in cost reporting periods beginning on or after October 1, 2004 from long-term care hospitals as described in §412.23(e)(2)(i) meeting the criteria in §412.22(e)(2), or satellite facilities of long-term care hospitals that meet the criteria in §412.22(h).

(b) Patients admitted from hospitals not located in the same building or on the same campus as the long-term care hospital. Payments to the long-term care hospital for patients admitted to the long-term hospital or to a satellite of the long-term care hospital from another hospital that is not the co-located hospital are made under the rules in this subpart with no adjustment under this section.

(c) Patients admitted from the hospital located in the same building or on the same campus as the long-term care hospital or satellite facility. Payments to the long-term care hospital for patients admitted to it or to its satellite facility from the co-located hospital will be made under either paragraph (c)(1) or paragraph (c)(2) of this section.

(1) For any cost reporting period beginning on or after October 1, 2004 in which the long-term care hospital or its satellite facility has a Medicare inpatient population of whom no more than 25 percent were referred to the hospital or its satellite facility from

the co-located hospital, payments are made under the rules at §412.500 through §412.541 in this subpart with no adjustment under this section.

(2) Except as provided in paragraph (d), (e), or (f) of this section, for any cost reporting period beginning on or after October 1, 2004 in which the long-term care hospital or satellite facility has a Medicare inpatient population of whom more than 25 percent were referred to the hospital or satellite facility from the co-located hospital, payments for the patients who are admitted from the co-located hospital and who cause the long-term care hospital or satellite facility to exceed the 25 percent threshold for discharges of patients from the co-located hospital are the lesser of the amount otherwise payable under this subpart or the amount payable under this subpart that is equivalent to the amount that would be otherwise determined under the rules at Subpart A, §412.1(a). Payments for the remainder of the long-term care hospital's or satellite facility's patients are made under the rules in this subpart at §412.500 through §412.541 with no adjustment under this section.

(3) In determining the percentage of patients admitted to the long-term care or satellite facility from the co-located hospital under paragraphs (c)(1) and (c)(2) of this section, patients on whose behalf an outlier payment was made to the co-located hospital are not counted towards the 25 percent threshold.

(d) Special treatment of rural hospitals. In the case of a long-term care hospital or satellite facility that is located in a rural area as defined in §412.62(f) and is co-located with another hospital for any cost reporting period beginning on or after October 1, 2004 in which the long-term care hospital or satellite facility has a Medicare inpatient

population of whom more than 50 percent were referred to the long-term care hospital or satellite facility from the co-located hospital, payments for the patients who are admitted from the co-located hospital and who cause the long-term care hospital or satellite facility to exceed the 50 percent threshold for discharges of patients from the co-located hospital are the lesser of the amount otherwise payable under this subpart or the amount payable under this subpart that is equivalent to the amount that would otherwise be payable under Subpart A, §412.1(a). Payments for the remainder of the long-term care hospital's or satellite facility's patients are made under the rules in this subpart at §412.500 through §412.541 with no adjustment under this section.

(2) In determining the percentage of patients admitted from the co-located hospital under paragraph (d)(1) of this section, patients on whose behalf outlier payment was made at the co-located hospital are not counted toward the 50 percent threshold.

(e) Special treatment of urban single or MSA dominant hospitals. In the case of a long-term care hospital or satellite facility that is co-located with the only other hospital in the MSA or with a MSA dominant hospital as defined in paragraph (e)(4) of this section, for any cost reporting period beginning on or after October 1, 2004 in which the long-term care hospital or satellite facility has a Medicare inpatient population of whom more than the percentage calculated under paragraph (e)(2) of this section were referred to the hospital from the co-located hospital, payments for the patients who are admitted from the co-located hospital and who cause the long-term care hospital to exceed the applicable threshold for discharges of patients from the co-located hospital are the lesser of the amount otherwise payable under this subpart or the amount under this subpart that

is equivalent to the amount that would otherwise be determined under Subpart A, §412.1(a). Payments for the remainder of the long-term care hospital's or satellite facility's patients are made under the rules in this subpart with no adjustment under this section.

(2) For purposes of paragraph (e)(1) of this section, the percentage used is the percentage of total Medicare discharges in the Metropolitan Statistical Area in which the hospital is located that are from the co-located hospital for the cost reporting period for which the adjustment was made, but in no case is less then 25 percent or more than 50 percent.

(3) In determining the percentage of patients admitted from the co-located hospital under paragraph (e)(1) of this section, patients on whose behalf outlier payment was made at the co-located hospital are not counted toward the applicable threshold.

(4) For purposes of this paragraph, an "MSA-dominant hospital" is a hospital that has discharged more than 25 percent of the total hospital Medicare discharges in the MSA in which the hospital is located.

(f) Transition period for long-term care hospitals and satellite facilities paid under this subpart. In the case of a long-term care hospital or a satellite facility that is paid under the provisions of this Subpart O of Part 412 on October 1, 2004 or of a hospital that is paid under the provisions of this Subpart O on October 1, 2005 and whose qualifying period under §412.23(e) began on or before October 1, 2004, the amount paid is calculated as specified below:

(1) For each discharge during the first cost reporting period beginning on or after October 1, 2004, and before October 1, 2005, the amount paid is the amount payable under this subpart, with no adjustment under this §412.534.

(2) For each discharge during the cost reporting period beginning on or after October 1, 2005, and before October 1, 2006, the percentage that may be admitted from the host with no payment adjustment may not exceed the lesser of the percentage of patients admitted from the host during fiscal year 2004 or 75 percent.

(3) For each discharge during the cost reporting period beginning on or after October 1, 2006, and before October 1, 2007, the percentage that may be admitted from the host with no payment adjustment may not exceed the lesser of the percentage of patients admitted from the host during fiscal year 2004 or 50 percent.

(4) For each discharge during cost reporting periods beginning on or after October 1, 2007, the percentage that may be admitted from the host with no payment adjustment may not exceed 25 percent or the applicable percentage determined under paragraph (d) or (e) of this section.

C. Part 413 is amended as follows:

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

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

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

2. Section 413.40 is amended by--

A. Republishing the introductory text of paragraphs (c)(4) and (c)(4)(iii) and revising paragraphs (c)(4)(iii)(A)(1) and (c)(4)(iii)(A)(2).

B. Republishing the introductory text of paragraph (c)(4)(iii)(B) and revising paragraph (c)(4)(iii)(B)(4)(i).

C. Revising the introductory text of paragraphs (d)(4)(i) and (d)(4)(ii).

The revisions read as follows:

§413.40 Ceiling on the rate of increase in hospital inpatient costs.

* * * * *

(c) Costs subject to the ceiling.

* * * * *

(4) Target amounts. The intermediary will establish a target amount for each hospital. The target amount for a cost reporting period is determined as follows:

* * * * *

(iii) In the case of a psychiatric hospital or unit, rehabilitation hospital or unit, or long-term care hospital, the target amount is the lower of the amounts specified in paragraph (c)(4)(iii)(A) or (c)(4)(iii)(B) of this section.

(A) The hospital-specific target amount.

(1) In the case of all hospitals and units, except long-term care hospitals for cost reporting periods beginning during FY 2001, the hospital-specific target amount is the net allowable costs in a base period increased by the applicable update factors .

(2) In the case of long-term care hospitals, for cost reporting periods beginning during FY 2001, the hospital-specific target amount is the net allowable costs in a base period increased by the applicable update factors multiplied by 1.25.

(B) One of the following for the applicable cost reporting period--

* * * * *

(4) For cost reporting periods beginning during fiscal years 2001 and 2002--

(i) The amounts determined under paragraph (c)(4)(iii)(B)(3)(i) of this section are: increased by the market basket percentage up through the subject period; or in the case of a long-term care hospital for cost reporting periods beginning during FY 2001, the amounts determined under paragraph (c)(4)(iii)(B)(3)(i) of this section, increased by the market basket percentage up through the subject period and further increased by 2 percent.

* * * * *

(d) Application of the target amount in determining the amount of payment.

* * * * *

(4) Continuous improvement bonus payments. (i) For cost reporting periods beginning on or after October 1, 1997, eligible hospitals (as defined in paragraph (d)(5) of this section) receive payments in addition to those in paragraph (d)(2) of this section, as applicable. These payments are equal to the lesser of--

* * * * *

(ii) For cost reporting periods beginning on or after October 1, 2000, and before September 30, 2001, eligible psychiatric hospitals and units and long-term care hospitals (as defined in paragraph (d)(5) of this section) receive payments in addition to those in paragraph (d)(2) of this section, as applicable. These payments are equal to the lesser of--

* * * * *

3. Section 413.64 is amended by--

A. Revising the introductory text of paragraph (h)(2) and adding a new paragraph (h)(2)(vi).

B. Removing paragraph (h)(3)(iv).

C. Removing and reserving paragraph (h)(4).

The additions and revisions read as follows:

§413.64 Payments to providers: Specific rules.

* * * * *

(h) Periodic interim payment method of reimbursement.

* * * * *

(2) Covered services furnished on or after July 1, 1987. Effective with claims received on or after July l, 1987, or as otherwise specified, the periodic interim payment (PIP) method is available for the following:

* * * * *

(vi) Effective for payments made on or after July l, 2004, inpatient CAH services furnished by a CAH as specified in §413.70. Payment on a PIP basis is described in §413.70(d).

* * * * *

(4) [Reserved]

* * * * *

4. Section 413.70 is amended by--

A. Revising the heading of paragraph (a) and paragraph (a)(1).

B. Adding a new paragraph (a)(4).

C. Revising paragraph (b)(2)(i) introductory text, paragraph (b)(2)(i)(A), and paragraph (b)(2)(i)(B).

D. Removing paragraphs (b)(2)(i)(C) and (b)(2)(i)(D).

E. Revising paragraph (b)(2)(iii).

F. Revising the heading of paragraph (b)(3) and the contents of paragraphs (b)(3)(i) and (b)(3)(ii).

G. Revising paragraph (b)(4).

H. Adding a new paragraph (d).

I. Adding a new paragraph (e).

The revisions and additions read as follows:

§413.70 Payment for services of a CAH.

(a) Payment for inpatient services furnished by a CAH (other than services of distinct part units). (1) Effective for cost reporting periods beginning on or after

January 1, 2004, payment for inpatient services of a CAH, other than services of a distinct part unit of the CAH, is 10l percent of the reasonable costs of the CAH in providing CAH services to its inpatients, as determined in accordance with section 1861(v)(1)(A) of the Act and the applicable principles of cost reimbursement in this part and in Part 415 of this chapter, except that the following payment principles are excluded when determining payment for CAH inpatient services:

(i) Lesser of cost or charges;

(ii) Ceilings on hospital operating costs;

(iii) Reasonable compensation equivalent (RCE) limits for physician services to providers; and

(iv) The payment window provisions for preadmission services, specified in §412.2(c)(5) of this subchapter and §413.40(c)(2).

* * * * *

(4) Payment for inpatient services of distinct part psychiatric or rehabilitation units is described in paragraph (e) of this section.

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

* * * * *

(2) Reasonable costs for facility services. (i) Effective for cost reporting periods beginning on or after January 1, 2004, payment for outpatient services of a CAH is 101 percent of the reasonable costs of the CAH in providing CAH services to its outpatients, as determined in accordance with section 1861(v)(1)(A) of the Act and the applicable principles of cost reimbursement in this part and in Part 415 of this chapter, except that

the following payment principles are excluded when determining payment for CAH outpatient services:

(A) Lesser of cost or charges; and

(B) RCE limits.

(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 at 101 percent of reasonable cost 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 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) Election to be paid 101 percent of reasonable costs for facility services plus fee schedule for professional services.

(i) A CAH may elect to be paid for outpatient services in any cost reporting period beginning on or after July 1, 2004 under the method described in paragraphs (b)(3)(ii) and (b)(3)(iii) of this section.

(A) The election must be made in writing, made on an annual basis, and delivered to the fiscal intermediary servicing the CAH at least 30 days before the start of the cost reporting period for which the election is made.

(B) An election of this payment method, once made for a cost reporting period, remains in effect for all of that period and, effective for cost reporting periods beginning on or after July 1, 2004, applies to all services furnished to outpatients during that period by a physician or other practitioner who has reassigned his or her rights to bill for those services to the CAH in accordance with 42 CFR Part 424, Subpart F of this chapter. If a physician or other practitioner does not reassign his or her billing rights to the CAH in accordance with 42 CFR Part 424, payment for the physician's or practitioner's services to CAH outpatients will be made on a fee schedule or other applicable basis as specified in Subpart B of Part 414 of this subchapter.

(C) In the case of a CAH that made an election under this section before November 1, 2003, for a cost reporting period beginning before December 1, 2003, the rules in paragraph (b)(3)(i)(B) of this section are effective for cost reporting periods beginning on or after July 1, 2001.

(D) An election made under paragraph (b)(3)(i)(B) or paragraph (b)(3)(i)(C) of this section is effective only for a period for which it was made and does not apply to an election that was withdrawn or revoked prior to the start of the cost reporting period for which it was made.

(ii) If the CAH elects payment under this method, payment to the CAH for each outpatient visit will be the sum of the following:

(A) For facility services not including any services for which payment may be made under paragraph (b)(3)(ii)(B) of this section, 101 percent of the reasonable costs of the services as determined under paragraph (b)(2)(i) of this section; and

(B) For professional services that are furnished by a physician or other practitioner who has reassigned his or her rights to bill for those services to the CAH in accordance with Part 424, Subpart F of this chapter, and that would otherwise be payable to the physician or other practitioner if the rights to bill for them had not been reassigned, 115 percent of the amounts that otherwise would be paid for the service if the CAH had not elected payment under this method.

* * * * *

(4) Costs of certain emergency room on-call providers. (i) Effective for cost reporting periods beginning on or after October 1, 2001, the reasonable costs of outpatient CAH services under paragraph (b) of this section may include amounts for reasonable compensation and related costs for an emergency room physician who is on call but who is not present on the premise of the CAH involved, is not otherwise furnishing physicians' services, and is not on call at any other provider or facility. Effective for costs incurred for services furnished on or after January 1, 2005, the payment amount of 101 percent of the reasonable costs of outpatient CAH services may also include amounts for reasonable compensation and related costs for the following emergency room providers who are on call but who are not present on the premise of the CAH involved, are not otherwise furnishing physicians' services, and are not on call at any other provider or facility: physician assistants, nurse practitioners, and clinical nurse specialists.

(ii) For purposes of this paragraph (b)(4)--

(A) "Amounts for reasonable compensation and related costs" means all allowable costs of compensating emergency room physicians, physician assistants, nurse practitioners, and clinical nurse specialists who are on call to the extent that the costs are found to be reasonable under the rules specified in paragraph (b)(2) of this section and the applicable sections of Part 413. Costs of compensating these specified medical emergency room staff are allowable only if the costs are incurred under written contracts that require the physician, physician assistant, nurse practitioner, or clinical nurse specialist to come to the CAH when the physician's or other practitioner's presence is medically required.

(B) Effective for costs incurred on or after January 1, 2005, an "emergency room physician, physician assistant, nurse practitioner, or clinical nurse specialist who is on call" means a doctor of medicine or osteopathy, a physician assistant, a nurse practitioner, or a clinical nurse specialist, with training or experience in emergency care who is immediately available by telephone or radio contact, and is available onsite within the timeframes specified in §485.618(d) of this chapter.

* * * * *

(d) Periodic interim payments. Subject to the provisions of §413.64(h), a CAH receiving payments under this section may elect to receive periodic interim payments (PIP) for Part A inpatient CAH services, effective for payments made on or after July l, 2004. Payment is made biweekly under the PIP method unless the CAH requests a longer fixed interval (not to exceed one month) between payments. The biweekly interim payment amount is based on the total estimated Medicare payment (after estimated

beneficiary deductibles and coinsurance) for the cost reporting period. Each payment is made 2 weeks after the end of a biweekly period of service, as described in §413.64(h)(6). These PIP provisions are further described in §413.64(h)(6). Under certain circumstances that are described in §413.64(g), a CAH that is not receiving PIP may request an accelerated payment.

(e) Payment for services of distinct part psychiatric and rehabilitation units of CAHs. Payment for inpatient services of distinct part psychiatric units of CAHs is made in accordance with regulations governing IPPS-excluded psychiatric units of hospitals at §413.40. Payment for inpatient services of distinct part rehabilitation units of CAHs is made in accordance with regulations governing the IRF PPS at Subpart P (§§412.600 through 412.632) of Part 412 of this subchapter.

§413.80 [Redesignated as §413.89]

5. Section 413.80 is redesignated as §413.89.

§413.85 [Amended]

6. In §413.85--

A. Under paragraph (b)(2), the cross-reference "§413.86" is removed and the cross-reference "§§413.75 through 413.83" is added in its place.

B. Under paragraph (c)(3), under the definition "Redistribution of costs," the cross-reference "§413.86" is removed and "§413.75 through 413.83" is added in its place.

7. Section 413.86 is removed and §§413.75 through 413.83 are added under Subpart F to read as follows:

Subpart F--Specific Categories of Costs

§413.75 Direct GME payments: General requirements.

§413.76 Direct GME payments: Calculation of payments for GME costs.

§413.77 Direct GME payments: Determination of per resident amounts.

§413.78 Direct GME payments: Determination of the total number of FTE residents.

§413.79 Direct GME payments: Determination of the weighted number of FTE residents.

§413.80 Direct GME payments: Determination of weighting factors for foreign medical graduates.

§413.81 Direct GME payments: Application of community support and redistribution of costs in determining FTE resident counts.

§413.82 Direct GME payments: Special rules for States that formerly had a waiver from Medicate reimbursement principles.

§413.83 Direct GME payments: Adjustment of a hospital's target amount or prospective payment hospital-specific rate.

§413.75 Direct GME payments: General requirements.

(a) Statutory basis and scope-- (1) Basis. This section and §§413.76 through 413.83 implement section 1886(h) of the Act by establishing the methodology for Medicare payment of the cost of direct graduate medical educational activities.

(2) Scope. This section and §§413.76 through 413.83 apply to Medicare payments to hospitals and hospital-based providers for the costs of approved residency

programs in medicine, osteopathy, dentistry, and podiatry for cost reporting periods beginning on or after July 1, 1985.

(b) Definitions. For purposes of this section and §§413.76 through 413.83, the following definitions apply:

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

Approved geriatric program means a fellowship program of one or more years in length that is approved by one of the national organizations listed in §415.152 of this chapter under that respective organization's criteria for geriatric fellowship programs.

Approved medical residency program means a program that meets one of the following criteria:

(1) Is approved by one of the national organizations listed in §415.152 of this chapter.

(2) May count towards certification of the participant in a specialty or subspecialty listed in the current edition of either of the following publications:

(i) The Directory of Graduate Medical Education Programs published by the American Medical Association, and available from American Medical Association, Department of Directories and Publications, 515 North State Street, Chicago, Illinois 60610; or

(ii) The Annual Report and Reference Handbook published by the American Board of Medical Specialties, and available from American Board of Medical Specialties, One Rotary Center, Suite 805, Evanston, Illinois 60201.

(3) Is approved by the Accreditation Council for Graduate Medical Education (ACGME) as a fellowship program in geriatric medicine.

(4) Is a program that would be accredited except for the accrediting agency's reliance upon an accreditation standard that requires an entity to perform an induced abortion or require, provide, or refer for training in the performance of induced abortions, or make arrangements for such training, regardless of whether the standard provides exceptions or exemptions.

Base period means a cost reporting period that began on or after October 1, 1983 but before October 1, 1984.

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

CPI--U stands for the Consumer Price Index for All Urban Consumers as compiled by the Bureau of Labor Statistics.

Foreign medical graduate means a resident who is not a graduate of a medical, osteopathy, dental, or podiatry school, respectively, accredited or approved as meeting the standards necessary for accreditation by one of the following organizations:

(1) The Liaison Committee on Medical Education of the American Medical Association.

(2) The American Osteopathic Association.

(3) The Commission on Dental Accreditation.

(4) The Council on Podiatric Medical Education.

FMGEMS stands for the Foreign Medical Graduate Examination in the Medical Sciences (Part I and Part II).

FTE stands for full-time equivalent.

GME stands for graduate medical education.

Medicare GME affiliated group means--

(1) Two or more hospitals that are located in the same urban or rural area (as those terms are defined in §412.62(f) of this subchapter) or in a contiguous area and meet the rotation requirements in §413.79(g)(2).

(2) Two or more hospitals that are not located in the same or in a contiguous urban or rural area, but meet the rotation requirement in §413.79(g)(2), and are jointly listed--

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

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

(3) Two or more hospitals that are under common ownership and, effective for all Medicare GME affiliation agreements beginning July 1, 2003, meet the rotation requirement in §413.79(g)(2).

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

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

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

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

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

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

Medicare patient load means, with respect to a hospital's cost reporting period, the total number of hospital inpatient days during the cost reporting period that are attributable to patients for whom payment is made under Medicare Part A divided by total hospital inpatient days. In calculating inpatient days, inpatient days in any distinct part of the hospital furnishing a hospital level of care are included and nursery days are excluded.

Primary care resident is a resident enrolled in an approved medical residency training program in family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine or osteopathic general practice.

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

Resident means an intern, resident, or fellow who participates in an approved medical residency program, including programs in osteopathy, dentistry, and podiatry, as required in order to become certified by the appropriate specialty board.

Rural track FTE limitation means the maximum number of residents (as specified in §413.79(l)) training in a rural track residency program that an urban hospital may include in its FTE count and that is in addition to the number of FTE residents already included in the hospital's FTE cap.

Rural track or integrated rural track means an approved medical residency training program established by an urban hospital in which residents train for a portion of the program at the urban hospital and then rotate for a portion of the program to a rural hospital(s) or a rural nonhospital site(s).

Shared rotational arrangement means a residency training program under which a resident(s) participates in training at two or more hospitals in that program.

(c) Payment for GME costs--General rule. Beginning with cost reporting periods starting on or after July 1, 1985, hospitals, including hospital-based providers, are paid for the costs of approved GME programs as described in §§413.76 through 413.83.

(d) Documentation requirements. To include a resident in the FTE count for a particular cost reporting period, the hospital must furnish the following information. The information must be certified by an official of the hospital and, if different, an official responsible for administering the residency program.

(1) The name and social security number of the resident.

(2) The type of residency program in which the individual participates and the number of years the resident has completed in all types of residency programs.

(3) The dates the resident is assigned to the hospital and any hospital-based providers.

(4) The dates the resident is assigned to other hospitals, or other freestanding providers, and any nonprovider setting during the cost reporting period, if any.

(5) The name of the medical, osteopathic, dental, or podiatric school from which the resident graduated and the date of graduation.

(6) If the resident is an FMG, documentation concerning whether the resident has satisfied the requirements of this section.

(7) The name of the employer paying the resident's salary.

§413.76 Direct GME payments: Calculation of payments for GME costs.

A hospital's Medicare payment for the costs of an approved residency program is calculated as follows:

(a) Step one. The hospital's updated per resident amount (as determined under §413.77) is multiplied by the actual number of FTE residents (as determined under §413.79). This result is the aggregate approved amount for the cost reporting period.

(b) Step two. The product derived in step one is multiplied by the hospital's Medicare patient load.

(c) Step three. For portions of cost reporting periods occurring on or after January 1, 1998, the product derived in step one is multiplied by the proportion of the hospital's inpatient days attributable to individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1876 of the Act and who are entitled to Medicare Part A or with a Medicare+Choice organization under Title XVIII, Part C of the Act. This amount is multiplied by an applicable payment percentage equal to--

(1) 20 percent for 1998;

(2) 40 percent for 1999;

(3) 60 percent in 2000;

(4) 80 percent in 2001; and

(5) 100 percent in 2002 and subsequent years.

(d) Step four. Effective for portions of cost reporting periods occurring on or after January 1, 2000, the product derived from step three is reduced by a percentage equal to the ratio of the Medicare+Choice nursing and allied health payment "pool" for the current calendar year as described at §413.87(f), to the projected total Medicare+Choice direct GME payments made to all hospitals for the current calendar year.

(e) Step five. (1) For portions of cost reporting periods beginning on or after January 1, 1998 and before January 1, 2000, add the results of steps two and three.

(2) Effective for portions of cost reporting periods beginning on or after January 1, 2000, add the results of steps two and four.

(f) Step six. The product derived in step two is apportioned between Part A and Part B of Medicare based on the ratio of Medicare's share of reasonable costs excluding GME costs attributable to each part as determined through the Medicare cost report.

§413.77 Direct GME payments: Determination of per resident amounts.

(a) Per resident amount for the base period—(1) Except as provided in paragraph (d) of this section, the intermediary determines a base-period per resident amount for each hospital as follows:

(i) Determine the allowable GME costs for the cost reporting period beginning on or after October 1, 1983 but before October 1, 1984. In determining these costs, GME costs allocated to the nursery cost center, research and other nonreimbursable cost centers, and hospital-based providers that are not participating in Medicare are excluded

and GME costs allocated to distinct-part hospital units and hospital-based providers that participate in Medicare are included.

(ii) Divide the costs calculated in paragraph (a)(1)(i) of this section by the average number of FTE residents working in all areas of the hospital complex (including those areas whose costs were excluded under paragraph (a)(1)(i) of this section) for its cost reporting period beginning on or after October 1, 1983 but before October 1, 1984.

(2) In determining the base-period per resident amount under paragraph (a)(1) of this section, the intermediary--

(i) Verifies the hospital's base-period GME costs and the hospital's average number of FTE residents;

(ii) Excludes from the base-period GME costs any nonallowable or misclassified costs, including those previously allowed under §412.113(b)(3) of this chapter; and

(iii) Upon a hospital's request, includes GME costs that were misclassified as operating costs during the hospital's prospective payment base year and were not allowable under §412.113(b)(3) of this chapter during the GME base period. These costs may be included only if the hospital requests an adjustment of its prospective payment hospital-specific rate or target amount as described in §413.82(a) of this chapter.

(3) If the hospital's cost report for its GME base period is no longer subject to reopening under §405.1885 of this chapter, the intermediary may modify the hospital's base-period costs solely for purposes of computing the per resident amount.

(4) If the intermediary modifies a hospital's base-period GME costs as described in paragraph (a)(2)(ii) of this section, the hospital may request an adjustment of its

prospective payment hospital-specific rate or target amount as described in §413.82(a) of this chapter.

(5) The intermediary notifies each hospital that either had direct GME costs or received indirect education payment in its cost reporting period beginning on or after October 1, 1984, and before October 1, 1985, of its base-period average per resident amount. A hospital may appeal this amount within 180 days of the date of that notice.

(b) Per resident amount for cost reporting periods beginning on or after July 1, 1985, and before July 1, 1986. For cost reporting periods beginning on or after July 1, 1985, and before July 1, 1986, a hospital's base-period per resident amount is adjusted as follows:

(1) If a hospital's base period began on or after October 1, 1983, and before July 1, 1984, the amount is adjusted by the percentage change in the CPI-U that occurred between the hospital's base period and the first cost reporting period to which the provisions of this section apply. The adjusted amount is then increased by one percent.

(2) If a hospital's base period began on or after July 1, 1984 and before October 1, 1984, the amount is increased by one percent.

(c) Per resident amount for cost reporting periods beginning on or after July 1, 1986. Subject to the provisions of paragraph (d) of this section, for cost reporting periods beginning on or after July 1, 1986, a hospital's base-period per resident amount is adjusted as follows:

(1) Except as provided in paragraph (c)(2) of this section, each hospital's per resident amount for the previous cost reporting is adjusted by the projected change in the CPI-U for the 12-month cost reporting period. This adjustment is subject to revision during the settlement of the cost report to reflect actual changes in the CPI-U that occurred during the cost reporting period.

(2) For cost reporting periods beginning on or after October 1, 1993 through September 30, 1995, each hospital's per resident amount for the previous cost reporting period will not be adjusted for any resident FTEs who are not either a primary care resident or an obstetrics and gynecology resident.

(d) Per resident amount for cost reporting periods beginning on or after October 1, 2000 and ending on or before September 30, 2013. For cost reporting periods beginning on or after October 1, 2000 and ending on or before September 30, 2013, a hospital's per resident amount for each fiscal year is adjusted in accordance with the following provisions:

(1) General provisions. For purposes of this §413.77--

(i) Weighted average per resident amount. The weighted average per resident amount is established as follows:

(A) Using data from hospitals' cost reporting periods ending during FY 1997, CMS calculates each hospital's single per resident amount by adding each hospital's primary care and nonprimary care per resident amounts, weighted by its respective FTEs, and dividing by the sum of the FTEs for primary care and nonprimary care residents.

(B) Each hospital's single per resident amount calculated under paragraph (d)(1)(i)(A) of this section is standardized by the 1999 geographic adjustment factor for the physician fee schedule area (as determined under §414.26 of this chapter) in which the hospital is located.

(C) CMS calculates an average of all hospitals' standardized per resident amounts that are determined under paragraph (d)(1)(i)(B) of this section. The resulting amount is the weighted average per resident amount.

(ii) Primary care/obstetrics and gynecology and nonprimary care per resident amounts. A hospital's per resident amount is an amount inclusive of any CPI-U adjustments that the hospital may have received since the hospital's base year, including any CPI-U adjustments the hospital may have received because the hospital trains primary care/obstetrics and gynecology residents and nonprimary care residents as specified under paragraph (c)(2) of this section.

(2) Adjustment beginning in FY 2001 and ending in FY 2013. For cost reporting periods beginning on or after October 1, 2000, and ending on or before September 30, 2013, a hospital's per resident amount is adjusted in accordance with paragraphs (d)(2)(i) through (d)(2)(iv) of this section, in that order:

(i) Updating the weighted average per resident amount for inflation. The weighted average per resident amount (as determined under paragraph (d)(1)(i) of this section) is updated by the estimated percentage increase in the CPI-U during the period beginning with the month that represents the midpoint of the cost reporting periods

ending during FY 1997 (that is, October 1, 1996) and ending with the midpoint of the hospital's cost reporting period that begins in FY 2001.

(ii) Adjusting for locality. The updated weighted average per resident amount determined under paragraph (d)(2)(i) of this section (the national average per resident amount) is adjusted for the locality of each hospital by multiplying the national average per resident amount by the 1999 geographic adjustment factor for the physician fee schedule area in which each hospital is located, established in accordance with §414.26 of this chapter.

(iii) Determining necessary revisions to the per resident amount. The locality-adjusted national average per resident amount, as calculated in accordance with paragraph (d)(2)(ii) of this section, is compared to the hospital's per resident amount and is revised, if appropriate, according to the following three categories:

(A) Floor. (1) For cost reporting periods beginning on or after October 1, 2000, and before October 1, 2001, if the hospital's per resident amount would otherwise be less than 70 percent of the locality-adjusted national average per resident amount for FY 2001 (as determined under paragraph (d)(2)(ii) of this section), the per resident amount is equal to 70 percent of the locality-adjusted national average per resident amount for FY 2001.

(2) For cost reporting periods beginning on or after October 1, 2001, and before October 1, 2002, if the hospital's per resident amount would otherwise be less than 85 percent of the locality-adjusted national average per resident amount for FY 2002 (as determined under paragraph (d)(2)(ii) of this section), the per resident amount is equal to 85 percent of the locality-adjusted national average per resident amount for FY 2002.

(3) For subsequent cost reporting periods beginning on or after October 1, 2002, the hospital's per resident amount is updated using the methodology specified under paragraph (c)(1) of this section.

(B) Ceiling. If the hospital's per resident amount is greater than 140 percent of the locality-adjusted national average per resident amount, the per resident amount is adjusted as follows for FY 2001 through FY 2013:

(1) FY 2001. For cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2001, if the hospital's FY 2000 per resident amount exceeds 140 percent of the FY 2001 locality-adjusted national average per resident amount (as calculated under paragraph (d)(2)(ii) of this section), subject to the provision stated in paragraph (d)(2)(iii)(B)(5) of this section, the hospital's per resident amount is frozen at the FY 2000 per resident amount and is not updated for FY 2001 by the CPI-U factor.

(2) FY 2002. For cost reporting periods beginning on or after October 1, 2001, and on or before September 30, 2002, if the hospital's FY 2001 per resident amount exceeds 140 percent of the FY 2002 locality-adjusted national average per resident amount, subject to the provision stated in paragraph (d)(2)(iii)(B)(5) of this section, the hospital's per resident amount is frozen at the FY 2001 per resident amount and is not updated for FY 2002 by the CPI-U factor.

(3) FY 2003. For cost reporting periods beginning on or after October 1, 2002, and on or before September 30, 2003, if the hospital's per resident amount for the previous cost reporting period is greater than 140 percent of the locality-adjusted national

average per resident amount for that same previous cost reporting period (for example, for cost reporting periods beginning in FY 2003, compare the hospital's per resident amount from the FY 2002 cost report to the hospital's locality-adjusted national average per resident amount from FY 2002), subject to the provision stated in paragraph (d)(2)(iii)(B)(5) of this section, the hospital's per resident amount is adjusted using the methodology specified in paragraph (c)(1) of this section, except that the CPI-U applied for a 12-month period is reduced (but not below zero) by 2 percentage points.

(4) FY 2004 through FY 2013. For cost reporting periods beginning on or after October 1, 2003, and on or before September 30, 2013, if the hospital's preceding year per resident amount exceeds 140 percent of the current year's locality-adjusted national average per resident amount (as calculated under paragraph (d)(2)(ii) of this section), subject to the provision stated in paragraph (d)(2)(iii)(B)(5) of this section, the hospital-specific per resident amount is frozen for the current year at the preceding year's hospital-specific per resident amount and is not updated by the CPI-U factor.

(5) General rule for hospitals that exceed the ceiling. For cost reporting periods beginning on or after October 1, 2000, and on or before September 30, 2013, if a hospital's per resident amount exceeds 140 percent of the hospital's locality-adjusted national average per resident amount and it is adjusted under any of the criteria under paragraphs (d)(2)(iii)(B)(1) through (d)(2)(iii)(B)(3) of this section, the current year per resident amount cannot be reduced below 140 percent of the locality-adjusted national average per resident amount.

(C) Per resident amounts greater than or equal to the floor and less than or equal to the ceiling. For cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2013, if a hospital's per resident amount is greater than or equal to 70 percent and less than or equal to 140 percent of the hospital's locality-adjusted national average per resident amount for each respective fiscal year, the hospital's per resident amount is updated using the methodology specified in paragraph (c)(1) of this section.

(e) Exceptions--(1) Base period for certain hospitals. If a hospital did not have any approved medical residency training programs or did not participate in Medicare during the base period, but either condition changes in a cost reporting period beginning on or after July 1, 1985, the intermediary establishes a per resident amount for the hospital using the information from the first cost reporting period during which the hospital participates in Medicare and the residents are on duty during the first month of that period. Any GME program costs incurred by the hospital before that cost reporting period are reimbursed on a reasonable cost basis. The per resident amount is based on the lower of the amount specified in paragraph (e)(1)(i) or in paragraph (e)(1)(ii) of this section, subject to the provisions of paragraph (e)(1)(iii) of this section.

(i) The hospital's actual costs, incurred in connection with the GME program for the hospital's first cost reporting period in which residents were on duty during the first month of the cost reporting period.

(ii) Except as specified in paragraph (e)(1)(iii)of this section--

(A) For base periods that begin before October 1, 2002, the updated weighted mean value of per resident amounts of all hospitals located in the same geographic wage area, as that term is used in the prospective payment system under Part 412 of this chapter.

(B) For base periods beginning on or after October 1, 2002, the updated weighted mean value of per resident amounts of all hospitals located in the same geographic wage area is calculated using all per resident amounts (including primary care and obstetrics and gynecology and nonprimary care) and FTE resident counts from the most recently settled cost reports of those teaching hospitals.

(iii) If, under paragraph (e)(1)(ii)(A) or paragraph (e)(1)(ii)(B) of this section, there are fewer than three existing teaching hospitals with per resident amounts that can be used to calculate the weighted mean value per resident amount, for base periods beginning on or after October 1, 1997, the per resident amount equals the updated weighted mean value of per resident amounts of all hospitals located in the same census region as that term is used in §412.62(f)(1)(i) of this chapter.

(2) Short or long base-period cost reporting periods. If a hospital's base-period cost reporting period reflects GME costs for a period that is shorter than 50 weeks or longer than 54 weeks, the intermediary converts the allowable costs for the base period into a daily figure. The daily figure is then multiplied by 365 or 366, as appropriate, to derive the approved per resident amount for a 12-month base-period cost reporting period. If a hospital has two cost reporting periods beginning in the base period, the later period serves as the base-period cost reporting period.

(3) Short or long cost reporting periods beginning on or after July 1, 1985. If a hospital's cost reporting period is shorter than 50 weeks or longer than 54 weeks, the hospital's intermediary should contact CMS Central Office to receive a special CPI-U adjustment factor.

(f) Residency match. Effective for cost reporting periods beginning on or after October 1, 2004, with respect to a resident who matches simultaneously for a first year of training in a primary care specialty, and for an additional year(s) of training in a nonprimary care specialty, the per resident amount that is used to determine direct GME payment with respect to that resident is the nonprimary care per resident amount for the first year of training in the primary care specialty and for the duration of the resident's training in the nonprimary care specialty.

(g) Special use of locality-adjusted national average per resident amount. Effective for portions of cost reporting periods beginning on or after July 1, 2005, for a hospital that counts additional residents as a result of an increase in its FTE resident cap under §413.79(c)(4) direct GME payments attributable to those additional FTE residents are calculated using the locality-adjusted national average per resident amount, as determined under paragraph (d)(2)(ii) of this section. The hospital will receive direct GME payments based on the sum of the following two direct GME calculations:

(1) A calculation using the per resident amount(s) as determined under paragraph (d) of this section and the hospital's number of FTE residents that is not attributable to an FTE resident cap increase under §413.79(c)(4); and

(2) A calculation using the locality-adjusted national average per resident amount, as determined under paragraph (d)(2)(ii) of this section, inflated to the hospital's current cost reporting period, and the hospital's number of FTE residents that is attributable to the increase in the hospital's FTE resident cap under §413.79(c)(4).

§413.78 Direct GME payments: Determination of the total number of FTE residents.

Subject to the weighting factors in §§413.79 and 413.80, and subject to the provisions of §413.81, the count of FTE residents is determined as follows:

(a) Residents in an approved program working in all areas of the hospital complex may be counted.

(b) No individual may be counted as more than one FTE. A hospital cannot claim the time spent by residents training at another hospital. Except as provided in paragraphs (c), (d), and (e) of this section, if a resident spends time in more than one hospital or in a nonprovider setting, the resident counts as partial FTE based on the proportion of time worked at the hospital to the total time worked. A part-time resident counts as a partial FTE based on the proportion of allowable time worked compared to the total time necessary to fill a full-time internship or residency slot.

(c) On or after July 1, 1987, and for portions of cost reporting periods occurring before January 1, 1999, the time residents spend in nonprovider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs is not excluded in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met--

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

(2) There is a written agreement between the hospital and the outside entity that states that the resident's compensation for training time spent outside of the hospital setting is to be paid by the hospital.

(d) For portions of cost reporting periods occurring on or after January 1, 1999, and before October 1, 2004, the time residents spend in nonprovider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs may be included in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met--

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

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

(3) The hospital must incur all or substantially all of the costs for the training program in the nonhospital setting in accordance with the definition in §413.75(b).

(4) The hospital is subject to the principles of community support and redistribution of costs as specified in §413.81.

(e) For portions of cost reporting periods occurring on or after October 1, 2004, the time residents spend in nonprovider settings such as freestanding clinics, nursing

homes, and physicians' offices in connection with approved programs may be included in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met--

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

(2) The hospital must incur all or substantially all of the costs of the training program in a nonhospital setting(s) (in accordance with the definition under §413.75(b)).

(3) The hospital must comply with one of the following:

(i) The hospital must pay all or substantially all of the costs of the training program in a nonhospital setting(s) attributable to training that occurs during a month by the end of the third month following the month in which the training in the nonhospital site occurred; or

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

(4) The hospital is subject to the principles of community support and redistribution of costs as specified in §413.81.

§413.79 Direct GME payments: Determination of the weighted number of FTE residents.

Subject to the provisions in §413.80, CMS determines a hospital's number of FTE residents by applying a weighting factor to each resident and then summing the resulting numbers that represent each resident. The weighting factor is determined as follows:

(a) Initial residency period. Generally, for purposes of this section, effective July 1, 1995, an initial residency period is defined as the minimum number of years required for board eligibility.

(1) Prior to July 1, 1995, the initial residency period equals the minimum number of years required for board eligibility in a specialty or subspecialty plus 1 year. An initial residency period may not exceed 5 years in order to be counted toward determining FTE status except in the case of a resident in an approved geriatric program whose initial residency period may last up to 2 additional years.

(2) Effective October 1, 2003, for a resident who trains in an approved geriatric program that requires the residents to complete 2 years of training to initially become board eligible in the geriatric specialty, the 2 years spent in the geriatrics program are treated as part of the resident's initial residency period.

(3) Effective July 1, 2000, for residency programs that began before, on, or after November 29, 1999, the period of board eligibility and the initial residency period for a resident in an approved child neurology program is the period of board eligibility for pediatrics plus 2 years.

(4) Effective August 10, 1993, residents or fellows in an approved preventive medicine residency or fellowship program also may be counted as a full FTE resident for up to 2 additional years beyond the initial residency period limitations.

(5) For combined residency programs, an initial residency period is defined as the time required for individual certification in the longer of the programs. If the resident is enrolled in a combined medical residency training program in which all of the individual programs (that are combined) are for training primary care residents (as defined in §413.75(b)) or obstetrics and gynecology residents, the initial residency period is the time required for individual certification in the longer of the programs plus 1 year.

(6) For residency programs other than those specified in paragraphs (a)(2) through (a)(4) of this section, the initial residency period is the minimum number of years of formal training necessary to satisfy the requirements for initial board eligibility in the particular specialty for which the resident is training, as specified in the most recently published edition of the Graduate Medical Education Directory.

(7) For residency programs in osteopathy, dentistry, and podiatry, the minimum requirement for certification in a specialty or subspecialty is the minimum number of years of formal training necessary to satisfy the requirements of the appropriate approving body listed in §415.152 of this chapter.

(8) For residency programs in geriatric medicine, accredited by the appropriate approving body listed in §415.152 of this chapter, these programs are considered approved programs on the later of--

(i) The starting date of the program within a hospital; or

(ii) The hospital's cost reporting periods beginning on or after July 1, 1985.

(9) The time spent in residency programs that do not lead to certification in a specialty or subspecialty, but that otherwise meet the definition of approved programs, as described in §413.75(b), is counted toward the initial residency period limitation.

(10) Effective for cost reporting periods beginning on or after October 1, 2004, if a hospital can document that a resident simultaneously matched for one year of training in a particular specialty program, and for a subsequent year(s) of training in a different specialty program, the resident's initial residency period will be determined based on the period of board eligibility associated with the program for which the resident matched for the subsequent year(s) of training.

(b) Weighting factor--(1) If the resident is in an initial residency period, the weighting factor is one.

(2) If the resident is not in an initial residency period, the weighting factor is 1.00 during the period beginning on or after July 1, 1985 and before July 1, 1986, .75 during the period beginning on or after July 1, 1986 and before July 1, 1987, and .50 thereafter without regard to the hospital's cost reporting period.

(c) Unweighted FTE counts.

(1) Definitions. As used in this paragraph (c):

(i) Otherwise applicable resident cap refers to a hospital's FTE resident cap that is determined for a particular cost reporting period under paragraph (c)(2) of this section.

(ii) Reference resident level refers to a hospital's resident level in the applicable reference period specified under paragraph (c)(3)(ii) of this section.

(iii) Resident level refers to the number of unweighted allopathic and osteopathic FTE residents who are training in a hospital in a particular cost reporting period.

(2) Determination of the FTE resident cap. Subject to the provisions of paragraphs (c)(3) and (c)(4)of this section and §413.81, for purposes of determining direct GME payment--

(i) For cost reporting periods beginning on or after October 1, 1997, a hospital's resident level may not exceed the hospital's unweighted FTE count (or, effective for cost reporting periods beginning on or after April 1, 2000, 130 percent of the unweighted FTE count for a hospital located in a rural area) for these residents for the most recent cost reporting period ending on or before December 31, 1996.

(ii) If a hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 1997, and before October 1, 2001, exceeds the limit described in this section, the hospital's total weighted FTE count (before application of the limit) will be reduced in the same proportion that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996.

(iii) If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section, the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced in the same proportion that the number of FTE residents for that cost reporting period exceeds

the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996.

(iv) Hospitals that are part of the same Medicare GME affiliated group (as described under §413.75(b)) may elect to apply the limit on an aggregate basis as described under paragraph (f) of this section.

(v) The fiscal intermediary may make appropriate modifications to apply the provisions of this paragraph (c) of this section based on the equivalent of a 12-month cost reporting period.

(3) Determination of the reduction to the FTE resident cap due to unused FTE resident slots. If a hospital's reference resident level is less than its otherwise applicable FTE resident cap as determined under paragraph (c)(2) of this section or paragraph (e) of this section in the reference cost reporting period (as described under paragraph (c)(3)(ii) of this section), for portions of cost reporting periods beginning on or after July 1, 2005, the hospital's otherwise applicable FTE resident cap is reduced by 75 percent of the difference between the otherwise applicable FTE resident cap and the reference resident level. Under this provision--

(i) Exemption for certain rural hospitals. A rural hospital, as defined at §412.62(f)(iii), with less than 250 beds (as determined at §412.105(b)) in its most recent cost reporting period ending on or before September 30, 2002, is exempt from any reduction to the otherwise applicable FTE resident cap limit under paragraph (c)(3) of this section.

(ii) Reference cost reporting periods.

(A) To determine a hospital's reference resident level, CMS uses one of the following periods:

(1) A hospital's most recent cost reporting period ending on or before September 30, 2002, for which a cost report has been settled or if the cost report has not been settled, the as-submitted cost report (subject to audit); or

(2) A hospital's cost reporting period that includes July 1, 2003 if the hospital submits a timely request to CMS to increased its resident level due to an expansion of an existing program and that expansion is not reflected on the hospital's most recent settled cost report. An expansion of an existing program means that, except for expansions due to newly approved programs under paragraph (c)(3)(ii)(A)(3) of this section, the number of unweighted allopathic and osteopathic FTE residents in any cost reporting period after the hospital's most recent settled cost report, up to and including the hospital's cost report that includes July 1, 2003, is greater than the number of unweighted allopathic and osteopathic FTE residents in programs that were existing at that hospital during the hospital's most recent settled cost report.

(3) A hospital may submit a timely request that CMS adjust the resident level for purposes of determining any reduction under paragraph (c)(3) of this section for the following purposes:

(i) In the hospital's reference cost reporting period under paragraph (c)(3)(ii)(A)(1) of this section, to include the number of FTE residents for which a new program was accredited by the appropriate allopathic or osteopathic accrediting body

(listed under §415.152 of this chapter) before January 1, 2002, if the program was not in operation during the reference cost reporting period under paragraph (c)(3)(ii)(A)(1); or

(ii) In the hospital's reference cost reporting period under paragraph (c)(3)(ii)(A)(2) of this section, to include the number of FTE residents for which a new program was accredited by the appropriate allopathic or osteopathic accrediting body (listed under §415.152 of this chapter) before January 1, 2002, if the program was not in operation during the cost reporting period that includes July 1, 2003, and if the hospital also qualifies to use its cost report under paragraph (c)(3)(ii)(A)(2) of this section due to an expansion of an existing program.

(B) If the cost report that is used to determine a hospital's otherwise applicable FTE resident cap in the reference period is not equal to 12 months, the fiscal intermediary may make appropriate modifications to apply the provisions of paragraph (c)(3)(i)(A) of this section based on the equivalent of a 12-month cost reporting period.

(iii) If the new program described in paragraph (c)(3)(ii)(A)(3)(i) or paragraph (c)(3)(ii)(A)(ii) was accredited for a range of residents, the hospital may request that its reference resident level in its applicable reference cost reporting period under paragraph (c)(3)(ii)(A)(1) or (c)(3)(ii)(A)(2) of this section be adjusted to reflect the maximum number of accredited slots applicable to that hospital.

(iv) Consideration of Medicare GME affiliated group agreements. For hospitals that are members of the same affiliated group for the program year July 1, 2003 through June 30, 2004, in determining whether a hospital's otherwise applicable resident FTE resident cap is reduced under paragraph (c)(3) of this section, CMS treats these hospitals

as a group. Using information from the hospitals' cost reports that include July 1, 2003, if the hospitals' aggregate FTE resident counts are equal to or greater than the aggregate otherwise applicable FTE resident cap for the affiliated group, then no reductions are made under paragraph (c)(3) of this section to the hospitals' otherwise applicable FTE resident caps. If the hospitals' aggregate FTE resident count is below the aggregate otherwise applicable FTE resident cap, then CMS determines on a hospital-specific basis whether the individual hospital's FTE resident count is less than its otherwise applicable resident cap (as adjusted by affiliation agreement(s)) in the hospital's cost report that includes July 1, 2003. If the hospital's FTE resident count is in excess of its otherwise applicable FTE resident cap, the hospital will not have its otherwise applicable FTE resident cap reduced under paragraph (c)(3) of this section. Hospitals in the affiliated group that have FTE resident counts below their individual otherwise applicable FTE resident caps are subject to a pro rata reduction in their otherwise applicable FTE resident caps that is equal, in total, to 75 percent of the difference between the aggregate FTE cap and the aggregate FTE count for the affiliated group. The pro rata reduction to the individual hospital's otherwise applicable resident cap is calculated by dividing (a) the difference between the hospital's individual otherwise applicable FTE resident cap and the hospital's FTE resident count by (b) the total amount by which all of the hospitals' individual FTE resident counts are below their otherwise affiliated FTE resident caps, multiplying the quotient by (c) the difference between the aggregate FTE resident cap and the aggregate FTE resident counts for the affiliated group, and (d) multiplying that result by 75 percent.

(4) Determination of an increase in otherwise applicable resident cap. For portions of cost reporting periods beginning on or after July 1, 2005, a hospital may receive an increase in its otherwise applicable FTE resident cap up to an additional 25 FTEs (as determined by CMS) if the hospital meets the requirements and qualifying criteria of section 1886(h)(7) of the Act and implementing instructions issued by CMS and if the hospital submits an application to CMS within the timeframe specified by CMS.

(5) Special rules for hospitals that participate in demonstration projects or voluntary resident reduction plans.

(i) If a hospital was participating in a demonstration project under section 402 of Pubic Law 90-248 or the voluntary reduction plan under §413.88 for a greater period of time than the time period that elapsed since it withdrew from participation (or if it completed its participation) in the demonstration program or the voluntary reduction plan, for purposes of determining a possible reduction to the FTE resident caps under paragraph (c)(3) of this section, CMS compares the higher of the hospital's base number of residents (after subtracting any dental and podiatric FTE residents) or the hospital's reference resident level to the hospital's otherwise applicable resident cap determined under paragraph (c)(2) of this section.

(ii) If a hospital participated in the demonstration project or the voluntary resident reduction plan for a period of time that is less than the time that elapsed since it withdraw from participation in the demonstration project or the voluntary reduction plan, the special rules in paragraph(c)(5)(i) do not apply, and the hospital is subject to the

procedures applicable to all other hospitals for determining possible reductions to the FTE resident caps under paragraph (c)(3) of this section.

(iii) CMS will not redistribute residency positions that are attributable to a hospital's participation in a demonstration project or a voluntary resident reduction plan to other hospitals that seek to increase their FTE resident caps under paragraph (c)(4) of this section.

(d) Weighted FTE counts. Subject to the provisions of §413.81, for purposes of determining direct GME payment--

(1) For the hospital's first cost reporting period beginning on or after October 1, 1997, the hospital's weighted FTE count is equal to the average of the weighted FTE count for the payment year cost reporting period and the preceding cost reporting period.

(2) For cost reporting periods beginning on or after October 1, 1998, and before October 1, 2001, the hospital's weighted FTE count is equal to the average of the weighted FTE count for the payment year cost reporting period and the preceding two cost reporting periods.

(3) For cost reporting periods beginning on or after October 1, 2001, the hospital's weighted FTE count for primary care and obstetrics and gynecology residents is equal to the average of the weighted primary care and obstetrics and gynecology counts for the payment year cost reporting period and the preceding two cost reporting periods, and the hospital's weighted FTE count for nonprimary care residents is equal to the

average of the weighted nonprimary care FTE counts for the payment year cost reporting period and the preceding two cost reporting periods.

(4) The fiscal intermediary may make appropriate modifications to apply the provisions of this paragraph (d) based on the equivalent of 12-month cost reporting periods.

(5) If a hospital qualifies for an adjustment to the limit established under paragraph (c)(2) of this section for new medical residency programs created under paragraph (e) of this section, the count of the residents participating in new medical residency training programs above the number included in the hospital's FTE count for the cost reporting period ending during calendar year 1996 is added after applying the averaging rules in this paragraph (d), for a period of years. Residents participating in new medical residency training programs are included in the hospital's FTE count before applying the averaging rules after the period of years has expired. For purposes of this paragraph (d), for each new program started, the period of years equals the minimum accredited length for each new program. The period of years begins when the first resident begins training in each new program.

(6) Subject to the provisions of paragraph (h) of this section, FTE residents that are displaced by the closure of either another hospital or another hospital's program are added to the FTE count after applying the averaging rules in this paragraph (d), for the receiving hospital for the duration of the time that the displaced residents are training at the receiving hospital.

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

(e) New medical residency training programs. If a hospital establishes a new medical residency training program as defined in paragraph (l) of this section on or after January 1, 1995, the hospital's FTE cap described under paragraph (c) of this section may be adjusted as follows:

(1) If a hospital had no allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, and it establishes a new medical residency training program on or after January 1, 1995, the hospital's unweighted FTE resident cap under paragraph (c) of this section may be adjusted based on the product of the highest number of residents in any program year during the third year of the first program's existence for all new residency training programs and the number of years in which residents are expected to complete the program based on the minimum accredited length for the type of program. The adjustment to the cap may not exceed the number of accredited slots available to the hospital for the new program.

(i) If the residents are spending an entire program year (or years) at one hospital and the remainder of the program at another hospital, the adjustment to each respective hospital's cap is equal to the product of the highest number of residents in any program year during the third year of the first program's existence and the number of years the residents are training at each respective hospital.

(ii) Prior to the implementation of the hospital's adjustment to its FTE cap beginning with the fourth year of the hospital's residency program(s), the hospital's cap may be adjusted during each of the first 3 years of the hospital's new residency program using the actual number of residents participating in the new program. The adjustment may not exceed the number of accredited slots available to the hospital for each program year.

(iii) Except for rural hospitals, the cap will not be adjusted for new programs established more than 3 years after the first program begins training residents.

(iv) An urban hospital that qualifies for an adjustment to its FTE cap under paragraph (e)(1) of this section is not permitted to be part of a Medicare GME affiliated group for purposes of establishing an aggregate FTE cap.

(v) A rural hospital that qualifies for an adjustment to its FTE cap under paragraph (e)(1) of this section is permitted to be part of a Medicare GME affiliated group for purposes of establishing an aggregate FTE cap.

(2) If a hospital had allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, the hospital's unweighted FTE cap may be adjusted for new medical residency training programs established on or after January 1, 1995 and on or before August 5, 1997. The adjustment to the hospital's FTE resident limit for the new program is based on the product of the highest number of residents in any program year during the third year of the newly established program and the number of years in which residents are expected to complete each program based on the minimum accredited length for the type of program.

(i) If the residents are spending an entire program year (or years) at one hospital and the remainder of the program at another hospital, the adjustment to each respective hospital's cap is equal to the product of the highest number of residents in any program year during the third year of the first program's existence and the number of years the residents are training at each respective hospital.

(ii) Prior to the implementation of the hospital's adjustment to its FTE cap beginning with the fourth year of the hospital's residency program, the hospital's cap may be adjusted during each of the first 3 years of the hospital's new residency program, using the actual number of residents in the new programs. The adjustment may not exceed the number of accredited slots available to the hospital for each program year.

(3) If a hospital with allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, is located in a rural area (or other hospitals located in rural areas that added residents under paragraph (e)(1) of this section), the hospital's unweighted FTE limit may be adjusted in the same manner described in paragraph (e)(2) of this section to reflect the increase for residents in the new medical residency training programs established after August 5, 1997. For these hospitals, the limit will be adjusted for additional new programs but not for expansions of existing or previously existing programs.

(4) A hospital seeking an adjustment to the limit on its unweighted resident count policy must provide documentation to its fiscal intermediary justifying the adjustment.

(f) Medicare GME affiliated group. A hospital may receive a temporary adjustment to its FTE cap, which is subject to the averaging rules under paragraph (e)(3)

of this section, to reflect residents added or subtracted because the hospital is participating in a Medicare GME affiliated group (as defined under §413.75(b)). Under this provision--

(1) Each hospital in the Medicare GME affiliated group must submit the Medicare GME affiliation agreement, as defined under §413.75(b) of this section, to the CMS fiscal intermediary servicing the hospital and send a copy to CMS's Central Office no later than July 1 of the residency program year during which the Medicare GME affiliation agreement will be in effect.

(2) Each hospital in the Medicare GME affiliated group must have a shared rotational arrangement, as defined in §413.75(b), with at least one other hospital within the Medicare GME affiliated group, and all of the hospitals within the Medicare GME affiliated group must be connected by a series of such shared rotational arrangements.

(3) During the shared rotational arrangements under a Medicare GME affiliation agreement, as defined in §413.75(b), more than one of the hospitals in the Medicare GME affiliated group must count the proportionate amount of the time spent by the resident(s) in its FTE resident counts. No resident may be counted in the aggregate as more than one FTE.

(4) The net effect of the adjustments (positive or negative) on the Medicare GME affiliated hospitals' aggregate FTE cap for each Medicare GME affiliation agreement must not exceed zero.

(5) If the Medicare GME affiliation agreement terminates for any reason, the FTE cap of each hospital in the Medicare GME affiliated group will revert to the

individual hospital's pre-affiliation FTE cap that is determined under the provisions of paragraph (c) of this section.

(g) Newly constructed hospitals. A hospital that began construction of its facility prior to August 5, 1997, and sponsored new medical residency training programs on or after January 1, 1995, and on or before August 5, 1997, that either received initial accreditation by the appropriate accrediting body or temporarily trained residents at another hospital(s) until the facility was completed, may receive an adjustment to its FTE cap.

(1) The newly constructed hospital's FTE cap is equal to the lesser of--

(i) The product of the highest number of residents in any program year during the third year of the newly established program and the number of years in which residents are expected to complete the programs based on the minimum accredited length for each type of program; or

(ii) The number of accredited slots available to the hospital for each year of the programs.

(2) If the new medical residency training programs sponsored by the newly constructed hospital have been in existence for 3 years or more by the time the residents begin training at the newly constructed hospital, the newly constructed hospital's cap will be based on the number of residents training in the third year of the programs begun at the temporary training site.

(3) If the new medical residency training programs sponsored by the newly constructed hospital have been in existence for less than 3 years by the time the residents

begin training at the newly constructed hospital, the newly constructed hospital's cap will be based on the number of residents training at the newly constructed hospital in the third year of the programs (including the years at the temporary training site).

(4) A hospital that qualifies for an adjustment to its FTE cap under this paragraph (g) may be part of an affiliated group for purposes of establishing an aggregate FTE cap.

(5) The provisions of this paragraph (g) are applicable during portions of cost reporting periods occurring on or after October 1, 1999.

(h) Closure of hospital or hospital residency program.

(1) Definitions. For purposes of this section--

(i) Closure of a hospital means the hospital terminates its Medicare agreement under the provisions of §489.52 of this chapter.

(ii) Closure of a hospital residency training program means the hospital ceases to offer training for residents in a particular approved medical residency training program.

(2) Closure of a hospital. A hospital may receive a temporary adjustment to its FTE cap to reflect residents added because of another hospital's closure if the hospital meets the following criteria:

(i) The hospital is training additional residents from a hospital that closed on or after July 1, 1996.

(ii) No later than 60 days after the hospital begins to train the residents, the hospital submits a request to its fiscal intermediary for a temporary adjustment to its FTE cap, documents that the hospital is eligible for this temporary adjustment by identifying

the residents who have come from the closed hospital and have caused the hospital to exceed its cap, and specifies the length of time the adjustment is needed.

(3) Closure of a hospital's residency training program. If a hospital that closes its residency training program voluntarily agrees to temporarily reduce its FTE cap according to the criteria specified in paragraph (h)(3)(ii) of this section, another hospital(s) may receive a temporary adjustment to its FTE cap to reflect residents added because of the closure of the residency training program if the criteria specified in paragraph (h)(3)(i) of this section are met.

(i) Receiving hospital(s). A hospital may receive a temporary adjustment to its FTE cap to reflect residents added because of the closure of another hospital's residency training program if--

(A) The hospital is training additional residents from the residency training program of a hospital that closed a program; and

(B) No later than 60 days after the hospital begins to train the residents, the hospital submits to its fiscal intermediary a request for a temporary adjustment to its FTE cap, documents that it is eligible for this temporary adjustment by identifying the residents who have come from another hospital's closed program and have caused the hospital to exceed its cap, specifies the length of time the adjustment is needed, and submits to its fiscal intermediary a copy of the FTE reduction statement by the hospital that closed its program, as specified in paragraph (h)(3)(ii)(B) of this section.

(ii) Hospital that closed its program(s). A hospital that agrees to train residents who have been displaced by the closure of another hospital's program may receive a temporary FTE cap adjustment only if the hospital with the closed program--

(A) Temporarily reduces its FTE cap based on the FTE residents in each program year training in the program at the time of the program's closure. This yearly reduction in the FTE cap will be determined based on the number of those residents who would have been training in the program during that year had the program not closed; and

(B) No later than 60 days after the residents who were in the closed program begin training at another hospital, submit to its fiscal intermediary a statement signed and dated by its representative that specifies that it agrees to the temporary reduction in its FTE cap to allow the hospital training the displaced residents to obtain a temporary adjustment to its cap; identifies the residents who were in training at the time of the program's closure; identifies the hospitals to which the residents are transferring once the program closes; and specifies the reduction for the applicable program years.

(i) Additional FTEs for residents on maternity or disability leave or other approved leave of absence. Effective for cost reporting periods beginning on or after November 29, 1999, a hospital may receive an adjustment to its FTE cap of up to three additional resident FTEs, if the hospital meets the following criteria:

(1) The additional residents are residents of a primary care program that would have been counted by the hospital as residents for purposes of the hospital's FTE cap but for the fact that the additional residents were on maternity or disability leave or a similar

approved leave of absence during the hospital's most recent cost reporting period ending on or before December 31, 1996;

(2) The leave of absence was approved by the residency program director to allow the residents to be absent from the program and return to the program after the leave of absence; and

(3) No later than 6 months after August 1, 2000, the hospital submits to the fiscal intermediary a request for an adjustment to its FTE cap, and provides contemporaneous documentation of the approval of the leave of absence by the residency director, specific to each additional resident that is to be counted for purposes of the adjustment.

(j) Residents previously trained at VA hospitals. For cost reporting periods beginning on or after October 1, 1997, a non-Veterans Affairs (VA) hospital may receive a temporary adjustment to its FTE cap to reflect residents who had previously trained at a VA hospital and were subsequently transferred to the non-VA hospital, if that hospital meets the following criteria:

(1) The transferred residents had been training previously at a VA hospital in a program that would have lost its accreditation by the ACGME if the residents continued to train at the VA hospital;

(2) The residents were transferred to the hospital from the VA hospital on or after January 1, 1997, and before July 31, 1998; and

(3) The hospital submits a request to its fiscal intermediary for a temporary adjustment to its FTE cap, documents that it is eligible for this temporary adjustment by

identifying the residents who have come from the VA hospital, and specifies the length of time those residents will be trained at the hospital.

(k) Residents training in rural track programs. Subject to the provisions of §413.81, an urban hospital that establishes a new residency program, or has an existing residency program, with a rural track (or an integrated rural track) may include in its FTE count residents in those rural tracks, in addition to the residents subject to its FTE cap specified under paragraph (c) of this section. An urban hospital with a rural track residency program may count residents in those rural tracks up to a rural track FTE limitation if the hospital complies with the conditions specified in paragraphs (k)(2) through (k)(6) of this section.

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

(i) For the first 3 years of the rural track's existence, the rural track FTE limitation for each urban hospital will be the actual number of FTE residents, subject to the rolling average at paragraph (d)(7) of this section, training in the rural track at the urban hospital.

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

(2) If an urban hospital rotates residents to a separately accredited rural track program at a rural nonhospital site(s) for two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2000, and before October 1, 2003, or for more than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003, the urban hospital may include those residents in its FTE count, subject to the requirements under §413.78(d). The urban hospital may include in its FTE count those residents in the rural track, not to exceed its rural track FTE limitation, determined as follows:

(i) For the first 3 years of the rural track's existence, the rural track FTE limitation for each urban hospital will be the actual number of FTE residents, subject to the rolling average specified in paragraph (d)(7) of this section, training in the rural track at the urban hospital and the rural nonhospital site(s).

(ii) Beginning with the fourth year of the rural track's existence, the rural track FTE limitation is equal to the product of--

(A) The highest number of residents in any program year who, during the third year of the rural track's existence, are training in the rural track at--

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

(2) The rural nonhospital site(s); and

(B) The number of years in which the residents are expected to complete each program based on the minimum accredited length for the type of program.

(3) If an urban hospital rotates residents in the rural track program to a rural hospital(s) for less than two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2000, and before October 1, 2003, or for one-half or less than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003, the rural hospital may not include those residents in its FTE count (if the rural track is not a new program under paragraph (e)(3) of this section, or if the rural hospital's FTE count exceeds that hospital's FTE cap), nor may the urban hospital include those residents when calculating its rural track FTE limitation.

(4) If an urban hospital rotates residents in the rural track program to a rural nonhospital site(s) for period of time is less than two-thirds of the duration of the

program for cost reporting periods beginning on or after April 1, 2000 and before October 1, 2003, or for one-half or less than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003, the urban hospital may include those residents in its FTE count, subject to the requirements under §413.78(d). The urban hospital may include in its FTE count those residents in the rural track, not to exceed its rural track limitation, determined as follows:

(i) For the first 3 years of the rural track's existence, the rural track FTE limitation for the urban hospital will be the actual number of FTE residents, subject to the rolling average specified in paragraph (d)(7) of this section, training in the rural track at the rural nonhospital site(s).

(ii) Beginning with the fourth year of the rural track's existence, the rural track FTE limitation is equal to the product of--

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

(B) The length of time in which the residents are being training at the rural nonhospital site(s) only.

(5) All urban hospitals that wish to count FTE residents in rural tracks, not to exceed their respective rural track FTE limitation, must also comply with all of the following conditions:

(i) An urban hospital may not include in its rural track FTE limitation or (assuming the urban hospital's FTE count exceeds its FTE cap) FTE count residents who are training in a rural track residency program that were already included as part of the hospital's FTE cap.

(ii) The hospital must base its count of residents in a rural track on written contemporaneous documentation that each resident enrolled in a rural track program at the hospital intends to rotate for a portion of the residency program to a rural area.

(iii) All residents that are included by the hospital as part of its rural track FTE count (not to exceed its rural track FTE limitation) must train in the rural area. However, where a resident begins to train in the rural track program at the urban hospital but leaves the program before completing the total required portion of training in the rural area, the urban hospital may count the time the resident trained in the urban hospital if another resident fills the vacated FTE slot and completes the training in the rural portion of the rural track program. An urban hospital may not receive GME payment for the time the resident trained at the urban hospital if another resident fills the vacated FTE slot and first begins to train at the urban hospital.

(6) If CMS finds that residents who are included by the urban hospital as part of its FTE count did not actually complete the training in the rural area, CMS will reopen the urban hospital's cost report within the 3-year reopening period as specified in

§405.1885 of this chapter and adjust the hospital's Medicare GME payments (and, where applicable, the hospital's rural track FTE limitation).

(l) For purposes of this section, a new medical residency training program means a medical residency that receives initial accreditation by the appropriate accrediting body or begins training residents on or after January 1, 1995.

§413.80 Direct GME payments: Determination of weighting factors for foreign medical graduates.

(a) The weighting factor for a foreign medical graduate is determined under the provisions of §413.79 if the foreign medical graduate--

(1) Has passed FMGEMS; or

(2) Before July 1, 1986, received certification from, or passed an examination of, the Educational Committee for Foreign Medical Graduates.

(b) Before July 1, 1986, the weighting factor for a foreign medical graduate is 1.0 times the weight determined under the provisions of §413.79. On or after July 1, 1986, and before July 1, 1987, the weighting factor for a graduate of a foreign medical school who was in a residency program both before and after July 1, 1986 but who does not meet the requirements set forth in paragraph (a) of this section is .50 times the weight determined under the provisions of §413.79.

(c) On or after July 1, 1987, these foreign medical graduates are not counted in determining the number of FTE residents.

(d) During the cost reporting period in which a foreign medical graduate passes FMGEMS, the weighting factor for that resident is determined under the provisions of

§413.79 for the part of the cost reporting period beginning with the month the resident passes the test.

(e) On or after September 1, 1989, the National Board of Medical Examiners Examination, Parts I and II, may be substituted for FMGEMS for purposes of the determination made under paragraphs (a) and (d) of this section.

(f) On or after June 1, 1992, the United States Medical Licensing Examination may be substituted for the FMGEMS for purposes of the determination made under paragraphs (a) and (d) of this section. On or after July 1, 1993, only the results of steps I and II of the United States Medical Licensing Examination will be accepted for purposes of making this determination.

§413.81 Direct GME payments: Application of community support and redistribution of costs in determining FTE resident counts.

(a) For purposes of determining direct GME payments, the following principles apply:

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

(2) Redistribution of costs. The costs of training residents that constitute a redistribution of costs from an educational institution to the hospital are not considered GME costs to the hospital for purposes of Medicare payment.

(b) Application. A hospital must continuously incur costs of direct GME of residents training in a particular program at a training site since the date the residents first

began training in that program in order for the hospital to count the FTE residents in accordance with the provisions of §§413.78, 413.79 (c) through (e), and 413.79(k). This rule also applies to providers that are paid for direct GME in accordance with §405.2468 of this chapter, §422.270 of this subchapter, and §413.70.

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

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

§413.82 Direct GME payments: Special rules for States that formerly had a waiver from Medicare reimbursement principles.

(a) Effective for cost reporting periods beginning on or after January 1, 1986, hospitals in States that, prior to becoming subject to the prospective payment system, had a waiver for the operation of a State reimbursement control system under section 1886(c) of the Act, section 402 of the Social Security Amendments of 1967 (42 U.S.C. 1395b-1 or section 222(a) of the Social Security Amendment of 1972 (42 U.S.C. 1395b-1 (note))

are permitted to change the order in which they allocate administrative and general costs to the order specified in the instructions for the Medicare cost report.

(b) For hospitals making this election, the base-period costs for the purpose of determining the per resident amount are adjusted to take into account the change in the order by which they allocate administrative and general costs to interns and residents in approved program cost centers.

(c) Per resident amounts are determined for the base period and updated as described in §413.77. For cost reporting periods beginning on or after January 1, 1986, payment is made based on the methodology described in §413.76.

§413.83 Direct GME payments: Adjustment of a hospital's target amount or prospective payment hospital-specific rate.

(a) Misclassified operating costs--(1) General rule. If a hospital has its base-period GME costs reduced under §413.77(a) of this section because those costs included misclassified operating costs, the hospital may request that the intermediary review the classification of the affected costs in its rate-of-increase ceiling or prospective payment base year for purposes of adjusting the hospital's target amount or hospital-specific rate. For those cost reports that are not subject to reopening under §405.1885 of this chapter, the hospital's reopening request must explicitly state that the review is limited to this one issue.

(2) Request for review. The hospital must request review of the classification of its rate-of-increase ceiling or prospective payment base year costs no later than 180 days after the date of the notice by the intermediary of the hospital's base-period average per

resident amount. A hospital's request for review must include sufficient documentation to demonstrate to the intermediary that adjustment of the hospital's hospital-specific rate or target amount is warranted.

(3) Effect of intermediary's review. If the intermediary, upon review of the hospital's costs, determines that the hospital's hospital-specific rate or target amount should be adjusted, the adjustment of the hospital-specific rate or the target amount is effective for the hospital's cost reporting periods subject to the prospective payment system or the rate-of-increase ceiling that are still subject to reopening under §405.1885 of this chapter.

(b) Misclassification of GME costs--(1) General rule. If costs that should have been classified as GME costs were treated as operating costs during both the GME base period and the rate-of-increase ceiling base year or prospective payment base year and the hospital wishes to receive benefit for the appropriate classification of these costs as GME costs in the GME base period, the hospital must request that the intermediary review the classification of the affected costs in the rate-of-increase ceiling or prospective payment base year for purposes of adjusting the hospital's target amount or hospital-specific rate. For those cost reports that are not subject to reopening under §405.1885 of this chapter, the hospital's reopening request must explicitly state that the review is limited to this one issue.

(2) Request for review. The hospital must request review of the classification of its costs no later than 180 days after the date of the intermediary's notice of the hospital's base-period average per resident amount. A hospital's request for review must include

sufficient documentation to demonstrate to the intermediary that modification of the adjustment of the hospital's hospital-specific rate or target amount is warranted.

(3) Effect of intermediary's review. If the intermediary, upon review of the hospital's costs, determines that the hospital's hospital-specific rate or target amount should be adjusted, the adjustment of the hospital-specific rate and the adjustment of the target amount is effective for the hospital's cost reporting periods subject to the prospective payment system or the rate-of-increase ceiling that are still subject to reopening under §405.1885 of this chapter.

§413.87 [Amended]

8. In §413.87--

A. Under paragraph (e), the cross-reference "§413.86(d)(4)" is removed and the cross-reference "413.76(d)" is added in its place.

B. Under paragraph (f)(1)(i), the cross-reference "413.86(d)(3)" is removed and the cross-reference "413.76(c)" is added in its place.

§413.88 [Amended]

9. In §413.88--

A. Under paragraph (b)(1), the cross-reference "413.86(b)" is removed and the cross-reference "§413.75(b)" is added in its place.

B. Under paragraph (b)(2), the cross-reference "§413.86(b)" is removed and the cross-reference "§413.75(b)" is added in its place.

C. Under paragraph (d)(7), the reference "413.86(b)" is removed and the cross-reference "§413.75(b)" is added in its place.

D. Under paragraphs (g)(1)(i)(A) and (B), the cross-reference "§413.86(g)" is removed and the cross-reference "§413.79" is added in its place, wherever it appears.

E. Under paragraph (h)(1)(i), the cross-reference "§413.86(d)" (2 times) is removed and the cross-reference "§413.76" (2 times) is added in its place.

10. Section 413.114 is amended by revising the last sentence of paragraph (a)(2) to read as follows:

§413.114 Payment for posthospital SNF care furnished by a swing-bed hospital.

(a) * * *

(2) Services furnished in cost reporting periods beginning on and after July 1, 2002. * * * Posthospital SNF care furnished in general routine inpatient beds in CAHs is paid based on reasonable cost for cost reporting periods beginning on and after July l, 2002 and before January 1, 2004, and is paid based on 101 percent of reasonable cost for cost reporting periods beginning on and after January 1, 2004, in accordance with the provisions of subparts A through G of this part (other than paragraphs (c) and (d) of this section).

* * * * *

11. Section 413.302 is amended by revising the definition of "Urban area" to read as follows:

§413.302 Definitions.

For purposes of this subpart I--

* * * * *

Urban area means--

(1) Prior to October 1, 2004, a Metropolitan Statistical Area (MSA), or New England County Metropolitan Area (NECMA), as defined by the Office of Management and Budget, or a New England county deemed to be an urban area as listed in §412.62(f)(1)(ii)(B) of this chapter.

(2) Effective October 1, 2004, a Metropolitan Statistical Area (MSA), as defined by the Office of Management and Budget, or a New England county deemed to be an urban area as specified under §412.64.

D. Part 418 is amended as follows:

PART 418—HOSPICE CARE

1. The authority citation for part 418 continues to read as follows:

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

Section 418.100 is amended as follows:

A. Revising paragraph (d)(1).

B. Revising paragraph (d)(4).

C. Adding a new paragraph (d)(5).

The revision and addition read as follows:

§418.100 Condition of Participation: Hospices that provide inpatient care directly.

* * * * *

(d) Standard: Fire protection. (1) Except as otherwise provided in this section--

(i) The hospice must meet the provisions applicable to nursing homes of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the

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

(ii) Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the LSC does not apply to a hospice.

* * * *` ` *

(4) Beginning March 13, 2006, a hospice must be in compliance with Chapter 9.2.9, Emergency Lighting.

(5) Beginning March 13, 2006, Chapter 19.3.6.3.2, exception number 2 does not apply to hospices.

* * * * *

E. Part 460 is amended as follows:

PART 460—PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

1. The authority citation for part 460 continues to read as follows:

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

Subpart E—PACE Administrative Requirements

2. Section 460.72 is amended by--

A. Revising paragraph (b)(1).

B. Revising paragraph (b)(3).

C. Adding paragraph (b)(4).

The revision and addition read as follows:

§460.72 Physical environment.

* * * * *

(b) Fire safety. (1) General rule. Except as otherwise provided in this section--

(i) A PACE center must meet the applicable provisions of the 2000 edition of the Life Safety Code (LSC) of the National Fire Protection Association that apply to the type of setting in which the center is located. The Director of the Office of the Federal Register has approved the NFPA 101® 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch

Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the **Federal Register** to announce the changes.

(ii) Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the LSC does not apply to PACE centers.

* * * * *

(3) Beginning March 13, 2006, a PACE center must be in compliance with Chapter 9.2.9, Emergency Lighting.

(4) Beginning March 13, 2006, Chapter 19.3.6.3.2, exception number 2 does not apply to PACE centers.

* * * * *

F. The title of Part 480 under Subchapter F is revised to read as follows:

PART 480--ACQUISITION, PROTECTION, AND DISCLOSURE OF QUALITY IMPROVEMENT ORGANIZATION INFORMATION

G. Part 480 is amended as follows:

1. The authority citation for Part 480 continues to read:

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

2. Section 480.106 is amended by adding a new paragraph (c) to read as follows:

§480.106 Exceptions to QIO notice requirements.

* * * * *

(c) Other. The notification requirements in §480.105(a) and (b)(2) do not apply if:

(1) The institution or practitioner has requested, in writing, that the QIO make the disclosure;

(2) The institution or practitioner has provided, in writing, consent for the disclosure; or

(3) The information is public information as defined in §480.101(b) and specified under §480.120.

3. Section 480.133 is amended by revising paragraph (a)(2)(iii) to read as follows:

§480.133 Disclosure of information about practitioners, reviewers and institutions.

(a) * * *

(2) Disclosure to others. * * *

(iii) A QIO may disclose to any person, agency, or organization information on a particular practitioner or reviewer at the written request of or with the written consent of that practitioner or reviewer. The recipient of the information has the same redisclosure rights and responsibilities as the requesting or consenting practitioner or reviewer as provided under this Subpart B.

* * * * *

4. Section 480.140 is amended by redesignating paragraphs (d) and (e) as paragraphs (e) and (f), respectively, and adding a new paragraph (d) to read as follows:

§480.140 Disclosure of quality review study information.

* * * * *

(d) A QIO may disclose quality review study information with identifiers of particular practitioners or institutions, or both, at the written request of, or with the written consent of, the identified practitioner(s) or institution(s).

(1) The consent or request must specify the information that is to be disclosed and the intended recipient of the information.

(2) The recipient of the information has the same redisclosure rights and responsibilities as the requesting or consenting practitioner or institution as provided under this Subpart B.

* * * * *

5. Cross-Reference Changes

§§480.101, 480.104, 480.105, 480.106, 480.120, 480.121, 480.130, 480.132, 480.133, 480.136, 480.137, 480.138, 480.141, 480.142 [Amended]

In the table below, for each section indicated in the left column, remove the cross-reference indicated in the middle column from wherever it appears in the section, and add the cross-reference in the right column:

Section	Remove	Add
480.101(b), under the definition "Patient representative"	§476.132(c)(3)	§480.132(c)(3)
480.104(a)(1)	§476.105	§480.105
480.104(a)(2)	§476.106	§480.106
480.104(a)(2)	§476.107	§480.107
480.104(d)	§476.120(a)(6)	§480.120(a)(6)
480.105(a)	§476.106	§480.106
480.105(b)(1)	§476.132	§480.132
480.105(b)(2)	§§476.137 and 476.138	§§480.137 and 480.138
480.105(b)(2)	§476.106	§480.106
480.106(a)	§476.105	§480.105

Section	Remove	Add
480.106(b)	§476.105	§480.105
480.120, introductory text	§§476.104 and 476.105	§§480.104 and 480.105
480.120(a)(5)	§476.139	§480.139
480.121	§476.105	§480.105
480.121	§476.120	§480.120
480.130	§§476.139(a) and 476.140	§§480.139(a) and 480.140
480.132(b)(2)	§476.139(a)	§480.139(a)
480.132(b)(3)	§476.140	§480.140
480.133(a)(2)(ii)	§§476.137 and 476.138	§§480.137 and 480.138
480.133(b)(2)	§476.139(a)	§480.139(a)
480.133(b)(3)	§476.140	§480.140
480.136(a), introductory text	§§476.139(a) and 476.140	§§480.139(a) and 480.140
480.137(a), introductory text	§§476.139(a) and 476.140	§§480.139(a) and 480.140
480.138(b)(2)	§§476.139(a) and 476.140	§§480.139(a) and 480.140
480.141	§§476.104 and 476.105	§§480.104 and 480.105
480.142(b)	§476.137	§480.137

H. Part 482 is amended as follows:

PART 482—CONDITIONS OF PARTICIPATION FOR HOSPITALS

1. The authority citation for part 482 continues to read as follows:

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

2. Section 482.41 is amended by-revising paragraph (b).

§482.41 Conditions of participation: Physical environment.

* * * * *

(b) Standard: Life safety from fire. (1) Except as otherwise provided in this section--

(i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office

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

(ii) Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the LSC does not apply to hospitals.

(2) After consideration of State survey agency findings, CMS may waive specific provisions of the Life Safety Code which, if rigidly applied, would result in unreasonable hardship upon the facility, but only if the waiver does not adversely affect the health and safety of the patients.

(3) The provisions of the Life Safety Code do not apply in a State where CMS finds that a fire and safety code imposed by State law adequately protects patients in hospitals.

(4) Beginning March 13, 2006, a hospital must be in compliance with Chapter 19.2.9, Emergency Lighting.

(5) Beginning March 13, 2006, Chapter 19.3.6.3.2, exception number 2 does not apply to hospitals.

(6) The hospital must have procedures for the proper routine storage and prompt disposal of trash.

(7) The hospital must have written fire control plans that contain provisions for prompt reporting of fires; extinguishing fires; protection of patients, personnel and guests; evacuation; and cooperation with fire fighting authorities.

(8) The hospital must maintain written evidence of regular inspection and approval by State or local fire control agencies.

* * * * *

3. Section 482.43 is amended by adding new paragraphs (c)(6), (c)(7), and (c)(8) to read as follows:

§ 482.43 Conditions of participation: Discharge planning.

* * * * *

(c) * * *

(6) The hospital must include in the discharge plan a list of HHAs or SNFs that are available to the patient, that are participating in the Medicare program, and that serve the geographic area (as defined by the HHA) in which the patient resides, or in the case of a SNF, in the geographic area requested by the patient. HHAs must request to be listed by the hospital as available.

(i) This list must only be presented to patients for whom home health care or post-hospital extended care services are indicated and appropriate as determined by the discharge planning evaluation.

(ii) For patients enrolled in managed care organizations, the hospital must indicate the availability of home health and posthospital extended care services through individuals and entities that have a contract with the managed care organizations.

(iii) The hospital must document in the patient's medical record that the list was presented to the patient or to the individual acting on the patient's behalf.

(7) The hospital, as part of the discharge planning process, must inform the patient or the patient's family of their freedom to choose among participating Medicare providers of posthospital care services and must, when possible, respect patient and family preferences when they are expressed. The hospital must not specify or otherwise limit the qualified providers that are available to the patient.

(8) The discharge plan must identify any HHA or SNF to which the patient is referred in which the hospital has a disclosable financial interest, as specified by the Secretary, and any HHA or SNF that has a disclosable financial interest in a hospital under Medicare. Financial interests that are disclosable under Medicare are determined in accordance with the provisions of Part 420, Subpart C, of this chapter.

I. Part 483 is amended as follows:

PART 483-REQUIREMENTS FOR STATES AND LONG TERM CARE FACILITIES

The authority citation for part 483 continues to read as follows:

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

2. Section 483.70 is amended by revising paragraph (a) to read as follows.

§ 483.70 Physical environment.

***** ***** ***** ***** *****

(a) Life safety from fire.

(1) Except as otherwise provided in this section--

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

(ii) Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the LSC does not apply to long-term care facilities.

(2) After consideration of State survey agency findings, CMS may waive specific provisions of the Life Safety ode which, if rigidly applied, would result in unreasonable hardship upon the facility, but only if the waiver does not adversely affect the health and safety of the patients.

(3) The provisions of the Life safety Code do not apply in a State where CMS finds, in accordance with applicable provisions of sections 1819(d)(2)(B)(ii) and 1919(d)(2)(B)(ii) of the Act, that a fire and safety code imposed by State law adequately protects patients, residents and personnel in long term care facilities.

(4) Beginning March 13, 2006, a long-term care facility must be in compliance with Chapter 19.2.9, Emergency Lighting.

(5) Beginning March 13, 2006, Chapter 19.3.6.3.2, exception number 2 does not apply to long-term care facilities.

* * * * *

3. Section 483.470 is amended by revising paragraph (j) to read as follows:

§483.470 Condition of participation: Physical environment.

*** * * * ***

(j) Standard: Fire protection.

(1) General. Except as otherwise provided in this section--

(i) The facility must meet the applicable provisions of either the Health Care Occupancies Chapters or the Residential Board and Care Occupancies Chapter of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101® 2000 edition

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

(ii) Chapter 19.3.6.3.2, exception number 2 of the adopted LSC does not apply to a facility.

(2) The State survey agency may apply a single chapter of the LSC to the entire facility or may apply different chapters to different buildings or parts of buildings as permitted by the LSC.

(3) A facility that meets the LSC definition of a residential board and care occupancy must have its evacuation capability evaluated in accordance with the Evacuation Difficulty Index of the Fire Safety Evaluation System for Board and Care facilities (FSES/BC).

(4) If CMS finds that the State has a fire and safety code imposed by State law that adequately protects a facility's clients, CMS may allow the State survey agency to apply the State's fire and safety code instead of the LSC.

(5) Beginning March 13, 2006, a facility must be in compliance with Chapter 19.2.9, Emergency Lighting.

(6) Beginning March 13, 2006, Chapter 19.3.6.3.2, exception number 2 does not apply to a facility.

(7) Facilities that meet the LSC definition of a health care occupancy. After consideration of State survey agency recommendations, CMS may waive, for appropriate periods, specific provisions of the Life Safety Code if the following requirements are met:

(i) The waiver would not adversely affect the health and safety of the clients.

(ii) Rigid application of specific provisions would result in an unreasonable hardship for the facility.

* * * * *

J. Part 485 is amended as follows:

PART 485--CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

1. The authority citation for Part 485 continues to read as follows:

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

2. Section 485.610 is amended by--

A. Revising the introductory text to paragraph (b).

B.. Adding a new paragraph (b)(3).

C. Revising paragraph (c).

The addition and revision read as follows:

§485.610 Condition of participation: Status and location.

* * * * *

(b) Standard: Location in a rural area or treatment as rural. The CAH meets the requirements of either paragraph (b)(1) or (b)(2) or (b)(3) of this section. * * *

(3) Effective only for October 1, 2004 through September 30, 2006, the CAH does not meet the location requirements in either paragraph (b)(1) or (b)(2) of this section and is located in a county that, in FY 2004, was not part of a Metropolitan Statistical Area as defined by the Office of Management and Budget, but as of FY 2005 was included as part of such an MSA as a result of the most recent census data and implementation of the new MSA definitions announced by OMB on June 6, 2003.

(c) Standard: Location relative to other facilities or necessary provider certification. The CAH is located more than a 35-mile drive (or, in the case of mountainous terrain or in areas with only secondary roads available, a 15-mile drive) from a hospital or another CAH, or before January 1, 2006, the CAH is certified by the State as being a necessary provider of health care services to residents in the area. A CAH that is designated as a necessary provider as of October 1, 2006, will maintain its necessary provider designation after October 1, 2006.

3. Section 485.618 is amended by--

A. Revising paragraph (d)(1) introductory text.

B. In paragraph (d)(2)(iv), removing the cross-reference "paragraph (d)(2)(ii)" and adding in its place the cross-reference "paragraph (d)(2)(iii)".

C. In paragraph (d)(3), removing the cross-reference "paragraph (d)(2)(ii)" and adding in its place the cross-reference "paragraph (d)(2)(iii)".

The revision reads as follows:

§485.618 Condition of participation: Emergency services.

* * * * *

(d) Standard: Personnel. (1) Except as specified in paragraph (d)(2) of this section, there must be a doctor of medicine or osteopathy, a physician assistant, a nurse practitioner, or a clinical nurse specialist, with training or experience in emergency care on call and immediately available by telephone or radio contact, and available onsite within the following timeframes:

* * * * *

4. Section 485.620 is amended by revising paragraph (a) to read as follows:

§485.620 Condition of participation: Number of beds and average length of stay.

(a) Standard: Number of beds. Except as permitted for CAHs having distinct part units under §485.646, the CAH maintains no more than 25 inpatient beds after January 1, 2004, that can be used for either inpatient or swing-bed services.

* * * * *

5. Section 485.623 is amended by--

A. Revising paragraph (d)(1)

B. Revising paragraph (d)(5).

C. Adding a new paragraph (d)(6).

The revisions and addition read as follows.

§485.623 Condition of participation: Physical plant and environment.

* * * * *

(d) Standard: Life safety from fire.

(1) Except as otherwise provided in this section--

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

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

* * * * *

(5) Beginning March 13, 2006, a critical access hospital must be in compliance with Chapter 9.2.9, Emergency Lighting.

(6) Beginning March 13, 2006, Chapter 19.3.6.3.2, exception number 2 does not apply to critical access hospitals.

6. Section 485.645 is amended by republishing the introductory text of paragraph (a) and revising paragraph (a)(2) to read as follows:

§485.645 Special requirements for CAH providers of long-term care services ("swing-beds").

* * * * *

(a) Eligibility. A CAH must meet the following eligibility requirements:

* * * * *

(2) The facility provides not more than 25 inpatient beds. Any bed of a unit of the facility that is licensed as a distinct-part SNF at the time the facility applies to the State for designation as a CAH is not counted under paragraph (a) of this section.

* * * * *

7. A new §485.647 is added under subpart F to read as follows:

§485.647 Condition of participation: psychiatric and rehabilitation distinct part units.

(a) Conditions.

(1) If a CAH provides inpatient psychiatric services in a distinct part unit, the services furnished by the distinct part unit must comply with the hospital requirements specified in Subparts A, B, C, and D of Part 482 of this subchapter, the common requirements of §412.25(a)(2) through (f) of Part 412 of this chapter for hospital units excluded from the prospective payment systems, and the additional requirements of §412.27 of Part 412 of this chapter for excluded psychiatric units.

(2) If a CAH provides inpatient rehabilitation services in a distinct part unit, the services furnished by the distinct part unit must comply with the hospital requirements specified in Subparts A, B, C, and D of Part 482 of this subchapter, the common requirements of §412.25(a)(2) through (f) of Part 412 of this chapter for hospital units excluded from the prospective payments systems, and the additional requirements of §§412.29 and §412.30 of Part 412 of this chapter related specifically to rehabilitation units.

(b) Eligibility requirements.

(1) To be eligible to receive Medicare payments for psychiatric or rehabilitation services as a distinct part unit, the facility provides no more than 10 beds in the distinct part unit.

(2) The beds in the distinct part are excluded from the 25 inpatient-bed count limit specified in §485.620(a).

(3) The average annual 96-hour length of stay requirement specified under §485.620(b) does not apply to the 10 beds in the distinct part units specified in paragraph (b)(1) of this section, and admissions and days of inpatient care in the distinct part units are not taken into account in determining the CAH's compliance with the limits on the number of beds and length of stay in §485.620.

K. Part 489 is amended as follows:

PART 489--PROVIDER AGREEMENT AND SUPPLIER APPROVAL

1. The authority citation for part 489 continues to read as follows:

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

2. Section 489.20 is amended as follows:

A. In paragraph (m), the cross-reference "§489.24(d)" is removed and the cross-reference "§489.24(e)" is added in its place.

B. A new paragraph (t) is added.

§489.20 Basic commitments.

* * * * *

(t) Hospitals that are not otherwise subject to the Occupational Safety and Health Act of 1970 (or a State occupational safety and health plan that is approved under section 18(b) of the Occupational Safety and Health Act) must comply with the bloodborne pathogens (BBP) standards under 29 CFR 1910.1030. A hospital that fails to comply with the BBP standards may be subject to a civil money penalty in accordance with section 17 of the Occupational Safety and Health Act of 1970, including any adjustments of the civil money penalty amounts under the Federal Civil Penalties Inflation Adjustment Act, for a violation of the BBP standards. A civil money penalty will be imposed and collected in the same manner as civil money penalties under section 1128A(a) of the Social Security Act.

§489.53 [Amended]

3. In §489.53 (b)(2), the cross-reference "489.24 (d)" is removed and the cross-reference "489.24 (e)" is added in its place.

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare--Hospital Insurance; and Program No. 93.774, Medicare--Supplementary Medical Insurance Program)

Dated:_____

_____

Mark B. McClellan,

Administrator, Centers for

Medicare & Medicaid Services

Dated:_____

_____

Tommy G. Thompson,

Secretary

BILLING CODE 4120-01-P

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

Addendum--Schedule of Standardized Amount Effective with Discharges Occurring On or After October 1, 2004 and Update Factors and Rate-of-Increase Percentages Effective With Cost Reporting Periods Beginning On or After October 1, 2004

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, 2004, except for SCHs, MDHs, and hospitals located in Puerto Rico, each hospital's payment per discharge under the IPPS will be based on 100 percent of the Federal national rate, which will be based on the national adjusted standardized amount. This amount reflects the national average hospital costs per case from a base year, updated for inflation.

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

Under section 1886(d)(5)(G) of the Act, MDHs are paid based on the Federal national rate or, if higher, the Federal national rate plus 50 percent of the difference

between the Federal national rate and the updated hospital-specific rate based on FY 1982 or FY 1987 costs per discharge, whichever is higher. MDHs do not have the option to use their FY 1996 hospital-specific rate.

For hospitals in Puerto Rico, the payment per discharge is based on the sum of 25 percent of a Puerto Rico rate that reflects base year average costs per case of Puerto Rico hospitals and 75 percent of the Federal national rate. (See section II.D.3. of this Addendum for a complete description.)

As discussed below in section II. of this Addendum, we are making changes in the determination of the prospective payment rates for Medicare inpatient operating costs for FY 2005. The changes, to be applied prospectively effective with discharges occurring on or after October 1, 2004, affect the calculation of the Federal rates. In section III. of this Addendum, we discuss our changes for determining the prospective payment rates for Medicare inpatient capital-related costs for FY 2005. 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 factors 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 2005

The basic methodology for determining prospective payment rates for hospital inpatient operating costs is set forth at §§412.63 and 412.64. The basic methodology for determining the prospective payment rates for hospital inpatient operating costs for

hospitals located in Puerto Rico is set forth at §§412.210, 412.211, 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, 1B, 1C, and 1D of section VI. of this Addendum reflect—

- The requirements of section 401 of Pub. L. 108-173, equalizing the standardized amounts for urban and other areas at the level computed for urban hospitals during FY 2004, updated by the applicable percentage increase required under section 501(a) of Pub. L. 108-173;

- The requirements of section 403 of Pub. L. 108-173, establishing two labor-related shares that are applicable to the standardized amounts depending on whether the hospital's payments would be higher with a lower (in the case of a wage index below 1.0000) or higher (in the case of a wage index above 1.0000) labor share;

- Updates of 3.3 percent for all areas (that is, the full market basket percentage increase of 3.3 percent, as required by section 501(a) of Pub. L. 108-173), and reflecting the requirements of section 501(b) of Pub. L. 108-173, to reduce the applicable percentage increase by 0.4 percentage points for hospitals that fail to submit data in a form and manner specified by the Secretary, relating to the quality of inpatient care furnished by the hospital;

- An adjustment to ensure the DRG recalibration and wage index update and changes are budget neutral, as provided for under sections 1886(d)(4)(C)(iii) and (d)(3)(E) of the Act, by applying new budget neutrality adjustment factors to the standardized amount;

- An adjustment to ensure the effects of the special transition measures adopted in relation to the implementation of new labor market areas are budget neutral;

- An adjustment to ensure the effects of geographic reclassification are budget neutral, as provided for in section 1886(d)(8)(D) of the Act, by removing the FY 2004 budget neutrality factor and applying a revised factor;

- An adjustment to apply the new outlier offset by removing the FY 2004 outlier offsets and applying a new offset;

- An adjustment to ensure the effects of the rural community hospital demonstration required under section 410A of Pub. L. 108-173 are budget neutral, as required under section 410A(c)(2) of Pub. L. 108-173.

A. Calculation of the Adjusted Standardized Amount

1. Standardization of Base-Year Costs or Target Amounts

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

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

Under sections 1886(d)(2)(H) and (d)(3)(E) of the Act, the Secretary estimates, from time-to-time, the proportion of costs that are wages and wage-related costs. The standardized amount is divided into labor-related and nonlabor-related amounts; only the proportion considered the labor-related amount is adjusted by the wage index. The current labor-related share is 71.1 percent. The current labor-related share in Puerto Rico is 71.3 percent.

Section 403 of Pub. L. 108-173 revises the proportion of the standardized amount that is considered labor-related. Specifically, section 403 of Pub.L. 108-173 requires that 62 percent of the standardized amount be adjusted by the wage index, unless doing so would result in lower payments to a hospital than would otherwise be made (section 403(b) Pub.L. 108-173 extends this provision to the Puerto Rico standardized amounts). As a consequence, we are adjusting 62 percent of the national and Puerto Rico standardized amount by the wage index for all hospitals whose wage indexes are less than or equal to 1.0000; otherwise, the wage index is applied to 71.1 percent of the standardized amount.

2. Computing the Average Standardized Amount

Sections 1886(d)(2)(D) and (d)(3) of the Act previously required the Secretary to compute the following two average standardized amounts for discharges occurring in a fiscal year: one for hospitals located in large urban areas and one for hospitals located in other areas. In addition, under sections 1886(d)(9)(B)(iii) and (d)(9)(C)(i) of the Act, the average standardized amount per discharge was determined for hospitals located in large urban and other areas in Puerto Rico. In accordance with section 1886(b)(3)(B)(i) of the Act, the large urban average standardized amount was 1.6 percent higher than the other area average standardized amount.

Section 402(b) of 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. Subsequently, Pub. L. 108-89 extended section 402(b) of Pub. L. 108-7 beginning with discharges on or after October 1, 2003 and before March 31, 2004. Finally, section 401(a) of Pub. L. 108-173 requires that, beginning with FY 2004 and thereafter, an equal standardized amount is to be computed for all hospitals at the level computed for large urban hospitals during FY 2003, updated by the applicable percentage update. This provision in effect makes permanent the equalization of the standardized amounts at the level of the previous standardized amount for large urban hospitals. Section 401(c) Pub.L. 108-173 also equalizes the Puerto Rico-specific urban and other area rates. Accordingly, we are providing in this final rule for a single national standardized amount, and a single Puerto Rico standardized amount, for FY 2005 and thereafter.

3. Updating the Average Standardized Amount

In accordance with section 1886(d)(3)(A)(iv) of the Act, we are updating the equalized standardized amount for FY 2005 by the full estimated market basket percentage increase for hospitals in all areas, as specified in section 1886(b)(3)(B)(i)(XIX) of the Act, as amended by section 501 of Pub. L. 108-173. The percentage change in the market basket reflects the average change in the price of goods and services purchased by hospitals to furnish inpatient care. The most recent forecast of the hospital market basket increase for FY 2005 is 3.3 percent. Thus, for FY 2005, the update to the average standardized amount equals 3.3 percent for hospitals in all areas.

As discussed above in section IV.E. of this final rule, section 501(b) of Pub. L. 108-173 amended section 1886(b)(3)(B) of the Act to add a new subclause (vii) to revise the mechanism used to update the standardized amount for payment for inpatient hospital operating costs. Specifically, the amendment provides for a reduction of 0.4 percentage points to the update percentage increase (also known as the market basket update) for each of FYs 2005 through 2007 for any "subsection (d) hospital" that does not submit data on a set of 10 quality indicators established by the Secretary as of November 1, 2003. The statute also provides that any reduction will apply only to the fiscal year involved, and will not be taken into account in computing the applicable percentage increase for a subsequent fiscal year. This measure establishes an incentive for hospitals to submit data on quality measures established by the Secretary. The standardized amount in Tables 1A through 1D of section VI. of this addendum reflect these differential amounts.

Although the update factors for FY 2005 are set by law, we are required by section 1886(e)(3) of the Act to report to the Congress our initial recommendation of update factors for FY 2005 for both IPPS hospitals and hospitals excluded from the IPPS. Our recommendation on the update factors (which is required by sections 1886(e)(4)(A) and (e)(5)(A) of the Act) is set forth as Appendix B of this final rule.

4. Other Adjustments to the Average Standardized Amount

As in the past, we are adjusting the FY 2005 standardized amount to remove the effects of the FY 2004 geographic reclassifications and outlier payments before applying the FY 2005 updates. We then apply the new offsets for outliers and geographic reclassifications to the standardized amount for FY 2005.

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

Budget neutrality is determined by comparing aggregate IPPS payments before and after making the changes that are required to be budget neutral (for example, reclassifying and recalibrating the DRGs, updating the wage data, and geographic reclassifications). We include outlier payments in the payment simulations because outliers may be affected by changes in these payment parameters.

We are also adjusting the standardized amount this year by an amount estimated to ensure that aggregate IPPS payments do not exceed the amount of payments that would have been made in the absence of the rural community hospital demonstration required under section 410A of Pub. L. 108-173. This demonstration is required to be budget neutral under section 410A(c)(2) of Pub. L. 108-173.

a. Recalibration of DRG Weights and Updated Wage Index--Budget Neutrality Adjustment

Section 1886(d)(4)(C)(iii) of the Act specifies that, beginning in FY 1991, the annual DRG reclassification and recalibration of the relative weights must be made in a manner that ensures that aggregate payments to hospitals are not affected. As discussed in section II. of the preamble, we normalized the recalibrated DRG weights by an adjustment factor, so that the average case weight after recalibration is equal to the average case weight prior to recalibration. However, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payments to hospitals are affected by factors other than average case weight. Therefore, as we have done in past years, we are 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. For FY 2005, we are applying an occupational mix adjustment to the wage index. We describe the

occupational mix adjustment in section III.C. of this final rule. Since section 1886(d)(3)(E) of the Act requires us to update the wage index on a budget neutral basis, we are including the effects of this occupational mix adjustment on the wage index in our budget neutrality calculations.

We are also adjusting the standardized amounts this year to ensure that the special transition to full implementation of the labor market areas is budget neutral. Specifically, we ensured budget neutrality by comparing aggregate IPPS payments including the special blended wage indexes that we are providing for certain hospitals in this final rule with the payments that would have been made if those hospitals had not received blended wage indexes. As we discuss in section II. B. 3. d. of this final rule, we are providing a special blended wage index for hospitals whose FY 2005 wage indexes would decrease solely because of the adoption of the new labor market areas. Specifically, any hospital experiencing a decrease in their wage index relative to its FY 2004 wage index because of the labor market area changes will receive 50 percent of the wage index using the new labor market definitions and 50 percent of the wage index that the provider would have received under the old MSA standards.

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. As discussed in section IV.N.6 of the preamble,

we are imputing a floor for States that have no rural areas under the labor market definitions that apply within the IPPS. We are also including the effects of this new provision in our calculation of the wage update budget neutrality factor.

We previously were required to adjust the rates to ensure that any add-on payments for new technology under section 1886(d)(5)(K) of the Act be budget neutral. However, section 503(d)(2) of Pub. L. 108-173 has repealed this requirement. We discuss this provision in section II.E. of this final rule. In accordance with this provision, we are making no budget neutrality adjustment to account for approval of new technologies for add-on payments in FY 2005.

To comply with the requirement that DRG reclassification and recalibration of the relative weights be budget neutral, and the requirement that the updated wage index be budget neutral, we used FY 2003 discharge data to simulate payments and compared aggregate payments using the FY 2004 relative weights and wage index to aggregate payments using the FY 2005 relative weights and wage index. The same methodology was used for the FY 2004 budget neutrality adjustment (although the FY 2004 adjustment included the effects of new technology add-on payments).

Based on this comparison, we computed a budget neutrality adjustment factor equal to 0.999876. We also are adjusting the Puerto Rico-specific standardized amount for the effect of DRG reclassification and recalibration. We computed a budget neutrality adjustment factor for Puerto Rico-specific standardized amount equal to 1.000564. These budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the FY 2004 budget neutrality adjustments.

Using the same data, we also compared payments including the effects of the blended wage indexes that we are providing in this final rule for certain hospitals with what payments would have been in the absence of these blended wage indexes. As discussed above, we are providing blended wage indexes for hospitals whose FY 2005 wage indexes decrease solely as a result of the labor market changes. Based on this comparison, we computed a budget neutrality adjustment of 0.998162.

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, 2004. (See the discussion in the September 4, 1990 final rule (55 FR 36073)).

b. Reclassified Hospitals--Budget Neutrality Adjustment

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

Under section 1886(d)(8)(D) of the Act, the Secretary is required to adjust the standardized amount to ensure that aggregate payments under the IPPS after implementation of the provisions of sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act are equal to the aggregate prospective payments that would have been made absent these provisions. (Neither the wage index reclassifications provided under section 508 of Pub. L. 108-173 nor the wage index adjustments provided under section 505 of Pub. L. 108-173 are budget neutral. Section 508(b) Pub.L. 108-173

provides that the wage index reclassifications approved under section 508(a) Pub.L. 108-173 “shall not be effected in a budget neutral manner.” Section 505(a) of Pub.L. 108-173 similarly provides that any increase in a wage index under that section shall not be taken into account “in computing any budget neutrality adjustment with respect to such index under” section 1886(d)(8)(D) of the Act.) To calculate this budget neutrality factor, we used FY 2003 discharge data to simulate payments, and compared total IPPS payments prior to any reclassifications under sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act to total IPPS payments after such reclassifications. Based on these simulations, we are applying an adjustment factor of 0.993833 to ensure that the effects of this reclassification are budget neutral.

The adjustment factor is applied to the standardized amount after removing the effects of the FY 2004 budget neutrality adjustment factor. We note that the FY 2005 adjustment reflects FY 2005 wage index reclassifications approved by the MGCRB or the Administrator, and the effects of MGCRB reclassifications approved in FY 2003 and FY 2004 (section 1886(d)(10)(D)(v) of the Act makes wage index reclassifications effective for 3 years).

c. Outliers

Section 1886(d)(5)(A) of the Act provides for payments in addition to the basic prospective payments, for "outlier" cases involving extraordinarily high costs. To qualify for outlier payments, a case must have costs above a fixed-loss cost threshold amount (a dollar amount by which the costs of a case must exceed payments in order to qualify for outlier payment). To determine whether the costs of a case exceed the fixed-loss

threshold, a hospital's cost-to-charge ratio is applied to the total covered charges for the case to convert the charges to costs. Payments for eligible cases are then made based on a marginal cost factor, which is a percentage of the costs above the threshold.

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

i. FY 2005 outlier fixed-loss cost threshold. In the August 1, 2003 IPPS final rule (68 FR 45476-45478), we established a threshold for FY 2004 that was equal to the prospective payment rate for the DRG, plus any IME and DSH payments and any additional payments for new technology, plus $31,000. The marginal cost factor (the percent of costs paid after costs for the case exceed the threshold) was 80 percent.

To calculate the FY 2005 outlier thresholds, in the proposed rule we simulated payments by applying proposed FY 2005 rates and policies using cases from the FY 2003 MedPAR file. Therefore, in order to determine the appropriate FY 2005 threshold, it was necessary to inflate the charges on the MedPAR claims by 2 years, from FY 2003 to FY 2005. We used a 2-year average annual rate of change in charges per case to inflate

FY 2003 charges to approximate FY 2005 charges. This was the same methodology as we used to determine the FY 2004 threshold.

The 2-year average annual rate of change in charges per case from FY 2001 to FY 2002, and from FY 2002 to FY 2003, was 14.5083 percent annually, or 31.1 percent over 2 years. As we have done in the past, we used hospital cost-to-charge ratios from the most recent Provider Specific File, in this case the December 2003 update. This file includes cost-to-charge ratios reflecting implementation of changes we made last year (68 FR 34494). As of October 1, 2003, fiscal intermediaries use either the most recent settled or the most recent tentative settled cost report, whichever is from the latest reporting period. Because in the past cost-to-charge ratios were taken from the latest settled cost reports and for some hospitals there were delays in settling their cost reports, the cost-to-charge ratios on the Provider Specific File may have been from cost reporting periods that were several years prior. This change results in more up-to-date and, generally, lower cost-to-charge ratios. Using this methodology, in the May 18, 2004 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 $35,085.

We also stated in the May 18, 2004 proposed rule that the proposed outlier threshold for FY 2005 was higher than might have been anticipated on the basis of the more up-to-date and, generally, lower cost-to-charge ratios used in our calculations. We believed that a significant factor in this result may have been the 2-year average annual rates of change that we are employing to update charges in the MedPAR data from FY

2003 to FY 2005. As we discussed above, for the proposed rule, we used the 2-year average annual rate of change in charges per case from FY 2001 to FY 2002, and from FY 2002 to FY 2003, which is 14.5083 percent annually, or 31.1 percent over 2 years. These rates of increase derive from the period before the changes we made last year to the outlier payment policy and to the calculation of cost-to-charge ratios (68 FR 34494). In fact, they derive from the years just prior to the adoption of the policy changes, when some hospitals were increasing charges at a rapid rate in order to increase their outlier payments. Therefore, they represent rates of increase that may be higher than the rates of increase under our new policy. We have always used actual data from prior years, rather than projections, to update charges for purposes of determining the outlier threshold. In light of the proposed increase to the outlier threshold for FY 2005 compared to the threshold previously in effect, in the May 18, 2004 proposed rule we solicited comments on the data we were proposing to use to update charges for purposes of computing the threshold. We especially encouraged commenters to provide any recommendations for data that might better reflect current trends in charge increases.

Comment: Several commenters opposed our proposal to raise the outlier threshold. These commenters urged us to lower the threshold or at least maintain the threshold at its current level. Some commenters explained that this increase to the threshold would make it more difficult for hospitals to qualify for outlier payments and put them at greater risk when treating high cost cases. The commenters also requested that we take into account all changes from the June 9, 2003 final rule on outliers when calculating the outlier threshold. The commenters further noted that, in the proposed

rule, we estimated total outlier payments for FY 2004 to be 4.4 percent of all inpatient payments, which is 0.7 percentage points less than the 5.1 percent that is offset from the standardized amounts. Based on this analysis, one commenter estimated the threshold should have been set at $26,565 instead of $31,000 to result in outlier payments of 5.1 percent for FY 2004. Other commenters recommended similarly lower thresholds.

Most commenters also stated that we estimated a 2-year average annual rate of change in charges of 31 percent. Some commenters recommended that we use the market basket rate rather than charge data to update charges or return to the previous methodology that measured the percent change in costs using the two most recently available cost reports. One commenter also expressed concern over the estimated rate of increase in charges. The commenters urged us to revise this figure and, if necessary, use other data than historical data to set the outlier threshold. One commenter suggested that we limit the impact of hospital charge increases by requiring hospitals to report their percentage rate increases. This would allow us to adjust individual hospital cost-to-charge ratios without penalizing all hospitals for the actions of a few hospitals. The commenter also recommended the possibility of comparing changes in costs, adjusted for acuity, between cost reporting years.

Two commenters submitted the same data analysis explaining why the outlier threshold should be lowered. Both of the commenters noted that using the March 2004 Hospital Provider Cost Report Information System (HCRIS) file rather than the December 2003 HCRIS file for hospitals' cost-to-charge ratios resulted in a threshold of $32,510 instead of the proposed $35,085 for FY 2005. As a result, one of the

commenters was strongly opposed to the proposed charge inflation methodology because it would overstate the outlier threshold and cause a payment reduction to hospitals.

The data analysis also used the March 2004 HCRIS file and a blend of a cost and charge inflation factor of 7.17 percent for costs and 14.5083 percent for charges and accounted for the fact that hospitals' CCRs are expected to decline throughout the fiscal year as a result of the use of more current data reflecting the changes in hospital charging practices after the June 9, 2003 final rule. This resulted in a threshold of $28,445. One of the commenters noted that in last year's **Federal Register**, similar recommendations were made to account for the decline in CCRs when setting the outlier threshold. At that time, based on a similar analysis for FY 2004, the commenter recommended a threshold of $25,375 and estimates that a threshold of $25,325 in FY 2004 would have resulted in outlier payments equal to 5.1 percent of total DRG payment. Based on the analysis above, the commenter believes this is an appropriate mechanism for estimating the outlier threshold and recommends an outlier threshold of $28,445 or lower for FY 2005. The other commenter further noted that this blend of cost and charge inflation factors may make the threshold more accurate and reliable and may help control for some of the time lag issues.

The analysis then applied the same methodology described above, but instead used a charge inflation factor of 14.5083 percent from FY 2003 to FY 2004, and projected a charge inflation factor of 10 percent from FY 2004 to FY 2005. This resulted in a threshold of $26,660 for FY 2005. One of the commenters explained that a projection of charges for FY 2005 is necessary because, due to various circumstances that have

occurred in the past year such as increased pressure on hospitals to reduce charges for the uninsured and hearings and investigations, significant charge increases by hospitals, charges will not be increasing at the same high rate as in recent years. The commenter believes it is necessary to account for these industry changes in estimating charge increases or there will be an overstatement of the outlier threshold. Based on this analysis, the commenter recommended that, if the trend in the rate of increase reflects a decline, the threshold for FY 2005 should be lower than $28,445 to account for the declining rate of increase in charges in the coming fiscal year. In addition, based on this analysis, the other commenter recommended an outlier threshold of no higher than $27,000 for FY 2005, in order to ensure that hospitals receive outlier payments equal to at least 5.1 percent of total DRG payments and have access to these special payments in order to offset the cost of high cost cases.

One of the commenters also compared our methodology prior to FY 2003 in which we used cost inflation in our estimate of the outlier threshold. The commenter used a cost inflation factor of 7.17 percent when estimating the threshold for FY 2005. Using a methodology of cost inflation without a charge inflation factor and without the latest HCRIS file resulted in an outlier threshold of $24,465 for FY 2005. The commenter added that using the same cost methodology with the latest HCRIS file yielded an outlier threshold of $22,830 for FY 2005. The commenter explained that we started using the charge inflation factor instead of costs because there were problems with timely cost reports due to the implementation of the Outpatient PPS. This problem has

now been resolved and along with the reasons stated above recommended that revert to a methodology using costs when calculating the annual outlier threshold.

One of the commenters also noted that none of the calculations above factored in the impact of reconciliation that would result in an even lower outlier threshold.

Other commenters offered similar analysis and recommended similarly lower thresholds. MedPAC also expressed concern that the proposed outlier threshold for FY 2005 would lead to outlier payments that are too low in FY 2005. MedPAC recommended that we take into account the anticipated slower growth in charges and identify methods and data that would permit our estimate of charge growth to reflect current trends, such as by inflating charges from FY 2003 to FY 2005 using the rate of change in charges between the 9 months after the June 9, 2003 change in outlier policy and the same period the preceding year.

Response: In response to the many comments we received suggesting that we revise the methodology for determining the outlier threshold, we have revised our methodology in order to calculate the FY 2005 outlier thresholds. We believe this revision to our methodology for FY 2005 is necessary in order to address both the changes to the outlier payment methodology and the exceptionally high rate of hospital charge inflation that is reflected in the data for FYs 2001, 2002, and 2003. We also incorporated the policies from the June 9, 2003 regulation into our calculation of the outlier threshold for FY 2004. Due to the limited time from the publication of that regulation to the publication of the IPPS final rule for FY 2004, however, we had insufficient data to determine the full impact that the changes to the outlier methodology

would have on hospital charges. For FY 2005, because we now have more recent data reflecting the impact of the changes to the outlier payment methodology upon hospital charges, we have revised our methodology for computing the outlier threshold for FY 2005 to account for these changes in hospital charges.

We simulated payments by applying FY 2005 rates and policies using cases from the FY 2003 MedPAR file. Therefore, in order to determine the appropriate FY 2005 threshold, it is necessary to inflate the charges on the MedPAR claims by 2 years, from FY 2003 to FY 2005. Instead of using the 2-year average annual rate of change in charges per case from FY 2001 to FY 2002 and FY 2002 to FY 2003, however, we are using more recent data to determine the annual rate of change in charges for the FY 2005 outlier threshold. Specifically, we are taking the unprecedented step of using the first half-year of data from FY 2003 and comparing this data to the first half year of data for FY 2004. We believe this comparison will result in a more accurate determination of the rate of change in charges per case between FY 2003 and FY 2005. Although a full year of data is available from FY 2003, we do not have a full year of FY 2004 data. We therefore believe it is optimal to employ comparable periods in determining the rate of change from one year to the next. We also believe this methodology is the best methodology for determining the rate of change in charges per case since it uses the most recent charge data available. Also, as stated in the June 9, 2003 Federal Register (68 FR 34505), we believe the use of charge inflation is more appropriate than our previous methodology of cost inflation because charges tend to increase at a much faster rate than costs. Although some of the commenters have pointed out that charges have increased at

a slower rate since the June 9, 2003 outlier final rule, we believe the use of charges is still appropriate because the basic tendency of charges to increase faster than costs is still evident.

We note that we are adopting this methodology to calculate the outlier threshold for FY 2005 as a result of the special circumstances surrounding the revisions to the outlier payment methodology. We will continue to consider other methodologies for determining charge inflation when calculating the outlier threshold in the future.

As stated above, we are using a new methodology to establish the FY 2005 threshold. The 1-year average annual rate of change in charges per case from the first half of FY 2003 to the first half of FY 2004 was 8.9772 percent, or 18.76 percent over 2 years. As discussed above, as we have done in the past, we used hospital cost-to-charge ratios from the most recent Provider Specific File, in this case the April 2004 update. This file includes cost-to-charge ratios reflecting implementation of changes we made last year to the policy affecting the applicable cost-to-charge ratios (68 FR 34494). We do not believe that it is necessary to make a specific adjustment to our methodology for computing the outlier threshold to account for any decline in cost-to-charge ratios in FY 2005, as the commenter has requested. We have already taken into account the most significant factor in the decline in cost-to-charge ratios, specifically, the change from using the most recent final settled cost report to the most recent tentatively settled cost report. Furthermore, we strongly prefer to employ actual data rather than projections in estimating the outlier threshold because we employ actual data in updating charges,

themselves. However, we will continue to monitor the experience and evaluate whether further requirements to our methodology are warranted.

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 $25,800.

We are not including in the calculation of the outlier threshold the possibility that hospitals' cost-to-charge ratios and outlier payments may be reconciled upon cost report settlement. Reconciliation occurs when hospitals' cost-to-charge-ratios at the time of cost report settlement are different than the tentatively settled cost-to-charge- ratio used to make outlier payments during the fiscal year. However, we believe that due to changes in hospital charging practices following implementation of the new outlier regulations in the June 9, 2003 final rule, the majority of hospitals' cost-to-charge ratios will not fluctuate significantly enough between the tentatively settled cost report and the final settled cost report to meet the criteria to trigger reconciliation of their outlier payments. Furthermore, it is difficult to predict which specific hospitals may be subject to reconciliation in any given year. As a result, we believe it is appropriate to omit reconciliation from the outlier threshold calculation.

ii. Other changes concerning outliers. As stated in the September 1, 1993 final rule (58 FR 46348), we establish outlier thresholds that are applicable to both hospital inpatient operating costs and hospital inpatient capital-related costs. When we modeled the combined operating and capital outlier payments, we found that using a common set of thresholds resulted in a lower percentage of outlier payments for capital-related costs

than for operating costs. We project that the thresholds for FY 2005 will result in outlier payments equal to 5.10 percent of operating DRG payments and 4.9385 percent of capital payments based on the Federal rate.

In accordance with section 1886(d)(3)(B) of the Act, we reduced the FY 2005 standardized amount by the same percentage to account for the projected proportion of payments paid to outliers.

The outlier adjustment factors that are applied to the standardized amount for FY 2005 are as follows:

	Operating Standardized Amounts	**Capital Federal Rate**
National	0.949005	0.950615
Puerto Rico	0.973192	0.973757

We apply the outlier adjustment factors after removing the effects of the FY 2004 outlier adjustment factors on the standardized amount.

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

The June 9, 2003 outlier final rule (68 FR 34494) eliminated the application of the statewide average for hospitals whose cost-to-charge ratios fall below 3 standard deviations from the national mean cost-to-charge ratio. However, for those hospitals for

which the fiscal intermediary computes operating cost-to-charge ratios greater than 1.240 or capital cost-to-charge ratios greater than 0.169, or hospitals for whom the fiscal intermediary is unable to calculate a cost-to-charge ratio (as described at §412.84(i)(3) of our regulations), we are still using statewide average ratios to calculate costs to determine whether a hospital qualifies for outlier payments.[1] 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 replace the ratios published in the August 1, 2003 IPPS final rule (68 FR 45637). Table 8B in section VI. of this Addendum contains the comparable statewide average capital cost-to-charge ratios. Again, the cost-to-charge ratios in Tables 8A and 8B will be used during FY 2005 when hospital-specific cost-to-charge ratios based on the latest settled cost report are either not available or are outside the range noted above.

iii. FY 2003 and FY 2004 outlier payments. In the August 1, 2003 IPPS final rule (68 FR 45478), we stated that, based on available data, we estimated that actual FY 2003 outlier payments would be approximately 6.5 percent of actual total DRG payments. This estimate was computed based on simulations using the FY 2002 MedPAR file (discharge data for FY 2002 bills). That is, the estimate of actual outlier payments did not reflect actual FY 2003 bills, but instead reflected the application of FY 2003 rates and policies to available FY 2002 bills.

Our current estimate, using available FY 2003 bills, is that actual outlier payments for FY 2003 were approximately 5.7 percent of actual total DRG payments. Thus, the

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

data indicate that, for FY 2003, the percentage of actual outlier payments relative to actual total payments is higher than we projected before FY 2003 (and, thus, exceeds the percentage by which we reduced the standardized amounts for FY 2003). Nevertheless, consistent with the policy and statutory interpretation we have maintained since the inception of the IPPS, we do not plan to make retroactive adjustments to outlier payments to ensure that total outlier payments for FY 2003 are equal to 5.1 percent of total DRG payments.

We currently estimate that actual outlier payments for FY 2004 will be approximately 3.5 percent of actual total DRG payments, 1.6 percentage points lower than the 5.1 percent we projected in setting outlier policies for FY 2004. This estimate is based on simulations using the FY 2003 MedPAR file (discharge data for FY 2003 bills). We used these data to calculate an estimate of the actual outlier percentage for FY 2004 by applying FY 2004 rates and policies, including an outlier threshold of $31,000 to available FY 2003 bills.

d. Section 410A of Pub.L. 108-173 Rural Community Hospital Demonstration Program Adjustment

Section 410A of Pub. L. 108-173 requires the Secretary to establish a demonstration that will modify reimbursement for inpatient services for up to fifteen small rural hospitals. Section 410A(c)(2)of Pub.L. 108-173 requires that "in conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented." As discussed in section IV.P. of this final rule, we are satisfying this requirement by

adjusting national IPPS rates by a factor that is sufficient to account for the added costs of this demonstration. We estimate that the average additional annual payment that will be made to each participating hospital under the demonstration will be approximately $855,893. We based this estimate on the recent historical experience of the difference between inpatient cost and payment for hospitals that would be eligible for the demonstration. For 15 participating hospitals, the total annual impact of the demonstration program is estimated to be $12,838,390. The required adjustment to the Federal rate used in calculating Medicare inpatient prospective payments as a result of the demonstration is 0.999855.

In order to achieve budget neutrality, we are adjusting national IPPS rates by an amount sufficient to account for the added costs of this demonstration. In other words, we are applying budget neutrality across the payment system as a whole rather than merely across the participants of this demonstration. We believe that the language of the statutory budget neutrality requirement permits the agency to implement the budget neutrality provision in this manner. This is because the statutory language requires that "aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration… was not implemented," but does not identify the range across which aggregate payments must be held equal.

In the May 18, 2004 proposed rule, we invited public comments on how we were proposing to implement this statutory provision.

Comment: One commenter observed that we have historically implemented demonstration projects on a budget neutral basis within the context of the given

demonstration. The commenter opposed our proposal to fund the Rural Community Hospital demonstration by reducing the payment rate to all hospitals paid on the basis of DRGs, saying that requiring nonparticipating hospitals to fund hospitals participating in a demonstration project is a poor policy precedent to set.

Response: The Rural Community Hospital Demonstration Program is mandated by section 410A of Pub.L. 108-173. It is aimed at testing the feasibility and advisability of payment for covered inpatient services based on reasonable cost for rural hospitals as defined by the legislation. The commenter is correct in stating that we usually implement demonstrations in which savings occurring among participants guarantee budget neutrality. However, in this case it is not realistic to expect hospitals chosen for the demonstration to generate an offsetting reduction in costs. Furthermore, we believe that the statutory authority allows us to define budget neutrality across the payment system. We believe that the method that we proposed to assure budget neutrality is the only feasible way to implement the demonstration, which is mandated by law.

5. FY 2005 Standardized Amount

The adjusted standardized amount is divided into labor and nonlabor portions. Tables 1A and 1B in section VI. of this Addendum contain the national standardized amount that we are applying to all hospitals, except hospitals in Puerto Rico. The amounts shown in the two tables differ only in that the labor-related share applied to the standardized amounts in Table 1A is 71.1 percent, and the labor-related share applied to the standardized amounts in Table 1B is 62 percent. As described in section II.A.1. of this Addendum, we are implementing section 403 of Pub. L. 108-173, which provides

that the labor-related share is 62 percent, unless the application of that percentage would result in lower payments to a hospital than would otherwise be made. The effect of this provision is that the labor-related share of the standardized amount is 62 percent for all hospitals whose wage indexes are less than or equal to 1.0000.

However, the labor-related share of the standardized amount remains 71.1 percent (reflecting the Secretary's current estimate of the proportion of costs that are wages and wage-related costs) for hospitals whose wage indexes are greater than 1.0000. In addition, both tables include standardized amounts reflecting the full 3.3 percent update for FY 2005, and standardized amounts reflecting the 0.4 percentage point reduction to the update applicable for hospitals that fail to submit quality data consistent with section 501(b) of Pub. L. 108-173. (Tables 1C and 1D show the new standardized amounts for Puerto Rico, reflecting the different labor shares that apply, that is, 71.3 percent or 62 percent.)

The following table illustrates the changes from the FY 2004 national average standardized amount. The first column shows the changes from the 2004 standardized amounts for hospitals that satisfy the quality data submission requirement for receiving the full update (3.3 percent). The second column shows the proposed changes for hospitals receiving the reduced update (2.9 percent). The first row in the table shows the updated (through FY 2003) average standardized amount after restoring the FY 2004 offsets for outlier payments and geographic reclassification budget neutrality. The DRG reclassification and recalibration and wage index budget neutrality factor is cumulative. Therefore, the FY 2004 factor is not removed from the amount in the table. We have

added separate rows to this table to reflect the different labor-related shares that apply to hospitals.

Comparison of FY 2004 Standardized Amounts to FY 2005 Single Standardized Amount with Full Update and Reduced Update

	Full Update (3.3 percent)	**Reduced Update (2.9 percent)**
FY 2004 Base Rate (after removing reclassification budget neutrality and outlier offset)	Labor: $3,331.21 Nonlabor: $1,354.03	Labor: $3,331.21 Nonlabor: $1,354.03
FY 2005 Update Factor	1.033	1.029
FY 2005 DRG Recalibrations and Wage Index Budget Neutrality Factor	0.999876	0.999876
FY 2005 Reclassification Budget Neutrality Factor	0.993833	0.993833
Adjusted for Blend of FY 2004 DRG Recalibration and Wage Index Budget Neutrality Factors*	Labor: $3,419.56 Nonlabor: $1,389.95	Labor: $3,406.32 Nonlabor: $1,384.56
FY 2005 Outlier Factor	0.949005	0.949005
FY 2005 New Labor Market Wage Index Transition Budget Neutrality Factor	0.998162	0.998162
Rural Demo Budget Neutrality Factor	0.999855	0.999855
Rate for FY 2005 (after multiplying FY 2004 base rate by above factors) where the wage index is less than or equal to 1.0000	Labor: $2,824.21 Nonlabor: $1,730.97	Labor: $2,813.27 Nonlabor: $1,724.27
Rate for FY 2005 (after multiplying FY 2004 base rate by above factors) where the wage index is greater than 1.0000	Labor: $3,238.73 Nonlabor: $1,316.45	Labor: $3,226.19 Nonlabor: $1,311.35

*In order to calculate this adjustment correctly, it is necessary to multiply on the DRG recalibration and wage index budget neutrality factor of 1.002608 (1.002588 from October 1, 2003 through March 31, 2004; 1.002628 from April 1, 2004 through September 30, 2004) and divide off the factor of 1.002628 from the second half of FY 2004. This is to account for the fact that it was necessary to employ different budget neutrality adjustments for the first and second halves of FY 2004 due to the extension of the extension of the standardized amount equalization, effective April 1, 2004.

Under section 1886(d)(9)(A)(ii) of the Act, the Federal portion of the Puerto Rico payment rate is based on the discharge-weighted average of the national large urban standardized amount (as set forth in Table 1A). The labor and nonlabor portions of the national average standardized amounts for Puerto Rico hospitals are set forth in Table 1C of section VI. of this Addendum. This table also includes the Puerto Rico standardized amounts. The labor share applied to the Puerto Rico standardized amount is 71.3 percent, or 62 percent, depending on which is more advantageous to the hospital. (Section 403(b) of Pub. L. 108-173 provides that the labor-related share for hospitals in Puerto Rico will be 62 percent, unless the application of that percentage would result in lower payments to the hospital.

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

Tables 1A through 1D, as set forth in section VI. of this Addendum, contain the labor-related and nonlabor-related shares that we are using 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 2005 wage index. The FY 2005 wage index is set forth in Tables 4A, 4B, 4C, and 4F of section VI. of this Addendum.

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

Section 1886(d)(5)(H) of the Act authorizes an adjustment to take into account the unique circumstances of hospitals in Alaska and Hawaii. Higher labor-related costs for these two States are taken into account in the adjustment for area wages described above. For FY 2005, we are adjusting the payments for hospitals in Alaska and Hawaii by multiplying the nonlabor portion of the standardized amount by the appropriate adjustment factor contained in the table below.

Table of Cost-of-Living Adjustment Factors,

Alaska and Hawaii Hospitals

Area	Cost of Living Adjustment Factor
Alaska-All areas	1.25
Hawaii:	
County of Honolulu	1.25
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 2005. 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 2005

General Formula for Calculation of Prospective Payment Rates for FY 2005

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

The prospective payment rate for SCHs equals the higher of the applicable Federal rate (from Table 1A or Table 1B) or the hospital-specific rate as described below. The 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 25 percent of the Puerto Rico rate plus 75 percent of the applicable national rate from Table 1C or Table 1D in section VI. of this Addendum.

1. Federal Rate

For discharges occurring on or after October 1, 2004 and before October 1, 2005, except for SCHs, MDHs, and hospitals in Puerto Rico, payment under the IPPS is based exclusively on the Federal rate.

The Federal rate is determined as follows:

Step 1--Select the appropriate average standardized amount considering the applicable wage index (Table 1A for wage indexes greater than 1.0000 and Table 1B for wage indexes less than or equal to 1.0000) and whether the hospital has submitted qualifying quality data (full update for qualifying hospitals, update minus 0.4 percent for nonqualifying hospitals).

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

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

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

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

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

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

a. Calculation of Hospital-Specific Rate

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

rate based on FY 1987 costs per discharge; or the updated hospital-specific rate based on FY 1996 costs per discharge.

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

Hospital-specific rates have been determined for each of these hospitals based on either the FY 1982 costs per discharge, the FY 1987 costs per discharge or, for SCHs, the FY 1996 costs per discharge. For a more detailed discussion of the calculation of the hospital-specific rates, we refer the reader to the September 1, 1983 interim final rule (48 FR 39772); the April 20, 1990 final rule with comment (55 FR 15150); the September 4, 1990 final rule (55 FR 35994); and the August 1, 2000 final rule (65 FR 47082). In addition, for both SCHs and MDHs, the hospital-specific rate is adjusted by the budget neutrality adjustment factor (that is, by 0.999876) 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, 2004.

b. Updating the FY 1982, FY 1987, and FY 1996 Hospital-Specific Rates for FY 2005

We are increasing the hospital-specific rates by 3.3 percent (the hospital market basket percentage increase) for SCHs and MDHs for FY 2005. Section 1886(b)(3)(C)(iv) of the Act provides that the update factor applicable to the hospital-specific rates for

SCHs is equal to the update factor provided under section 1886(b)(3)(B)(iv) of the Act, which, for SCHs in FY 2005, is the market basket rate of increase. Section 1886(b)(3)(D) of the Act provides that the update factor applicable to the hospital-specific rates for MDHs also equals the update factor provided under section 1886(b)(3)(B)(iv) of the Act, which, for FY 2005, is the market basket rate of increase.

3. General Formula for Calculation of Prospective Payment Rates for Hospitals Located in Puerto Rico Beginning On or After October 1, 2004 and Before October 1, 2005

Section 504 of Pub. L. 108-173 changes the current blend of 50 percent the Puerto Rico national prospective payment rate and 50 percent of the Puerto Rico-specific prospective payment rate to 62.5 percent Puerto Rico national and 37.5 percent Puerto Rico-specific effective for discharges occurring on or after April 1, 2004 and before October 1, 2004. Effective for discharges occurring on or after October 1, 2004, the effective blend is 75 percent of the Puerto Rico national prospective payment rate and 25 percent of the Puerto Rico-specific rate.

a. Puerto Rico Rate

The Puerto Rico prospective payment rate is determined as follows:

Step 1- Select the appropriate average standardized amount considering the applicable wage index (Table 1C for wage indexes greater than 1.0000 and Table 1D for wage indexes less than or equal to 1.0000).

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

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

Step 4-Multiply the result in Step 3 by 25 percent.

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

b. National Rate

The national prospective payment rate is determined as follows:

Step 1 - Select the appropriate average standardized amount considering the applicable wage index (Table 1C for wage indexes greater than 1.0000 and Table 1D for wage indexes less than or equal to 1.0000).

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

Step 3 - Multiply the result in Step 2 by 75 percent.

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

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

III. Changes to Payment Rates for Acute Care Hospital Inpatient Capital-Related Costs for FY 2005

The PPS for acute care hospital inpatient capital-related costs was implemented for cost reporting periods beginning on or after October 1, 1991. Effective with that cost reporting period, hospitals were paid during a 10-year transition period (which extended through FY 2001) to change the payment methodology for Medicare acute care hospital inpatient capital-related costs from a reasonable cost-based methodology to a prospective methodology (based fully on the Federal rate).

The basic methodology for determining Federal capital prospective rates is set forth in regulations at "412.308 through 412.352. Below we discuss the factors that we are using to determine the capital Federal rate for FY 2005, which will be effective for discharges occurring on or after October 1, 2004. The 10-year transition period ended with hospital cost reporting periods beginning on or after October 1, 2001 (FY 2002). Therefore, for cost reporting periods beginning in FY 2002, all hospitals (except Anew@ hospitals under "412.304(c)(2) and 412.324(b)) are paid based on 100 percent of the capital Federal rate. For FY 1992, we computed the standard Federal payment rate for capital-related costs under the IPPS by updating the FY 1989 Medicare inpatient capital cost per case by an actuarial estimate of the increase in Medicare inpatient capital costs per case. Each year after FY 1992, we update the capital standard Federal rate, as provided at '412.308(c)(1), to account for capital input price increases and other factors. The regulations at '412.308(c)(2) provide 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) exceptions under '412.348. Section 412.308(c)(4)(ii) requires that the capital standard Federal rate be adjusted so that the effects of the annual DRG reclassification and the recalibration of DRG weights and changes in the geographic adjustment factor are budget neutral.

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

To determine the appropriate budget neutrality adjustment factor and the regular exceptions payment adjustment during the 10-year transition period, we developed a dynamic model of Medicare inpatient capital-related costs; that is, a model that projected changes in Medicare inpatient capital-related costs over time. With the expiration of the budget neutrality provision, the capital cost model was only used to estimate the regular

exceptions payment adjustment and other factors during the transition period. As we explained in the August 1, 2001 IPPS final rule (66 FR 39911), beginning in FY 2003, an adjustment for regular exception payments is no longer necessary because regular exception payments were only made for cost reporting periods beginning on or after October 1, 1991, and before October 1, 2001 (see '412.348(b)). Because, effective with cost reporting periods beginning in FY 2002, payments are no longer being made under the regular exception policy, we no longer use the capital cost model. The capital cost model and its application during the transition period are described in Appendix B of the August 1, 2001 IPPS final rule (66 FR 40099).

In accordance with section 1886(d)(9)(A) of the Act, under the IPPS for acute care hospital operating costs, hospitals located in Puerto Rico are paid for operating costs under a special payment formula. Prior to FY 1998, hospitals in Puerto Rico were paid a blended capital rate that consisted of 75 percent of the applicable standardized amount specific to Puerto Rico hospitals and 25 percent of the applicable national average standardized amount. However, effective October 1, 1997, in accordance with section 4406 of 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 also revised the methodology for computing capital payments to hospitals in Puerto Rico and computing capital payments based on a blend of 50 percent of the Puerto Rico capital rate and 50 percent of the capital Federal rate.

As we discuss in section VI. of this Addendum to the final rule, section 504 of Pub. L. 108-173 increased the national portion of the operating IPPS payments for Puerto Rico hospitals from 50 percent to 62.5 percent and decreased the Puerto Rico portion of the operating IPPS payments from 50 percent to 37.5 percent for discharges occurring on or after April 1,2004 through September 30, 2004 (see the March 26, 2004 One-Time Notification (Change Request 3158)). In addition, section 504 of Pub. L. 108-173 provides that the national portion of operating IPPS payments for Puerto Rico hospitals is equal to 75 percent and the Puerto Rico portion of operating IPPS payments is equal to 25 percent for discharges occurring on or after October 1, 2004. Consistent with this change in operating IPPS payments to hospitals in Puerto Rico, for FY 2005, as we discuss in section V.B. of this Addendum to this final rule, we are revising the methodology for computing capital IPPS payments to hospitals located in Puerto Rico. We are computing capital payments to hospitals located in Puerto Rico based on a blend of 25 percent of the Puerto Rico capital rate and 75 percent of the capital Federal rate for discharges occurring on or after October 1, 2004.

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

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

In the final IPPS rule published in the **Federal Register** on August 1, 2003 (68 FR 45346), we established a capital Federal rate of $415.47 for FY 2004. However, a correction notice to the FY 2004 IPPS final rule issued in the **Federal Register** on October 6, 2003 (68 FR 57731) contains corrections and revisions to the wage index and geographic adjustment factor (GAF). In conjunction with the change to the wage index and GAF corrections, we established a revised capital IPPS standard Federal rate of $414.18 effective for discharges occurring in FY 2004. Furthermore, the One-Time Notification (Change Request 3158), issued on March 26, 2004, implemented various changes in operating IPPS payments required by sections 401, 402 and 504 of Pub. L. 108-173. As a result of these changes to payments under the operating IPPS, the fixed loss amount for determining the cost outlier threshold was revised effective for discharges occurring on or after April 1, 2004, through September 30, 2004. Because the regulations at '412.312(c) establish a unified outlier methodology for inpatient operating and capital-related costs, a single set of thresholds are used to identify outlier cases under both the operating IPPS and the capital IPPS. As a result of the revision to the fixed loss amount used for determining the cost outlier threshold effective for discharges occurring on or after April 1, 2004, through September 30, 2004, we established a new capital IPPS standard Federal rate of $413.48 effective for discharges occurring on or after April 1, 2004, through September 30, 2004.

Because there are two capital IPPS standard Federal rates in effect during FY 2004 ($414.18 from October 2003 through March 2004 and $413.48 from April 2004 through September 2004), we are using an average of the rates effective for the first half

of FY 2004 (October 1, 2003 through March 31, 2004) ($414.18) and the second half FY 2004 (April 1, 2004 through September 30, 2004) ($413.48) to determine the FY 2005 capital Federal rate. (The average is $413.83 (($414.18 + $413.48)/2.) As a result of the changes to the factors used to determine the capital Federal rate that are explained in this Addendum, the FY 2005 capital standard Federal rate is $416.63.

In the discussion that follows, we explain the factors that were used to determine the FY 2005 capital Federal rate. In particular, we explain why the FY 2005 capital Federal rate has increased 0.68 percent compared to the FY 2004 capital Federal rate. We also estimate aggregate capital payments will increase by 6.0 percent during this same period. This increase is due to several factors, including an increase in the number of hospital admissions, an increase in case-mix, an increase in the GAF values, and an estimated increase in outlier payments. This increase in capital payments is more than last year (1.4 percent), mostly due to the increase in wage index values (and GAF values) provided for by sections 505 and 508 of Pub. L. 108-173, and the projected increase in outlier payments as a result of the decrease in the fixed-loss amount for FY 2005. (We note that in the proposed rule, our projection that aggregate capital IPPS payments would remain unchanged largely because of a projected decrease in Medicare Part A (fee-for-service) admissions was incorrect. In fact, our estimate of aggregate capital IPPS payments should have included a projected increase (rather than decrease) in Medicare Part A enrollment and therefore, we should have estimated that aggregate capital IPPS payments would increase from FY 2004 to FY 2005 in the proposed rule.)

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 IPPS are estimated to increase in FY 2005 compared to FY 2004.

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. The update factor for FY 2005 under that framework is 0.7 percent based on the best data available at this time. The update factor is based on a projected 0.7 percent increase in the CIPI, a 0.0 percent adjustment for intensity, a 0.0 percent adjustment for case-mix, a 0.0 percent adjustment for the FY 2003 DRG reclassification and recalibration, and a forecast error correction of 0.0 percent. We explain the basis for the FY 2005 CIPI projection in section III.C. of this Addendum. Below we describe the 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 (Acoding 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 IPPS for operating costs, we adjust the update upwards to allow for real case-mix change, but remove the effects of coding changes on the case-mix index. We also remove the effect on total payments of prior year changes to the DRG classifications and relative weights, in order to retain budget neutrality for all case-mix index-related changes other than patient severity. (For example, we adjusted for the effects of the FY 2003 DRG reclassification and recalibration as part of our update for FY 2005.) We have adopted this case-mix index adjustment in the capital update framework as well.

For FY 2005, we are projecting a 1.0 percent total increase in the case-mix index. We estimate that the real case-mix increase will equal 1.0 percent in FY 2005. The net adjustment for change in case mix is the difference between the projected total increase in

case mix and the projected increase in real case-mix change. Therefore, the net adjustment for case-mix change in FY 2005 is 0.0 percentage points.

We estimate that FY 2003 DRG reclassification and recalibration 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 2005 to maintain budget neutrality.

The capital update framework contains an adjustment for forecast error. The input price index forecast is based on historical trends and relationships ascertainable at the time the update factor is established for the upcoming year. In any given year, there may be unanticipated price fluctuations that may result in differences between the actual increase in prices and the forecast used in calculating the update factors. In setting a prospective payment rate under the framework, we make an adjustment for forecast error only if our estimate of the change in the capital input price index for any year is off by 0.25 percentage points or more. There is a 2-year lag between the forecast and the measurement of the forecast error. A forecast error of 0.0 percentage points was calculated for the FY 2003 update. That is, current historical data indicate that the forecasted FY 2003 CIPI used in calculating the FY 2003 update factor (0.7 percent) slightly overstated the actual realized price increases (0.6 percent) by 0.1 percentage points. This slight overprediction was mostly due to an underestimation of the interest rate cuts by the Federal Reserve Board in 2003, which impacted the interest component of the CIPI. However, since this estimation of the change in the CIPI is less than 0.25

percentage points, it is not reflected in the update recommended under this framework. Therefore, we are making a 0.0 percent adjustment for forecast error in the update for FY 2005.

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

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

increase of one-half of the estimated annual increase in intensity, to allow for within-DRG severity increases and the adoption of quality-enhancing technology.

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

We calculate case-mix constant intensity as the change in total charges per admission, adjusted for price level changes (the CPI for hospital and related services), and changes in real case-mix. As we noted above, in accordance with '412.308(c)(1)(ii), we began updating the capital standard Federal rate in FY 1996 using an update framework that takes into account, among other things, allowable changes in the intensity of hospital services. For FYs 1996 through 2001, we found that case-mix constant intensity was declining and we established a 0.0 percent adjustment for intensity in each of those years. For FYs 2001 and 2002, we found that case-mix constant intensity was increasing and we established a 0.3 percent adjustment and 1.0 percent adjustment for intensity, respectively.

Using the methodology described above, for FY 2005 we examined the change in total charges per admission, adjusted for price level changes (the CPI for hospital and

related services), and changes in real case-mix for FYs 1999 through 2003. As we discussed in the May 18,2004 IPPS proposed rule (69 FR 28382), we found that, over this period and in particular the last 4 years of this period (FYs 2000 through 2003), the charge data appear to be skewed. More specifically, we found a dramatic increase in hospital charges for FYs 2000 through 2003 without a corresponding increase in the hospital case-mix index. These findings are similar to the considerable increase in hospitals= charges, which we found when we were determining the intensity factor in the FY 2004 update recommendation as discussed in the August 1, 2003 final rule (68 FR 45482). If hospitals were treating new or different types of cases, which would result in an appropriate increase in charges per discharge, then we would expect hospitals= case mix to increase proportionally.

As we discussed in the August 1, 2003 final rule (68 FR 45482), because our intensity calculation relies heavily upon charge data and we believe that this charge data may be inappropriately skewed, we established a 0.0 percent adjustment for intensity for FY 2004. In that same final rule, we stated that we believe that it is appropriate to propose a zero intensity adjustment until we believe that any increase in charges can be tied to intensity rather than to attempts to maximize outlier payments. As discussed previously in this section, we believe that the most recently available charge data used to make this determination may still be inappropriately skewed. Therefore, in the May 18, 2004 proposed rule (69 FR 28382), we proposed a 0.0 percent adjustment for intensity for FY 2005. As we explained in that same proposed rule, in the 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 2005 until any increase in charges can be tied to intensity rather than 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 framework for FY 2005.

Comment: One commenter recommended that we update the standard Federal rate for capital-related costs by the same percentage as the standardized amount for operating costs (that is, 3.3 percent).

Response: As noted above, the capital standard Federal rate is updated annually based on an analytical framework that takes into account changes in the input price index for capital costs (that is, CIPI or the capital market basket) and other policy adjustment factors. While the other policy adjustment factors in the capital PPS update framework (that is, case-mix change, intensity, and DRG reclassification and recalibration) are the same as the policy adjustment factors in our update recommendation for the standardized rate for operating costs discussed in Appendix B of this final rule, each update framework utilizes an input price index that measures the price changes associated with the respective category of costs (that is, capital costs or operating costs) during a given year. The 3.3 percent update to the standardized amount for operating costs for FY 2005 is based on our most recent estimate of the input price index for operating costs and thus it is not an appropriate index to use for updating the standard Federal rate for capital-related costs.

As discussed in section III.C. of this preamble, we believe that the CIPI is the most appropriate input price index for capital costs to measure capital price changes in a given year. As we discussed above, the final update to the standard capital Federal rate for FY 2005 is 0.7 percent. This update is based on a projected 0.7 percent increase in the CIPI. As we discussed above, we are not projecting any increase for intensity, case-mix, DRG reclassification and recalibration, or forecast error for FY 2005.

Above we described the basis of the components used to develop the 0.7 percent capital update factor for FY 2005 as shown in the table below.

CMS=s FY 2005 Update Factor to the Capital Federal Rate

Capital Input Price Index	0.7
Intensity:	0.0
Case-Mix Adjustment Factors:	
Projected Case-Mix Change	1.0
Real Across DRG Change	B1.0
Subtotal	0.0
Effect of FY 2003 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. In its March 2004 Report to Congress, MedPAC did not make an update recommendation for capital PPS payments for FY 2005. However, in that same report, MedPAC made an update recommendation for hospital inpatient and outpatient services (page 87). MedPAC reviews inpatient and outpatient services together since they are so closely interrelated. MedPAC=s recommendation of the full market basket

update for both the inpatient and outpatient PPSs is based on their assessment of beneficiaries= access to care, volume growth, access to capital, quality, and the relationship of Medicare payments to costs in the hospital sector.

2. Outlier Payment Adjustment Factor

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

In the August 1, 2003 IPPS final rule (68 FR 45482), we estimated that outlier payments for capital in FY 2004 would equal 4.79 percent of inpatient capital-related payments based on the FY 2004 capital Federal rate. Accordingly, we applied an outlier adjustment factor of 0.9521 to the FY 2004 capital Federal rate. However, as we noted above, we published a correction notice in the **Federal Register** on October 6, 2003 (68 FR 57731), which established revised rates and factors for FY 2004. In that same correction notice (68 FR 57734), we estimated that outlier payments for capital in FY 2004 would equal 4.77 percent of inpatient capital-related payments based on the FY 2004 capital Federal rate. Accordingly, we established a revised outlier adjustment of 0.9523 for use in determining the FY 2004 capital Federal rate. In addition, as we noted

above, a One-Time Notification (Change Request 3158) issued on March 26, 2004, implemented various changes in operating IPPS payments required by sections 401, 402, and 504 of Pub. L. 108-173, effective for discharges on or after April 1, 2004, through September 30, 2004. As a result of changes made to payments under the operating IPPS, the rates and some of the factors, including the outlier adjustment, under the capital IPPS were also revised effective for discharges on or after April 1, 2004, through September 30, 2004. The revised outlier adjustment effective for the second half of FY 2004 (April 2004 through September 2004) is 0.9508.

Based on the thresholds as set forth in section II.A.4.c. of this Addendum, we estimate that outlier payments for capital will equal 4.94 percent of inpatient capital-related payments based on the capital Federal rate in FY 2005. Therefore, we are applying an outlier adjustment factor of 0.9506 to the capital Federal rate. Thus, the percentage of capital outlier payments to total capital standard payments for FY 2005 is higher than the percentages estimated for the first half (4.77 percent for October 2003 through March 2004) and the second half (4.92 percent for April 2004 through September 2004) of FY 2004.

The outlier reduction factors are not built permanently into the capital rates; that is, they are not applied cumulatively in determining the capital Federal rate. As we discussed above, there were two outlier adjustment factors applied during FY 2004 (0.9523 from October 2003 through March 2004 and 0.9508 from April 2004 through September 2004). The FY 2005 outlier adjustment of 0.9506 is a -0.09 percent change from the average FY 2004 outlier adjustment of 0.9515 (the mean of the factors for the

first half of FY 2004 (0.9523) and the second half of FY 2004 (0.9508) calculated from unrounded numbers). The net change in the outlier adjustment to the capital Federal rate for FY 2005 is 0.9991 (0.9506/0.9515). Thus, the outlier adjustment decreases the FY 2005 capital Federal rate by 0.09 percent compared with the average FY 2004 outlier adjustment.

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

Section 412.308(c)(4)(ii) requires that the capital Federal rate be adjusted so that aggregate payments for the fiscal year based on the capital Federal rate after any changes resulting from the annual DRG reclassification and recalibration and changes in the geographic adjustment factor (GAF) are projected to equal aggregate payments that would have been made on the basis of the capital Federal rate without such changes. Since we implemented a separate geographic adjustment factor for Puerto Rico, we apply separate budget neutrality adjustments for the national geographic adjustment factor and the Puerto Rico geographic adjustment factor. We apply the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. Separate adjustments were unnecessary for FY 1998 and earlier fiscal years since the geographic adjustment factor for Puerto Rico was implemented in FY 1998.

In the past, we used the actuarial capital cost model (described in Appendix B of the August 1, 2001 IPPS final rule (66 FR 40099)) to estimate the aggregate payments that would have been made on the basis of the capital Federal rate with and without changes in the DRG classifications and weights and in the GAF to compute the

adjustment required to maintain budget neutrality for changes in DRG weights and in the GAF. During the transition period, the capital cost model was also used to estimate the regular exception payment adjustment factor. As we explain in section III.A.4. of this Addendum, beginning in FY 2002, an adjustment for regular exception payments is no longer necessary. Therefore, we are no longer using the capital cost model. Instead, we are using historical data based on hospitals= actual cost experiences to determine the exceptions payment adjustment factor for special exceptions payments.

To determine the final factors for FY 2005, we compared (separately for the national capital rate and the Puerto Rico capital rate) estimated aggregate capital Federal rate payments based on the FY 2004 DRG relative weights and the average FY 2004 GAF (that is, the mean of the GAFs applied from October 2003 through March 2004 and the GAFs applied from April 2004 through September 2004) to estimated aggregate capital Federal rate payments based on the FY 2005 relative weights and the FY 2005 GAF. For the first half of FY 2004 (October 1, 2003 through March 31, 2004), the budget neutrality adjustment factors were 0.9908 for the national capital rate and 0.9974 for the Puerto Rico capital rate (see the October 6, 2003 correction notice). For the second half of FY 2004 (April 1, 2004 through September 30, 2004), the budget neutrality adjustment factor was revised to 0.9907 for the national capital rate (see the March 26, 2004 One-Time Notification). The budget neutrality factor for the Puerto Rico capital rate remained unchanged (0.9974). In making the comparison, we set the regular and special exceptions reduction factors to 1.00.

To achieve budget neutrality for the changes in the national GAF, based on calculations using updated data, we are applying an incremental budget neutrality adjustment of 0.9997 for FY 2005 to the average of the previous cumulative FY 2004 adjustments of 0.9908 ((0.9908 + 0.9907)/2), yielding a cumulative adjustment of 0.9905 through FY 2005 (calculations were done with unrounded numbers). For the Puerto Rico GAF, we are applying an incremental budget neutrality adjustment of 0.9912 for FY 2005 to the average of the previous cumulative FY 2004 adjustment of 0.9974, yielding a cumulative adjustment of 0.9886 through FY 2005.

We then compared estimated aggregate capital Federal rate payments based on the FY 2004 DRG relative weights and the average FY 2004 GAF to estimated aggregate capital Federal rate payments based on the FY 2005 DRG relative weights and the FY 2005 GAF. The incremental adjustment for DRG classifications and changes in relative weights is 1.0009 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 2005 are 0.9914 nationally and 0.9895 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 Reclassi-fications and Recalibration	Combined		Geographic Adjustment Factor	DRG Reclassi-fications 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	---	---	---	C
1997	---	---	0.99873	1.00123	---	---	---	---
1998	---	---	0.99892	1.00015	---	---	---	1.00000
1999	0.99944	1.00335	1.00279	1.00294	0.99898	1.00335	1.00233	1.00233
2000	0.99857	0.99991	0.99848	1.00142	0.99910	0.99991	0.99901	1.00134
2001[1]	0.99782	1.00009	0.99791	0.99933	1.00365	1.00009	1.00374	1.00508
2001[2]	0.99771[3]	1.00009[3]	0.99780[3]	0.99922	1.00365[3]	1.00009[3]	1.00374[3]	1.00508
2002	0.99666[4]	0.99668[4]	0.99335[4]	0.99268	0.98991[4]	0.99668[4]	0.99662[4]	0.99164
2003[5]	0.99915	0.99662	0.99577	0.98848	1.00809	0.99662	1.00468	0.99628
2003[6]	0.99896[7]	0.99662[7]	0.99558[7]	0.98830	1.00809[7]	0.99662[7]	1.00468[7]	0.99628
2004[8]	1.00175[9]	1.00081[9]	1.00256[9]	0.99083	1.00028[9]	1.00081[9]	1.00109[9]	0.99736
2004[10]	1.00164[9]	1.00081[9]	1.00245[9]	0.99072	1.00028[9]	1.00081[9]	1.00109[9]	0.99736
2005	0.99967[11]	1.00094	1.0061[11]	0.99137	0.99115	1.00094	0.99208[11]	0.98946

[1]Factors effective for the first half of FY 2001 (October 2000 through March 2001).
[2]Factors effective for the second half of FY 2001 (April 2001 through September 2001).
[3]Incremental factors are applied to FY 2000 cumulative factors.
[4]Incremental factors are applied to the cumulative factors for the first half of FY 2001.
[5]Factors effective for the first half of FY 2003 (October 2002 through March 2003).
[6]Factors effective for the second half of FY 2003 (April 2003 through September 2003).
[7]Incremental factors are applied to FY 2002 cumulative factors.
[8]Factors effective for the first half of FY 2004 (October 2003 through March 2004).
[9]Incremental factors are applied to the cumulative factors for the second half of FY 2003.
[10]Factors effective for the second half of FY 2003 (April 2004 through September 2004).
[11]Incremental factors are applied to average of the cumulative factors for the first half (October 1, 2003 through March 31, 2004) and second half (April 1, 2004 through September 30, 2004) of FY 2004.

The methodology used to determine the final recalibration and geographic (DRG/GAF) budget neutrality adjustment factor for FY 2005 is similar to that used in establishing budget neutrality adjustments under the IPPS for operating costs. One difference is that, under the operating IPPS, 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 IPPS, there is a single DRG/GAF budget neutrality adjustment factor (the national capital rate and the Puerto Rico capital rate are determined separately) for changes in the GAF (including geographic reclassification) and the DRG relative weights. In addition, there is no adjustment for the effects that geographic reclassification has on the other payment parameters, such as the payments for serving low-income patients, indirect medical education payments, or the large urban add-on payments.

In the August 1, 2003 IPPS final rule (68 FR 45346), we calculated a GAF/DRG budget neutrality factor of 1.0059 for FY 2004. As we noted above, as a result of the revisions to the GAF effective for FY 2004 in the October 6, 2003 correction notice, we calculated a GAF/DRG budget neutrality factor of 1.0026 for discharges occurring in FY 2004. As we also noted above, as a result of implementing sections 401, 402, and 504 of Pub. L. 108-173, we calculated a GAF/DRG budget neutrality factor of 1.0026 for discharges occurring on or after April 1, 2004 through September 30, 2004. Furthermore, as noted above, the average of capital rates and factors in effect for the first half (October 2003 through March 2004) and second half (April 2004 through September 2004) of FY 2004 was used in determining the final FY 2005 capital rates.

For FY 2005, we are applying a GAF/DRG budget neutrality factor of 1.0006. 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 final incremental change in the adjustment from FY 2004 to FY 2005 is 1.0006. The cumulative change in the capital Federal rate due to this adjustment is 0.9914 (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 002, FY 2003, average FY 2004 and the final incremental factor for FY 2005: 0.9980 x 1.0053 x 0.9998 x 0.9994 x 0.9987 x 0.9989 x 1.0028 x 0.9985 x 0.9979 x 0.9934 x 0.9956 x 1.0025 x 1.0006 = 0.9914).

This final factor accounts for DRG reclassifications and recalibration and for changes in the GAF. It also incorporates the effects on the GAF of FY 2005 geographic reclassification decisions made by the MGCRB compared to FY 2004 decisions. However, it does not account for changes in payments due to changes in the DSH and IME adjustment factors or in the large urban add-on.

4. Exceptions Payment Adjustment Factor

Section 412.308(c)(3) requires that the capital standard Federal rate be reduced by an adjustment factor equal to the estimated proportion of additional payments for both regular exceptions and special exceptions under '412.348 relative to total capital PPS payments. In estimating the proportion of regular exception payments to total capital

PPS payments during the transition period, we used the actuarial capital cost model originally developed for determining budget neutrality (described in Appendix B of the August 1, 2001 IPPS final rule (66 FR 40099)) to determine the exceptions payment adjustment factor, which was applied to both the Federal and hospital-specific capital rates.

An adjustment for regular exception payments is no longer necessary in determining the FY 2005 capital Federal rate because, in accordance with '412.348(b), regular exception payments were only made for cost reporting periods beginning on or after October 1, 1991 and before October 1, 2001. Accordingly, as we explained in the August 1, 2001 IPPS final rule (66 FR 39949), in FY 2002 and subsequent fiscal years, no payments will be made under the regular exceptions provision. However, in accordance with '412.308(c), we still need to compute a budget neutrality adjustment for special exception payments under '412.348(g). We describe our methodology for determining the special exceptions adjustment used in calculating the FY 2005 capital Federal rate below.

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

at §412.348(g)(4); (2) an age of assets test as described at §412.348(g)(3); and (3) a project size requirement as described at §412.348(g)(5).

Based on information compiled from our fiscal intermediaries, six hospitals have qualified for special exceptions payments under §412.348(g). Since we have cost reports ending in FY 2003 for all of these hospitals, we calculated the adjustment based on actual cost experience. Using data from cost reports ending in FY 2003 from the March 2004 update of the HCRIS data, we divided the capital special exceptions payment amounts for the six hospitals that qualified for special exceptions by the total capital PPS payment amounts (including special exception payments) for all hospitals. Based on the data from cost reports ending in FY 2003, this ratio is rounded to 0.0004. Because we have not received all cost reports ending in FY 2003, we also divided the FY 2003 special exceptions payments by the total capital PPS payment amounts for all hospitals with cost reports ending in FY 2002. This ratio also rounds to 0.0004. Because special exceptions are budget neutral, we are offsetting the capital Federal rate by 0.04 percent for special exceptions payments for FY 2005. Therefore, the exceptions adjustment factor is equal to 0.9996 (1 - 0.0004) to account for special exceptions payments in FY 2005.

In the August 1, 2003 IPPS final rule (68 FR 45384) for FY 2004, we estimated that total (special) exceptions payments would equal 0.05 percent of aggregate payments based on the capital Federal rate. Therefore, we applied an exceptions adjustment factor of 0.9995 (1 B 0.0005) in determining the FY 2004 capital Federal rate. (We note that the special exceptions adjustment factor for FY 2004 was not revised in either the October 6, 2003 correction notice or the March 26, 2004 One-Time Notification.) As we

stated above, we estimate that exceptions payments in FY 2005 will equal 0.04 percent of aggregate payments based on the FY 2005 capital Federal rate. Therefore, we are applying an exceptions payment adjustment factor of 0.9996 to the capital Federal rate for FY 2005. The exceptions adjustment factor for FY 2005 is 0.01 percent higher than the factor for FY 2004 published in the August 1, 2003 IPPS final rule (68 FR 45346). The exceptions reduction factors are not built permanently into the capital rates; that is, the factors are not applied cumulatively in determining the capital Federal rate. Therefore, the net change in the exceptions adjustment factor used in determining the FY 2005 capital Federal rate is 1.0001 (0.9996/0.9995).

5. Capital Standard Federal Rate for FY 2005

In the August 1, 2003 IPPS final rule (68 FR 45346) we established a capital Federal rate of $415.47 for FY 2004. As we noted above, as a result of the revisions to the GAF for FY 2004, in the October 6, 2003 correction notice, we established a capital Federal rate of $414.18 for discharges occurring in FY 2004. As we also discussed above, a One-Time Notification issued on March 26, 2004, which implemented various changes in operating IPPS payments required by sections 401, 402, and 504 of Pub. L. 108-173, resulted in a revised capital Federal rate of $413.48 effective for discharges occurring on or after April 1, 2004 through September 30, 2004. Because there are two capital IPPS standard Federal rates in effect during FY 2004 ($414.18 from October 2003 through March 2004 and $413.48 from April 2004 through September 2004), we are using an average of the rates effective for the first half ($414.18) and the second half ($413.48) of FY 2004 of $413.83 (($414.18 + $413.48)/2) in determining the

FY 2005 capital Federal rate. In this final rule, we are establishing a capital Federal rate of $416.63 for FY 2005. The capital Federal rate for FY 2005 was calculated as follows:

! The FY 2005 update factor is 1.0070; that is, the update is 0.7 percent.

! The FY 2005 budget neutrality adjustment factor that is applied to the capital standard Federal payment rate for changes in the DRG relative weights and in the GAF is 1.0006.

! The FY 2005 outlier adjustment factor is 0.9506.

! The FY 2005 (special) exceptions payment adjustment factor is 0.9996.

Because 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 2005 affected the computation of the FY 2005 capital Federal rate in comparison to the average FY 2004 capital Federal rate. The FY 2005 update factor has the effect of increasing the capital Federal rate by 0.70 percent compared to the average FY 2004 Federal rate. The GAF/DRG budget neutrality factor has the effect of increasing the capital Federal rate by 0.06 percent. The FY 2005 outlier adjustment factor has the effect of decreasing the capital Federal rate by 0.09 percent compared to the average FY 2004 capital Federal rate and the FY 2005 exceptions payment adjustment factor has the effect of increasing the capital Federal rate by 0.01 percent compared to the exceptions payment adjustment factor for the FY 2004 capital Federal rate. The combined effect of all the

changes is to increase the capital Federal rate by 0.68 percent compared to the average FY 2004 capital Federal rate.

Comparison of Factors and Adjustments:
FY 2004 Capital Federal Rate[1] and
FY 2005 Capital Federal Rate

	FY 2004[1]	FY 2005	Change	Percent Change
Update factor[2]	1.0070	1.0070	1.0070	0.70
GAF/DRG Adjustment Factor[2]	1.0025	1.0006	1.0006	0.06
Outlier Adjustment Factor[3]	0.9515	0.9506	0.9991	- 0.09
Exceptions Adjustment Factor[3]	0.9995	0.9996	1.0001	0.01
Capital Federal Rate	$413.83	$416.63	1.0068	0.68

[1] Because there are two capital IPPS standard Federal rates in effect during FY 2004 ($414.18 from October 2003 through March 2004 and $413.48 from April 2004 through September 2004), an average of the rates and factors effective for the first half (October 2003 through March 2004) and the second half (April 2004 through September 2004)) of FY 2004 were used.

[2] The update factor and the GAF/DRG budget neutrality factors are built permanently into the capital rates. Thus, for example, the incremental change from FY 2004 to FY 2005 resulting from the application of the 1.006 GAF/DRG budget neutrality factor for FY 2005 is 1.0006.

3 The outlier reduction factor and the exceptions adjustment factor are not built permanently into the capital rates; that is, these factors are not applied cumulatively in determining the capital rates. Thus, for example, the net change resulting from the application of the FY 2005 outlier adjustment factor is0.9506/0.9515, or 0.9991.

We are also providing a chart that shows how the final FY 2005 capital Federal rate differs from the proposed FY 2005 capital Federal rate.

Comparison of Factors and Adjustments: FY 2005 Proposed Capital Federal Rate and FY 2005 Final Capital Federal Rate

	Proposed FY 2005	Final FY 2005	Change	Percent Change
Update Factor	1.0070	1.0070	1.0000	0.00
GAF/DRG Adjustment Factor	1.0015	1.0006	0.9991	-0.09
Outlier Adjustment Factor	0.9497	0.9506	1.0009	0.09
Exceptions Adjustment Factor	0.9996	0.9996	1.0000	0.00

	Proposed FY 2005	Final FY 2005	Change	Percent Change
Capital Federal Rate	$416.59	$416.63	1.0001	1.01

6. Special Capital Rate for Puerto Rico Hospitals

As discussed above, beginning in FY 1998, hospitals in Puerto Rico are currently paid based on 50 percent of the Puerto Rico capital rate and 50 percent of the capital Federal rate. The Puerto Rico capital rate is derived from the costs of Puerto Rico hospitals only, while the capital Federal rate is derived from the costs of all acute care hospitals participating in the PPS (including Puerto Rico). Section 504 of Pub. L. 108-173 increased the national portion of the operating IPPS payment for Puerto Rico hospitals from 50 percent to 75 percent and decreases the Puerto Rico portion of the operating IPPS payments for hospitals located in Puerto Rico from 50 percent to 37.5 percent for discharges occurring on or after April 1, 2004, through September 30, 2004. In addition, section 504 of Pub. L. 108-173 provides that the national portion of operating IPPS payments for Puerto Rico hospitals is equal to 75 percent and the Puerto Rico portions of the operating IPPS payments is equal to 37.5 percent for discharges occurring on or after October 1, 2004. As discussed in section V.B. of the preamble of this final rule, under the broad authority of section 1886(g) of the Act, for FY 2005 we are increasing the national portion of the capital IPPS payment to hospitals located in Puerto Rico from 50 percent to 75 percent, as well. Therefore, for discharges occurring on or after October 1, 2004, capital payments to hospitals in Puerto Rico will be based on a

blend of 25 percent of the Puerto Rico capital rate and 75 percent of the capital Federal rate.

To adjust hospitals' capital payments for geographic variations in capital costs, we apply a GAF to both portions of the blended capital rate. The GAF is calculated using the operating IPPS wage index and varies, depending on the MSA or rural area in which the hospital is located. We use the Puerto Rico wage index to determine the GAF for the Puerto Rico part of the capital-blended rate and the national wage index to determine the GAF for the national part of the blended capital rate.

Because we implemented a separate GAF for Puerto Rico in FY 1998, we also apply separate budget neutrality adjustments for the national GAF and for the Puerto Rico GAF. However, we apply the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. As we stated above in section III.A.4. of this Addendum, for Puerto Rico the GAF budget neutrality factor is 0.9912, while the DRG adjustment is 1.0009, for a combined cumulative adjustment of 0.9895.

In computing the payment for a particular Puerto Rico hospital, the Puerto Rico portion of the capital rate (50 percent for FY 2004; 25 percent for FY 2005 and thereafter) is multiplied by the Puerto Rico-specific GAF for the MSA in which the hospital is located, and the national portion of the capital rate (50 percent, for FY 2004; 75 percent, for FY 2005 and thereafter) is multiplied by the national GAF for the MSA in which the hospital is located (which is computed from national data for all hospitals in the United States and Puerto Rico). In FY 1998, we implemented a 17.78 percent

reduction to the Puerto Rico capital rate as a result of Pub. L. 105-33. In FY 2003, a small part of that reduction was restored.

For FY 2004, before application of the GAF, the special capital rate for Puerto Rico hospitals was $203.17 for discharges occurring on or after October 1, 2003 through March 31, 2004 (see the October 6, 2003 correction notice) and $202.96 for discharges occurring on or after April 1, 2004 through September 30, 2004 (see the March 26, 2004 One-Time Notification). With the changes we are proposing to the factors used to determine the capital rate, the FY 2005 special capital rate for Puerto Rico is $199.02.

B. Calculation of Inpatient Capital-Related Prospective Payments for FY 2005

Because the 10-year capital PPS transition period ended in FY 2001, all hospitals (except A new hospitals under §412.324(b) and under §412.304(c)(2)) are paid based on 100 percent of the capital Federal rate in FY 2005. The applicable 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 2005, the capital standard Federal rate is adjusted as follows: (Standard Federal Rate) x (DRG weight) x (GAF) x (Large Urban Add-on, if applicable) x (COLA adjustment for

hospitals located in Alaska and Hawaii) x (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 2005 are in section II.A.4.c. of this Addendum. For FY 2005, a case qualifies as a cost outlier if the cost for the case plus the IME and DSH payments is greater than the prospective payment rate for the DRG plus $25,800.

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 SCHs, urban hospitals with at least 100 beds that have a DSH patient percentage of at least 20.2 percent or qualify for DSH payments under §412.106(c)(2), and hospitals that have a combined Medicare and Medicaid inpatient utilization of at least 70 percent. Under §412.348(g)(8), the amount of a special exceptions payment is determined by comparing the cumulative payments made to the hospital under the capital PPS to the cumulative minimum payment level. This amount is offset by: (1) any amount by which a hospital's cumulative capital payments exceed its cumulative minimum payment levels applicable under the regular exceptions process for cost reporting periods beginning during which the hospital has been subject to the capital PPS; and (2) any amount by which a hospital's current year operating and capital payments (excluding 75 percent of

operating DSH payments) exceed its operating and capital costs. Under §412.348(g)(6), the minimum payment level is 70 percent for all eligible hospitals.

During the transition period, new hospitals (as defined under §412.300) were exempt from the capital PPS for their first 2 years of operation and were paid 85 percent of their reasonable costs during that period. Effective with the third year of operation through the remainder of the transition period, under §412.324(b) we paid the hospital under the appropriate transition methodology. If the hold-harmless methodology were applicable, the hold-harmless payment for assets in use during the base period would extend for 8 years, even if the hold-harmless payments extend beyond the normal transition period. As discussed in section VI.A. of the preamble of this 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 FY 2005

Based on the latest forecast by Global Insight, Inc. (first quarter of 2004), we are forecasting the CIPI to increase 0.7 percent in FY 2005. This reflects a projected 1.3 percent increase in vintage-weighted depreciation prices (building and fixed equipment, and movable equipment) and a 2.8 percent increase in other capital expense prices in FY 2005, partially offset by a 2.6 percent decline in vintage-weighted interest expenses in FY 2005. The weighted average of these three factors produces the 0.7 percent increase for the CIPI as a whole in FY 2005.

IV. 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 paid 100 percent of the IRF PPS Federal rate. Effective for cost reporting periods beginning on or after October 1, 2002, LTCHs also are no longer paid on a reasonable cost basis, but are paid under a LTCH DRG-based PPS. As part of the payment process for LTCHs, we established a 5-year transition period from reasonable cost-based reimbursement to a fully Federal PPS. However, a LTCH may elect to be paid based on 100 percent of the Federal prospective payment rate. We have proposed, but not finalized, an IPF PPS under which psychiatric hospitals and units would no longer be paid on a reasonable cost basis but would be paid on a prospective per diem basis. (68 FR 66920, November 28, 2003)

In accordance with existing §§413.40(c)(4)(ii) and (d)(1)(i) and (ii), where applicable, excluded psychiatric hospitals and units continue to be paid on a reasonable cost basis 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 blended methodology will have the TEFRA portion subject to the ceiling as well.

Section 1886(b)(7) of the Act had established a payment limitation for new rehabilitation hospitals and units, psychiatric hospitals and units, and long-term care

hospitals that first received payment as a hospital or unit excluded from the IPPS on or after October 1, 1997. However, effective for cost reporting periods beginning on or after October 1, 2002, this payment limitation is no longer applicable to new rehabilitation hospitals or units because they are paid 100 percent of the Federal prospective rate under the IRF PPS. Also, for LTCHs that have their cost reporting period beginning on or after October 1, 2002, those new LTCHs are paid based on 100 percent of the fully Federal prospective rate. In contrast, those "new" LTCHs that meet the definition of "new" under §412.40(f)(2)(ii) and that have their first cost reporting periods beginning on or after October 1, 1997 and before October 1, 2002, may be paid under the LTCH PPS transition methodology. Since those hospitals, by definition, would have been considered new before October 1, 2002, they would have been subject to the updated payment limitation on new hospitals that was published in the FY 2003 IPPS final rule (67 FR 50103). A discussion of how the payment limitation was calculated can be found in the August 29, 1997 final rule with comment period (62 FR 46019); the May 12, 1998 final rule (63 FR 26344); the July 31, 1998 final rule (63 FR 41000); and the July 30, 1999 final rule (64 FR 41529).

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

- Under existing §413.40(f)(2)(ii), for the first 12-month cost reporting periods beginning on or after October 1, 1997, the amount of payment for a new hospital or unit that was not paid as an excluded hospital or unit before October 1, 1997, is the lower of: (1) the hospital's net inpatient operating costs per case; or (2) 110 percent of the national

median of the target amounts for the same class of excluded hospitals and units, adjusted for differences in wage levels and updated to the first cost reporting period in which the hospital receives payment. The second 12-month cost reporting period is subject to the same target amount applied to the first cost reporting period.

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

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

Class of Excluded Hospital or Unit	FY 2005 Labor-Related Share	FY 2005 Nonlabor-Related Share
Psychiatric	$7,535	$2,995

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

V. Payment for Blood Clotting Factor Administered to Hemophilia Inpatients

In the August 1, 2003 IPPS final rule (68 FR 45487) and in the May 18, 2004 proposed rule (69 FR 28389), we instructed the fiscal intermediaries to use the Single

Drug Pricer (SDP) to price blood clotting factors. The SDP payment allowance for blood clotting factors is based on 95 percent of the average wholesale price (AWP). We did not receive any comment on this issue.

Section 303(c) of Pub. L. 108-173 amended the Act by adding section 1847A, which changed the drug pricing system under Medicare. Beginning in 2005, section 1847A of the Act establishes a new payment methodology based on average sales price (ASP). The ASP methodology requires that the Medicare payment allowance limit for clotting factors be equal to 106 percent of the weighted average of the lower of the ASP or the wholesale acquisition cost of the products within each HCPCS code. This payment is subject to the Part B deductible and coinsurance requirements.

While these changes will be applied to claims paid by Medicare carriers, for clotting factors furnished to inpatients under this provision, we have decided for FY 2005 to continue using the pricing limits currently in effect. We will evaluate these limits and, if warranted, we will propose a change for public comment in next year's proposed rule.

VI. Tables

This section contains the tables referred to throughout the preamble to this final rule and in this Addendum. Tables 1A, 1B, 1C, 1D, 2, $3A_1$, $3A_2$, $3B_1$, $3B_2$, $4A_1$, $4A_2$, $4B_1$, $4B_2$, $4C_1$, $4C_2$, $4D_1$, $4D_2$, $4F_1$, $4F_2$, 4G, 4H, 4J, 5, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H, 7A, 7B, 8A, 8B, $9A_1$, $9A_2$, 9B, 10, and 11 are presented below. The tables presented below are as follows:

Table 1A--National Adjusted Operating Standardized Amounts, Labor/Nonlabor

(71.1 Percent Labor Share/28.9 Percent Nonlabor Share If Wage Index Is

Greater Than 1)

Table 1B--National Adjusted Operating Standardized Amounts, Labor/Nonlabor (62 Percent Labor Share/38 Percent Nonlabor Share If Wage Index Is Less Than or Equal To 1)

Table 1C--Adjusted Operating Standardized Amounts for Puerto Rico, Labor/Nonlabor

Table 1D--Capital Standard Federal Payment Rate

Table 2--Hospital Case-Mix Indexes for Discharges Occurring in Federal Fiscal Year 2003; Hospital Average Hourly Wage for Federal Fiscal Years 2003 (1999 Wage Data), 2004 (2000 Wage Data), and 2005 (2001 Wage Data) Wage Indexes and 3-Year Average of Hospital Average Hourly Wages

Table $3A_1$--FY 2005 and 3-Year Average Hourly Wage for Urban Areas by MSA

Table $3A_2$--FY 2005 3-Year Average Hourly Wage for Urban Areas by CBSA

Table $3B_1$--FY 2005 and 3-Year Average Hourly Wage for Rural Areas by MSA

Table $3B_2$--FY 2005 and 3-Year Average Hourly Wage for Rural Areas by CBSA

Table $4A_1$--Wage Index and Capital Geographic Adjustment Factor (GAF) for Urban Areas by MSA

Table $4A_2$--Wage Index and Capital Geographic Adjustment Factor (GAF) for Urban Areas by CBSA

Table $4B_1$--Wage Index and Capital Geographic Adjustment Factor (GAF) for Rural Areas by MSA

Table $4B_2$--Wage Index and Capital Geographic Adjustment Factor (GAF) for Rural Areas by CBSA

Table $4C_1$--Wage Index and Capital Geographic Adjustment Factor (GAF) for Hospitals That Are Reclassified by MSA

Table $4C_2$--Wage Index and Capital Geographic Adjustment Factor (GAF) for Hospitals That Are Reclassified by CBSA

Table $4F_1$--Puerto Rico Wage Index and Capital Geographic Adjustment Factor (GAF) by MSA

Table $4F_2$--Puerto Rico Wage Index and Capital Geographic Adjustment Factor (GAF) by CBSA

Table 4G--Pre-Reclassified Wage Index for Urban Areas

Table 4H--Pre-Reclassified Wage Index for Rural Areas

Table 4J--Wage Index Adjustment for Commuting Hospital Employees (Out-Migration) in Qualifying Counties--FY 2005

Table 5--List of Diagnosis Related Groups (DRGs), Relative Weighting Factors, Geometric and Arithmetic Mean Length of Stay

Table 6A--New Diagnosis Codes

Table 6B--New Procedure Codes

Table 6C--Invalid Diagnosis Codes

Table 6D--Invalid Procedure Codes

Table 6E--Revised Diagnosis Code Titles

Table 6F--Revised Procedure Code Titles

Table 6G--Additions to the CC Exclusions List

Table 6H--Deletions from the CC Exclusions List

Table 7A--Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 2003 MedPAR Update March 2004 GROUPER V21.0

Table 7B--Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 2003 MedPAR Update March 2004 GROUPER V22.0

Table 8A--Statewide Average Operating Cost-to-Charge Ratios--July 2004

Table 8B--Statewide Average Capital Cost-to-Charge Ratios--July 2004

Table $9A_1$--Hospital Reclassifications and Redesignations by Individual Hospital by MSA--FY 2005

Table $9A_2$--Hospital Reclassifications and Redesignations by Individual Hospital by CBSA--FY 2005

Table 9B--Hospital Reclassifications and Redesignations by Individual Hospital Under Section 508 of Pub. L. 108-173--FY 2004

Table 10--Geometric Mean Plus the Lesser of .75 of the National Adjusted Operating Standardized Payment Amount (Increased to Reflect the Difference Between Costs and Charges) or .75 of One Standard Deviation of Mean Charges by Diagnosis-Related Groups (DRGs)--July 2004

Table 11--FY 2005 LTC-DRGs, Relative Weights, Geometric Average Length of Stay, and 5/6ths of the Geometric Average Length of Stay