

In addition, as discussed in 62 FR 45999 and 63 FR 26317, under section 4202 of Public Law 105-33, a hospital that was classified as a rural referral center for FY 1991 is to be classified as a rural referral center for FY 1998 and later years so long as that hospital continued to be located in a rural area and did not voluntarily terminate its rural referral center status. Otherwise, a hospital seeking rural referral center status must satisfy applicable criteria. One of the criteria under which a hospital may qualify as a rural referral center is to have 275 or more beds available for use. A rural hospital that does not meet the bed size requirement can qualify as a rural referral center if the hospital meets two mandatory prerequisites (specifying a minimum case-mix index and a minimum number of discharges) and at least one of three optional criteria (relating to specialty composition of medical staff, source of inpatients, or referral volume). With respect to the two mandatory prerequisites, a hospital may be classified as a rural referral center if its—

- Case-mix index is at least equal to the lower of the median case-mix index for urban hospitals in its census region, excluding hospitals with approved teaching programs, or the median case-mix index for all urban hospitals nationally; and

- Number of discharges is at least 5,000 per year, or if fewer, the median number of discharges for urban hospitals in the census region in which the hospital is located. (The number of discharges criterion for an osteopathic hospital is at least 3,000 discharges per year.)

1. Case-Mix Index

Section 412.96(c)(1) provides that CMS will establish updated national and regional case-mix index values in each year's annual notice of prospective payment rates for purposes of determining rural referral center status. The methodology we use to determine the national and regional case-mix index values is set forth in regulations at § 412.96(c)(1)(ii). The proposed national case-mix index value for FY 2002 in the May 4 proposed rule included all urban hospitals nationwide, and the proposed regional values for FY 2002 were the median values of urban hospitals within each census region, excluding those with approved teaching programs (that is, those hospitals receiving indirect medical education payments as provided in § 412.105). Those values were based on discharges occurring during FY 2000 (October 1, 1999 through September 30, 2000) and included bills posted to CMS's records through December 2000. (The proposed rule language erroneously cited the

period as FY 1999 (October 1, 1998 through September 30, 1999.)

We proposed that, in addition to meeting other criteria, hospitals with fewer than 275 beds, if they are to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 2001, must have a case-mix index value for FY 2000 that is at least—

- 1.3286; or
  - The median case-mix index value for urban hospitals (excluding hospitals with approved teaching programs as identified in § 412.105) calculated by CMS for the census region in which the hospital is located. (See the table set forth in the May 4, 2001 proposed rule at 66 FR 22687.)
- Based on the latest data available (FY 2000 bills received through March 31, 2001), in addition to meeting other criteria, hospitals with fewer than 275 beds, if they are to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 2001, must have a case-mix index value for FY 2000 that is at least—
- 1.3289; or
  - The median case-mix index value for urban hospitals (excluding hospitals with approved teaching programs as identified in § 412.105) calculated by CMS for the census region in which the hospital is located. The final median case-mix values by region are set forth in the following table:

Region	Case-Mix Index Value
1. New England (CT, ME, MA, NH, RI, VT) .....	1.2381
2. Middle Atlantic (PA, NJ, NY) .....	1.2319
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV) .....	1.3055
4. East North Central (IL, IN, MI, OH, WI) .....	1.2588
5. East South Central (AL, KY, MS, TN) .....	1.2530
6. West North Central (IA, KS, MN, MO, NE, ND, SD) .....	1.1690
7. West South Central (AR, LA, OK, TX) .....	1.2443
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY) .....	1.3275
9. Pacific (AK, CA, HI, OR, WA) .....	1.2991

Hospitals seeking to qualify as rural referral centers or those wishing to know how their case-mix index value compares to the criteria should obtain hospital-specific case-mix values from their fiscal intermediaries. Data are available on the Provider Statistical and Reimbursement (PS&R) System. In keeping with our policy on discharges, these case-mix index values are computed based on all Medicare patient discharges subject to DRG-based payment.

2. Discharges

Section 412.96(c)(2)(i) provides that CMS will set forth the national and

regional numbers of discharges in each year's annual notice of prospective payment rates for purposes of determining rural referral center status. As specified in section 1886(d)(5)(C)(ii) of the Act, the national standard is set at 5,000 discharges. However, in the May 4 proposed rule, we proposed to update the regional standards based on discharges for urban hospitals' cost reporting periods that began during FY 2000 (that is, October 1, 1999 through September 30, 2000). (The proposed rule language erroneously cited the period as FY 1999 (October 1, 1998 through September 30, 1999.) That is

the latest year for which we have complete discharge data available.

Therefore, we proposed that, in addition to meeting other criteria, a hospital, if it is to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 2001, must have as the number of discharges for its cost reporting period that began during FY 2000 a figure that is at least—

- 5,000; or
- The median number of discharges for urban hospitals in the census region in which the hospital is located. (See the table set forth in the May 4, 2001 proposed rule at 66 FR 22687.)

Based on the latest discharge data available for FY 2000, the final median number of discharges for urban

hospitals by census region areas are as follows:

Region	Number of Discharges
1. New England (CT, ME, MA, NH, RI, VT) .....	7,064
2. Middle Atlantic (PA, NJ, NY) .....	8,488
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV) .....	8,562
4. East North Central (IL, IN, MI, OH, WI) .....	7,616
5. East South Central (AL, KY, MS, TN) .....	6,276
6. West North Central (IA, KS, MN, MO, NE, ND, SD) .....	5,210
7. West South Central (AR, LA, OK, TX) .....	6,196
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY) .....	8,878
9. Pacific (AK, CA, HI, OR, WA) .....	7,106

We reiterate that an osteopathic hospital, if it is to qualify for rural referral center status for cost reporting periods beginning on or after October 1, 2001, must have at least 3,000 discharges for its cost reporting period that began during FY 2000.

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

*C. Indirect Medical Education (IME) Adjustment (§ 412.105)*

1. IME Adjustment Factor Formula Multiplier (Section 111 of Public Law 106-113 and section 302 of Public Law 106-554 and § 412.105(d)(3)).

Section 1886(d)(5)(B) of the Act provides that prospective payment hospitals that have residents in an approved graduate medical education (GME) program receive an additional payment to reflect the higher indirect operating costs associated with GME. The regulations regarding the calculation of this additional payment, known as the indirect medical education (IME) adjustment, are located at § 412.105. The additional payment is based in part on the applicable IME adjustment factor. The IME adjustment factor is calculated using a hospital's ratio of residents to beds, which is represented as *r*, and a multiplier, which is represented as *c*, in the following equation:  $c \times [(1 + r)^{405} - 1]$ . The formula is traditionally described in terms of a certain percentage increase in payment for every 10-percent increase in the resident-to-bed ratio.

Section 302 of Public Law 106-554 amended section 1886(d)(5)(B) of the Act to modify the transition for the IME formula multiplier, or *c*, that was first established by Public Law 105-33 and revised by Public Law 106-113.

As discussed in the August 1, 2000 final rule and the June 13, 2001 interim final rule with comment period, section 111(a) of Public Law 106-113 revised the formula multiplier for discharges occurring during FY 2001 (established

under Public Law 105-33 at 1.6) to 1.54. However, section 302(b) of Public Law 106-554 provides a special payment rule which states that, for discharges occurring on or after April 1, 2001 and before October 1, 2001, IME payments are to be made as if 'c' equaled 1.66, rather than 1.54. The multiplier of 1.54 for the first 6 months of FY 2001 represents a 6.25 percent increase in the level of the IME adjustment for every 10 percent increase in the resident-to-bed ratio, and the multiplier for the second 6 months of FY 2001 represents a 6.75 percent increase in the level of the IME adjustment for every 10 percent increase in the resident-to-bed ratio. This results in an aggregate 6.5 percent increase for every 10 percent increase in the resident-to-bed ratio for FY 2001. Section 547(a)(2) of Public Law 106-554 provides further clarification that these payment increases will not apply to discharges occurring after FY 2001 and will not be taken into account in calculating the payment amounts applicable for discharges occurring after FY 2001. In the June 13 interim final rule, we revised § 412.105(d)(3)(v) to reflect the additional payment provided for discharges occurring during FY 2001 under section 302(b) of Public Law 106-554.

As discussed in the May 4, 2001 proposed rule, section 302(a) of Public Law 106-554 provides that, for discharges occurring during FY 2002, the formula multiplier is 1.6. For discharges occurring during FY 2003 and thereafter, the formula multiplier is 1.35. As explained above, section 302(b) of Public Law 106-554 provides for a special payment rule which states that, for discharges occurring on or after April 1, 2001 and before October 1, 2001, IME payments are to be made as if "c" equaled 1.66 rather than 1.54. The multiplier of 1.6 for FY 2002 represents a 6.5 percent increase for every 10 percent increase in the resident-to-bed ratio. The multiplier for FY 2003 and

thereafter (1.35) represents a 5.5-percent increase for every 10-percent increase in the resident-to-bed ratio. In the May 4 proposed rule, we proposed to revise § 412.105(d)(3)(vi) to reflect the change in the formula multiplier for FY 2002 to 1.6 as made by section 302(a) of Public Law 106-554 for discharges occurring during FY 2002. We also proposed to add § 412.105(d)(3)(vii) to incorporate the formula multiplier of 1.35 for discharges occurring on or after October 1, 2002.

We did not receive any comments on the IME formula provisions of the June 13 interim final rule with comment period or the proposed amendments under the May 4 proposed rule. Therefore, we are adopting both changes to § 412.105(d)(3) as final without change.

2. Resident-to-Bed Ratio Cap (§ 412.105(a)(1))

In the May 4, 2001 proposed rule, we indicated that it had come to our attention that there is some misunderstanding about § 412.105(a)(1) regarding the determination of the resident-to-bed ratio that is used in calculating the IME adjustment. Section 4621(b)(1) of Public Law 105-33 amended section 1886(d)(5)(B) of the Act by adding a new clause (vi) to provide that, effective for cost reporting periods beginning on or after October 1, 1997, the resident-to-bed ratio may not exceed the ratio calculated during the prior cost reporting period (after accounting for the cap on the hospital's number of full-time equivalent (FTE) residents). We implemented this policy in the August 29, 1997 final rule with comment period (62 FR 46003) and the May 12, 1998 final rule (63 FR 26323) under regulations at § 412.105(a)(1). Existing § 412.105(a)(1) specifies that "[e]xcept for the special circumstances for affiliated groups and new programs described in paragraphs (f)(1)(vi) and (f)(1)(vii) of this section, for a hospital's cost reporting periods beginning on or

after October 1, 1997, this ratio may not exceed the ratio for the hospital's most recent prior cost reporting period." In the May 4 proposed rule, we proposed to clarify § 412.105(a)(1) to add a provision that this ratio may not exceed the ratio for the hospital's most recent prior cost reporting period *after accounting for the cap on the number of FTE residents.*

In general, the resident-to-bed ratio from the prior cost reporting period, which is to be used as the cap on the resident-to-bed ratio for the current payment cost reporting period, should only include an FTE count subject to the FTE cap on the number of allopathic and osteopathic residents, but is *not* subject to the rolling average. (An explanation of rolling average appears in section IV.H.3. of this preamble.)

The following illustrates the steps for determining the resident-to-bed ratio for the current payment year cost reporting period and the cap on the resident-to-bed ratio:

*Current payment year cost reporting period resident-to-bed ratio:*

*Step 1.* Determine the hospital's number of FTE residents in the current payment year cost reporting period.

*Step 2.* Compare the number of allopathic and osteopathic FTEs from step 1 to the hospital's FTE cap (§ 412.105(f)(1)(iv)). If the number of allopathic and osteopathic FTEs from step 1 exceeds the FTE cap, replace it with the number of FTEs in the FTE cap. Add any dental and podiatry FTEs from step 1 to the capped allopathic and osteopathic FTE count.

*Step 3.* Determine the 3-year rolling average of the FTE residents using the FTEs from the current payment year cost reporting period and the prior two cost reporting periods (subject to the FTE cap in each cost reporting period). (Include podiatry and dental residents, and exclude residents in new programs in accordance with § 412.105(f)(1)(iv) and revised (f)(1)(v). Residents in new programs are added to the quotient of the rolling average.)

*Step 4.* Determine the hospital's number of beds (see § 412.105(b)) in the current payment year cost reporting period.

*Step 5.* Determine the ratio of the number of FTEs from step 3 to the number of beds from step 4. The lower of this resident-to-bed ratio or the resident-to-bed ratio cap (calculated below) from the immediately preceding cost reporting period is used to calculate the hospital's IME adjustment factor for the current payment year cost reporting period.

*Resident-to-bed ratio cap:*

*Step 1.* Determine the hospital's number of FTE residents in its cost reporting period that immediately precedes the current payment year cost reporting period.

*Step 2.* Compare the number of allopathic and osteopathic FTEs from step 1 to the hospital's FTE cap. If the number of allopathic and osteopathic FTEs from step 1 exceeds the FTE cap, replace it with the number of FTEs in the FTE cap. Add any dental and podiatry FTEs from step 1 to the capped allopathic and osteopathic FTE count. (If there is an increase in the number of FTEs in the current payment year cost reporting period due to a new program or an affiliation agreement, these FTEs are added to FTEs in the preceding cost reporting period after applying the FTE cap.)

*Step 3.* Determine the hospital's number of beds (§ 412.105(b)) in its cost reporting period that immediately precedes the current payment year cost reporting period.

*Step 4.* Determine the ratio of the number of FTEs in step 2 to the number of beds in step 3. This ratio is the resident-to-bed ratio cap for the current payment year cost reporting period.

*Step 5.* Compare the resident-to-bed ratio cap in step 4 to the resident-to-bed ratio in the current payment year cost reporting period. The lower of the resident-to-bed ratio from the current payment year cost reporting period or the resident-to-bed ratio cap from the immediately preceding cost reporting period is used to calculate the hospital's IME adjustment factor for the current payment year cost reporting period.

We note that the resident-to-bed ratio cap is a cap on the resident-to-bed ratio calculated for all residents, including allopathic, osteopathic, dental, and podiatry residents (63 FR 26324, May 12, 1998). However, as described in existing § 412.105(a)(1), the resident-to-bed ratio cap may be adjusted to reflect an increase in the current cost reporting period's resident-to-bed ratio due to residents in a new GME program or an affiliation agreement. While an exception does not apply if the resident-to-bed ratio increases because of an increase in the number of podiatry or dentistry residents or because of a change in the number of beds, the ratio could increase after a one-year delay. An increase in the current cost reporting period's ratio (while subject to the FTE cap on the overall number of allopathic and osteopathic residents) thereby establishes a higher cap for the following cost reporting period.

The following is an example of the application of the cap on the resident-to-bed ratio:

*Example—Part 1:*

- Assume Hospital A has 50 FTEs in its cost reporting period ending September 30, 1996, thereby establishing an IME FTE resident cap of 50 FTEs.

- In its cost reporting period of October 1, 1996 to September 30, 1997 (the prior year), it has 50 FTEs and 200 beds, so that its resident-to-bed ratio for this period is  $50/200 = .25$ .

- In the (current year) cost reporting period of October 1, 1997 to September 30, 1998 (the first cost reporting period in which the FTE resident cap, the resident-to-bed ratio cap, and the rolling average apply), Hospital A has 50 FTEs and 200 beds.

- Hospital A's FTEs do not exceed its FTE cap, so its current number of FTEs (50) is used to calculate the 2-year rolling average:  $(50 + 50)/2 = 50$ .

- The result of the rolling average is used as the numerator of the resident-to-bed ratio. Thus, the resident-to-bed ratio is  $50/200 = .25$ .

- .25 is compared to the resident-to-bed ratio from the prior period of October 1, 1996 to September 30, 1997. Because the FTE resident cap and the rolling average were not yet effective in the period of October 1, 1996 to September 30, 1997, that period's resident-to-bed ratio does not have to be recalculated to account for the FTE resident cap.

Accordingly, the resident-to-bed ratio cap for October 1, 1997 to September 30, 1998 is .25.

- Because the resident-to-bed ratio does not exceed the prior year ratio, Hospital A would use the resident-to-bed ratio of .25 to determine the IME adjustment in its cost reporting period of October 1, 1997 to September 30, 1998.

*Example—Part 2:*

- In the (current year) cost reporting period of October 1, 1998 to September 30, 1999, Hospital A adds 1 podiatric and 1 dental resident, so that it has a total of 52 FTEs and 200 beds. Since the FTE resident cap only includes allopathic and osteopathic residents, Hospital A has not exceeded its FTE resident cap with the addition of a podiatric and a dental resident.

- Accordingly, the (now) 3-year rolling average would be  $(52 + 50 + 50)/3 = 50.67$ .

- 50.67 is used in the numerator of the current payment year's resident-to-bed ratio, so that the resident-to-bed ratio is  $50.67/200 = .253$ .

- .253 is compared to the resident-to-bed ratio from the prior year's cost reporting period of October 1, 1997 to September 30, 1998 that is recalculated to account for the FTE resident cap. Because Hospital A did not exceed its FTE resident cap of 50 FTEs in this period of October 1, 1997 to September 30, 1998, the recalculated resident-to-bed ratio would be  $50/200 = .25$ .

- Compare the current year resident-to-bed ratio (.253) to the resident-to-bed ratio cap (.25); .253 *does exceed* .25.

- Therefore, the resident-to-bed ratio in the period of October 1, 1998 to September 30, 1999 is capped at .25, which is to be used in calculating Hospital A's IME adjustment for October 1, 1998 to September 30, 1999.

*Example—Part 3:*

- In the cost reporting period of October 1, 1999 to September 30, 2000, Hospital A adds

2 internal medicine residents so that it has a total of 54 FTEs and 200 beds. While podiatric and dental residents are not included in the FTE resident cap, internal medicine residents are included. Hospital A has exceeded its IME FTE resident cap of 50 by 2 FTEs. Thus, 2 FTEs are excluded from the FTE count.

- Accordingly, the rolling average would be  $(52 + 52 + 50)/3 = 51.33$ .

- 51.33 is used in the numerator of the resident-to-bed ratio, so that the resident-to-bed ratio is  $51.33/200 = .257$ .

- .257 is compared to the resident-to-bed ratio from October 1, 1998 to September 30, 1999 that is recalculated to only account for the FTE resident cap. The recalculated resident-to-bed ratio would be 50 allopathic or osteopathic FTEs plus 1 podiatric and 1 dental resident, which is  $52/200 = .26$ .

- .26 is the resident-to-bed ratio cap for October 1, 1999 to September 30, 2000. .257 does not exceed .26.

- Therefore, the resident-to-bed ratio in the period of October 1, 1998 to September 30, 1999 is .257, which is to be used in calculating this period's IME adjustment.

If a hospital starts a new GME program, the adjustment to the resident-to-bed ratio cap applies for the period of years equal to the minimum accredited length for each new program started. (For example, for a new internal medicine program, the period of years equals 3; for a new surgery program, the period of years equals 5.) Within these program years, the number of new FTE residents in the current cost reporting period is added to the FTE resident count used in the numerator of the resident-to-bed ratio from the previous cost reporting period. The lower of the resident-to-bed ratio from the current cost reporting period or the adjusted resident-to-bed ratio from the preceding cost reporting period is used to calculate the hospital's IME adjustment for the current cost reporting period. If a hospital subsequently continues to expand its program, the numerator of the resident-to-bed ratio from the preceding cost reporting period would not be adjusted to reflect these additional residents. However, an increase in the ratio of the current cost reporting period would establish a higher cap for the following cost reporting period.

We also proposed to add a provision that the exception for new programs described in § 412.105(f)(1)(vii) applies for the period of years equal to the minimum accredited length for each new program.

Similarly, if a hospital increases the number of FTE residents in the current cost reporting period because of an affiliation agreement, the number of additional FTEs is added to the FTE resident count used in the numerator of the resident-to-bed ratio from the

previous cost reporting period. The lower of the resident-to-bed ratio from the current cost reporting period or the adjusted resident-to-bed ratio from the preceding cost reporting period is used to calculate the hospital's IME adjustment for the current cost reporting period.

*Comment:* Several commenters addressed our clarifications to the regulations at § 412.105(a)(1) regarding the cap on the resident-to-bed ratio. One commenter stated that the explanation in the proposed rule regarding the resident-to-bed ratio was thorough. Another commenter expressed appreciation for the inclusion of examples in the proposed rule's preamble. One commenter noted that, in the proposed rule under step 2 of the example of the calculation of the resident-to-bed ratio cap, we indicate that the lesser of the prior year FTEs or the FTE cap is used in the numerator of the resident-to-bed ratio. The commenter noted that we do not specify that, while the FTE cap only applies to allopathic and osteopathic FTEs, dentistry and podiatry FTEs should be included in the numerator of the resident-to-bed ratio. The commenter asked that we specify that the prior year podiatry and dentistry FTEs must be added to the FTE count used in the resident-to-bed ratio after the FTE cap has been applied.

*Response:* We agree with the commenter concerning the inclusion of dental and podiatry FTEs in step 2, and we have clarified the language in step 2 of the examples of both the current year resident-to-bed ratio and the resident-to-bed ratio cap calculation in the preamble of this final rule. Specifically, we state, "Compare the number of allopathic and osteopathic FTEs from step 1 to the hospital's FTE cap. If the number of allopathic and osteopathic FTEs from step 1 exceeds the FTE cap, replace it with the FTE cap. Add any dental or podiatry FTEs from step 1 to the capped allopathic and osteopathic FTE count." Furthermore, we are revising the proposed changes to the regulations text at § 412.105(a)(1) to state that ". . . this ratio may not exceed the ratio for the hospital's most recent prior cost reporting period after accounting for the cap on the number of allopathic and osteopathic residents as described in paragraph (f)(1)(iv) of this section, and adding to the capped numerator any dental and podiatric full-time equivalent residents. . . ."

*Comment:* One commenter noted that, in clarifying the regulations at § 412.105(a)(1) regarding the resident-to-bed ratio cap, we added that the exception to the resident-to-bed ratio

cap ". . . for new programs . . . applies for the period of years equal to the minimum accredited length for that type of program" (emphasis added). The commenter asked how we would apply the exception to the resident-to-bed ratio cap in a situation where a hospital has started several new programs with varying minimum accredited lengths.

*Response:* The exception at proposed § 412.105(a)(1) for new programs allows a hospital to add a full complement of residents and complete the initial cycle of a program before residents in the new programs are included in the application of the resident-to-bed ratio cap. In a situation where a hospital has started several new programs under § 412.105(f)(1)(vii), we would apply the exception to the resident-to-bed ratio cap to each new program individually based on each program's minimum accredited length. For example, if a hospital simultaneously starts a new internal medicine program (which has a minimum accredited length of 3 years) and an anesthesiology program (which has a minimum accredited length of 4 years), the FTE residents in the new internal medicine program will be subject to the resident-to-bed ratio cap in the fourth program year of the internal medicine program, while the anesthesiology FTE residents would still be excluded from the resident-to-bed ratio cap in the fourth program year of the anesthesiology programs. However, in subsequent program years, the anesthesiology FTE residents would be subject to the resident-to-bed ratio cap, as well.

The rules regarding the exception from the rolling average calculation for IME are the same for direct GME. The proposed revised regulations at § 412.105(f)(1)(v) and § 413.86(g)(5) in the May 4, 2001 proposed rule state that FTE residents in a new program are excluded from the rolling average calculation for the period of years equal to the minimum accredited length for the type of program. In this final rule, we are revising the regulations regarding the exceptions to the resident-to-bed ratio cap and the rolling average calculation for both IME and direct GME to clarify that these exceptions apply to each new program individually for which the FTE cap may be adjusted based on each program's minimum accredited length (§ 412.105(a)(1), 412.105(f)(1)(v), and 413.86(g)(5)(v)).

*Comment:* One commenter asserted that, in the proposed rule, it is inconsistent to account for both the FTE cap and the rolling average count of residents in the current year resident-to-bed ratio, but account for only the FTE cap in the resident-to-bed ratio cap

(which is the prior year's ratio). The commenter stated that their willingness to support the proposed rule depended on whether the residency program is increasing or decreasing its FTEs every year.

*Response:* Section 1886(d)(5)(B)(v)(I) of the Act, as amended by Public Law 105-33, states that the resident-to-bed ratio "may not exceed the ratio of the number of interns and residents, *subject to the limit under clause (v)*, with respect to the hospital for its most recent cost reporting period to the hospital's available beds . . . during that cost reporting period . . ." (emphasis added). Clause (v) is the FTE cap requirement; the statute does not specify clause (vi)(II), which is the rolling average requirement, in relation to the resident-to-bed ratio cap. Accordingly, the implementing regulations require that the resident-to-bed ratio cap should only account for the cap on the number of FTEs.

In addition, we note that the commenter is mistaken in indicating that the rules regarding the determination of the resident-to-bed ratio and the resident-to-bed ratio cap are proposed rules. These rules have been in place based on the statute since the effective date of Public Law 105-33. We simply took the opportunity in the proposed rule published on May 4, 2001 to further clarify our existing policy because we realized that there was some confusion surrounding these rules.

*Comment:* One commenter noted that, since under the provisions of § 413.86(g)(6)(i), the FTE cap for new programs is established based on the number of residents in the third year of the first program's existence, it follows that the FTE cap on the residents in the new programs is effective in the fourth program year. The commenter asked if the application of the cap is delayed until the expiration of the minimum accredited length of the new programs.

*Response:* The application of the FTE adjusted caps for new programs under § 413.86(g)(6)(i) and (g)(6)(ii) are not delayed until the expiration of the minimum accredited length of the new programs. Only the application of the resident-to-bed ratio cap for IME and the rolling average for both IME and direct GME are dependent upon the minimum accredited length of each new program. The regulations at § 413.86(g)(6)(i) state that the cap for new programs will 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" (*emphasis added*). In general, when a hospital qualifies for a cap adjustment under § 413.86(g)(6)(i), the hospital has three years from the time that a resident first begins training in the first new program to establish its FTE cap. The first day of the fourth program year, the FTE cap on that first program, and any other programs that may have been started within the initial three years of that first program, is permanently established and takes effect.

For example, if a hospital that qualifies for a cap adjustment under § 413.86(g)(6)(i) starts a newly accredited dermatology program on July 1, 2001, and then starts a newly accredited anesthesiology program on July 1, 2002, the cap for both programs, and for the hospital as a whole, will be adjusted as of July 1, 2004, the first day of the fourth program year of dermatology, which is the first program that the hospital started. The hospital's cap will be based on the sum of: (a) The product of the highest number of residents in either PGY1, PGY2, or PGY3 in the third year of the dermatology program and 4 years (the minimum accredited length of dermatology); and (b) the product of the highest number of residents in either PGY1 or PGY2 for the anesthesiology program and 4 years (the minimum accredited length for anesthesiology). Any programs begun after the first program's start date but before the fourth program year of the first program will not have a full 3 years before the hospital's cap is permanently adjusted.

The rules under § 413.86(g)(6)(ii) differ for hospitals that qualify for an FTE cap adjustment for new programs started on or after January 1, 1995 and on or before August 5, 1997. Section 413.86(g)(6)(ii) states that the FTE cap adjustment 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 the program based on the minimum accredited length for the type of program" (*emphasis added*). In contrast to hospitals that qualify for a cap adjustment under § 413.86(g)(6)(i), where the cap for the hospital takes effect for *all* programs in the fourth program year of the first program that was started by the hospital, hospitals that qualify for an FTE cap adjustment under § 413.86(g)(6)(ii) have a full 3 years to grow *each* new program, as long as those programs all started training residents or received accreditation between January 1, 1995 and on or before August 5, 1997. The adjustment

to the cap for each of those new programs would be applied individually, beginning with the *first day of the fourth program year of each new program*. (We note that rural hospitals that qualify for a cap adjustment under § 413.86(g)(6)(iii) may receive an FTE cap adjustment in the same manner as hospitals that qualify for the cap adjustment under § 413.86(g)(6)(ii), except that rural hospitals may receive this adjustment for programs started after August 5, 1997).

For example, assume a hospital that qualifies for a cap adjustment under § 413.86(g)(6)(ii) started a newly accredited internal medicine program on July 1, 1996, and a newly accredited dermatology program on July 1, 1997. The adjustment to the hospital's FTE cap because of the internal medicine program was effective July 1, 1999 (the first day of the fourth program year of internal medicine), and the cap adjustment resulting from the dermatology program was effective July 1, 2000 (the first day of the fourth program year for dermatology). The hospital's ultimate FTE cap is the sum of the FTE cap based on FTEs in the hospital's most recent cost reporting period ending on or before December 31, 1996, and the cap adjustments for the internal medicine and dermatology programs. (We note that since the internal medicine program began in 1996, depending on the hospital's cost reporting period, a portion of those FTEs may have already been included in the hospital's FTE cap. That portion that was included in the FTE cap must be subtracted from the cap adjustment that was calculated for the internal medicine program to avoid any double counting of the FTEs). The hospital's adjusted cap will be based on the sum of: (a) the product of the highest number of internal medicine residents in either PGY1, PGY2, or PGY3 in the third year of the internal medicine program and three (the minimum accredited length of internal medicine); and (b) the product of the highest number of dermatology residents in either PGY1, PGY2, or PGY3 for the dermatology program and four (the minimum accredited length for dermatology).

In summary, we reiterate that the application of the FTE cap adjustments for new programs is *not* delayed until the program year in which the minimum accredited length of each program expires. This would even apply to a new program with a minimum accredited length that exceeds 3 years. The FTE cap adjustment takes effect on the first day of the fourth program year of the first new program that was started

by hospitals qualifying for a cap adjustment under § 413.86(g)(6)(i). For hospitals qualifying for a cap adjustment under § 413.86(g)(6)(ii) and (g)(6)(iii), the cap adjustments take effect on the first day of the fourth program year of each new program. However, the application of the resident-to-bed ratio cap for IME and the rolling average for both IME and direct GME are dependent upon the minimum accredited length of each new program.

*Comment:* With regard to the counting of residents for IME payment purposes in nonhospital sites, one commenter stated that although time spent in nonhospital sites may be included in the IME FTE count effective for discharges occurring on or after October 1, 1997, the application of the 1996 FTE cap effectively disallows the current year's FTEs training in the nonhospital site, because the 1996 FTE cap was based on residents training only in the hospital. The commenter added that only those hospitals that are in a position to elect a Medicare affiliation agreement are able to "circumvent" the 1996 FTE limit; those that cannot are "penalized." The commenter further stated that the regulatory intent of allowing nonhospital training time to be counted is not fully met by having only certain hospitals able to affiliate. The commenter recommended that we should allow hospitals to recalculate the 1996 IME FTE cap to include those FTEs training in nonhospital sites, so that hospitals will effectively be able to count residents currently training in nonhospital sites for IME purposes.

*Response:* The commenter is addressing a provision in Public Law 105-33 that was implemented in regulations at § 412.105(f)(1)(ii)(C). We did not propose any substantive changes to this policy; we simply were correcting an oversight in the regulations text for IME. (Comments on regulations implementing this provision were addressed in the May 12, 1998 final rule (63 FR 26323) and the July 31, 1998 final rule (63 FR 40954).)

### 3. Conforming Changes (§ 412.105(f)(1)(ii)(C) and (f)(1)(v))

In the August 29, 1997 final rule with comment period (62 FR 46003), the May 12, 1998 final rule (63 FR 26323), and the July 31, 1998 final rule (63 FR 40986), to implement the provisions of Public Law 105-33, we set forth certain policies that affected payment for both direct and indirect GME. Some of these policies related to the FTE cap on allopathic and osteopathic residents, the rolling average, and payment for residents training in nonhospital settings. In the May 4 proposed rule, we

indicated that when we amended the regulations under § 413.86 for direct GME, we inadvertently did not make certain conforming changes in § 412.105 for IME. We proposed to make the following conforming changes:

- To revise § 412.105(f)(1)(ii)(C) to specify that, effective for discharges occurring on or after October 1, 1997, the time residents spend training in a nonhospital setting in patient care activities under an approved medical residency training program may be counted towards the determination of full-time equivalency if the criteria set forth at § 413.86(f)(3) or § 413.86(f)(4), as applicable, are met.

- To revise § 412.105(f)(1)(v) to specify that residents in new residency programs are not included in the rolling average for a period of years equal to the minimum accredited length for the type of program.

In addition, we proposed to revise § 412.105(f)(1)(ix) to specify, for IME purposes, a temporary adjustment to a hospital's FTE cap to reflect residents added because of another hospital's closure of its medical residency program (to conform to the May 4, 2001 proposed change for GME discussed in section IV.H.5. of this preamble).

We did not receive any comments on these conforming changes and are adopting them as final.

### D. Payments to Disproportionate Share Hospitals (DSH) (Sections 211 and 303 of Public Law 106-554 and § 412.106)

Effective for discharges beginning on or after May 1, 1986, hospitals that serve a disproportionate number of low-income patients (the DSH patient percentage as defined in section 1886(d)(5)(F) of the Act) receive additional payments through the DSH adjustment. Hospitals that meet the DSH patient percentage criteria are entitled to the DSH payment adjustment.

#### 1. Qualifying Thresholds for DSHs

In the June 13, 2001 interim final rule with comment period, we discussed the provisions of section 1886(d)(5)(F)(v) of the Act, as it existed prior to enactment of Public Law 106-554 and under § 412.106(c) of the existing regulations, which provided that a hospital qualified for DSH if the hospital had a DSH patient percentage equal to:

- At least 15 percent for an urban hospital with 100 or more beds or a rural hospital with 500 or more beds;
- At least 40 percent for an urban hospital with fewer than 100 beds;
- At least 45 percent for a rural hospital with 100 beds or fewer, if it is not also classified as an SCH;

- At least 30 percent for a rural hospital with more than 100 beds and fewer than 500 beds or which is classified as an SCH; or
- The hospital has 100 or more beds, is located in an urban area, and receives more than 30 percent of its net inpatient revenues from State and local government sources for the care of indigent patients not eligible for Medicare or Medicaid.

Section 211(a) of Public Law 106-554 amended section 1886(d)(5)(F)(v) to provide that, beginning with discharges occurring on or after April 1, 2001, the qualifying threshold is reduced to 15 percent for all hospitals. Therefore, in the June 13 interim final rule, we revised § 412.106(c) to reflect the change in DSH qualifying threshold percentages.

*Comment:* Several commenters responded on the subject of the calculation of the DSH payment adjustment. These commenters were concerned about how to apply the threshold changes as of April 1, 2000. They were also concerned about counting days in the calculation when a stay crosses over two cost reporting periods. Finally, these commenters were concerned about counting section 1115 expansion waiver days in the DSH payment adjustment calculation.

*Response:* Section 211(a) of Public Law 106-554 amended section 1886(d)(5)(F) of the Act to change the qualifying thresholds for the DSH payment adjustment to 15 percent for all hospital types, effective with discharges occurring on or after April 1, 2001. This means that the legislation is effective with discharges occurring on or after April 1, 2001, but not before. Therefore, fiscal intermediaries are required to determine whether a hospital meets the thresholds in place either before or after April 1, 2001, by applying the DSH patient percentage in the formula to each separate period. Days are counted based on the date of discharge. In other words, a hospital stay would be counted in the cost reporting year during which the patient was discharged.

Finally, counting section 1115 expansion waiver days in the DSH payment adjustment calculation was discussed in the August 1, 2000 **Federal Register** (65 FR 47086). This policy became effective for discharges occurring on or after January 20, 2000. Therefore, it is possible that a hospital will qualify for DSH payments as of January 20, 2000, whereas it did not qualify before January 20, 2000, and it should be paid accordingly. In other words, a hospital in that situation would receive Medicare DSH payments beginning January 20, 2000.

## 2. Calculation of the DSH Payment Adjustment

Section 211(b) of Public Law 106-554 further amended section 1886(d)(5)(F) to revise the calculation of the DSH payment adjustment for hospitals affected by the revised thresholds as specified in section 211(a) of the Act. In the June 13 interim final rule with comment period, we discussed these adjustments, which are effective for discharges occurring on or after April 1, 2001, as follows:

- Urban hospitals with fewer than 100 beds and whose DSH patient percentage is equal to or greater than 15 percent and less than 19.3 percent receive the DSH payment adjustment determined using the following formula:  
(DSH patient percentage - 15) (.65) + 2.5.

- Urban hospitals with fewer than 100 beds and whose DSH patient percentage is equal to or greater than 19.3 percent receive a flat add-on of 5.25 percent.

- Rural hospitals that are both rural referral centers and SCHs receive the DSH payment adjustment determined using the higher of the SCH adjustment or the rural referral center adjustment.

- Rural hospitals that are SCHs and are *not* rural referral centers and whose DSH patient percentage is equal to or greater than 15 percent and less than 19.3 percent receive the DSH payment adjustment determined using the following formula:

(DSH patient percentage - 15) (.65) + 2.5.

- Rural hospitals that are SCHs and are *not* rural referral centers and whose DSH patient percentage is equal to or greater than 19.3 percent and less than 30 percent receive a flat add-on of 5.25 percent.

- Rural hospitals that are SCHs and are *not* rural referral centers and whose DSH patient percentage is equal to or greater than 30 percent receive 10 percent.

- Rural referral centers whose DSH patient percentage is greater than or equal to 15 percent and less than 19.3 percent receive the DSH payment adjustment determined using the following formula:

(DSH patient percentage - 15) (.65) + 2.5.

- Rural referral centers whose DSH patient percentage is equal to or greater than 19.3 percent but less than 30 percent receive a flat add-on of 5.25 percent.

- Rural referral centers whose DSH patient percentage is equal to or greater than 30 percent receive the DSH payment adjustment determined using the following formula:

(DSH patient percentage—30) (.6) + 5.25.

- Rural hospitals with fewer than 500 beds and whose DSH patient percentage is equal to or greater than 15 percent and less than 19.3 percent receive the DSH payment adjustment using the following formula:

(DSH patient percentage—15) (.65) + 2.5.

- Rural hospitals with fewer than 500 beds and whose DSH patient percentage is equal to or greater than 19.3 percent receive a flat add-on of 5.25 percent.

If we calculate DSH patient percentages to the hundredth place (our current practice), these payment formulas result in an anomaly for some DSH patient percentages just below 19.3 percent (but greater than 19.2 percent). That is, as the percentage values approach 19.3, the DSH payment adjustment resulting from the formula exceeds 5.25 percent. This would result in a higher DSH payment adjustment for DSH patient percentages just below 19.3 than for percentages of 19.3 and above. We stated in the June 13 interim final rule that, because we believe it would be contrary to the Congress' intent for hospitals with a DSH patient percentage of less than 19.3 percent to receive a greater payment than those hospitals of the same class that have a DSH patient percentage of 19.3 or greater, we were implementing this provision so that, for DSH patient percentages below 19.3 for affected hospitals, the DSH payment adjustment will not exceed 5.25 percent.

In the June 13 interim final rule with comment period, we revised § 412.106(d) to reflect the changes in the disproportionate share adjustment.

## 3. Percentage Reduction to the DSH Payment Adjustment

Section 1886(d)(5)(F)(ix) of the Act, as amended by section 112 of Public Law 106-113, specifies a percentage reduction in the payments a hospital would otherwise receive under the DSH payment adjustment formula. Prior to enactment of section 303 of Public Law 106-554, the reduction percentages were as follows: 3 percent for FY 2001, 4 percent for FY 2002, and 0 percent for FY 2003 and each subsequent fiscal year.

Section 303 of Public Law 106-554 revised the amount of the percent reductions to 2 percent for discharges occurring in FY 2001, and to 3 percent for discharges occurring in FY 2002. The reduction continues to be 0 percent for FY 2003 and each subsequent fiscal year. Section 303 of Public Law 106-554 contains a special rule for FY 2001: For discharges occurring on or after October 1, 2000 and before April 1, 2001, the

reduction is to be 3 percent, and for discharges occurring on or after April 1, 2001 and before October 1, 2001, the reduction is to be 1 percent. Changes made by section 303 with respect to FY 2001 discharges were implemented in the June 13, 2001 interim final rule with comment period.

We are adopting as final the revisions to § 412.106(e) to reflect the change in the percentages made by section 303 of Public Law 106-554 that were included in the May 4, 2001 proposed rule and in the June 13, 2001 interim final rule with comment period. We also are making a technical change in the heading of paragraph (e).

### *E. Medicare-Dependent, Small Rural Hospitals (Section 404 of Public Law 106-113 and section 212 of Public Law 106-554 and 42 CFR 412.90(j) and 412.108)*

Section 6003(f) of the Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239) added section 1886(d)(5)(G) to the Act and created the category of Medicare-dependent, small rural hospital (MDH) that are eligible for a special payment adjustment under the hospital inpatient prospective payment system. Section 1886(d)(5)(G) of the Act define an MDH as any hospital that meets all of the following criteria:

- The hospital is located in a rural area.
- The hospital has 100 or fewer beds.
- The hospital is not classified as an SCH (as defined at § 412.92).
- In the hospital's cost reporting period that began during FY 1987, not less than 60 percent of its inpatient days or discharges were attributable to inpatients entitled to Medicare Part A benefits. If the cost reporting period is for less than 12 months, the hospital's most recent 12-month or longer cost reporting period before the short period is used.

(For a more detailed discussion, see the April 20, 1990 *Federal Register* (55 FR 15154)).

As provided by the law, MDHs were eligible for a special payment adjustment under the prospective payment system, effective for cost reporting periods beginning on or after April 1, 1990 and ending on or before March 31, 1993. Hospitals classified as MDHs were paid using the same methodology applicable to SCHs, that is, based on whichever of the following rates yielded the greatest aggregate payment for the cost reporting period:

- The national Federal rate applicable to the hospital.
- The updated hospital-specific rate using FY 1982 cost per discharge.

• The updated hospital-specific rate using FY 1987 cost per discharge.

Section 13501(e)(1) of the Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66) extended the MDH provision through FY 1994 and provided that, after the hospital's first three 12-month cost reporting periods beginning on or after April 1, 1990, the additional payment to an MDH whose applicable hospital-specific rate exceeded the Federal rate was limited to 50 percent of the amount by which the hospital-specific rate exceeded the Federal rate.

Section 4204(a)(3) of Public Law 105-33 reinstated the MDH special payment for discharges occurring on or after October 1, 1997 and before October 1, 2001, but did not revise the qualifying criteria for these hospitals or the payment methodology.

Section 404(a) of Public Law 106-113 extended the MDH provision to discharges occurring on or after October 1, 2002 and before October 1, 2006. In the August 1, 2000 interim final rule with comment period, we revised §§ 412.90(j) and 412.108 to reflect the extension of the MDH program through FY 2006.

As specified in the June 13, 2001 interim final rule with comment period, section 212 of Public Law 106-554 provided that, effective with cost reporting periods beginning on or after April 1, 2001, hospitals have the option to base MDH eligibility on two of the three most recently audited cost reporting periods for which the Secretary has a settled cost report, rather than on the cost reporting period that began during FY 1987. According to section 212, the criteria for at least 60 percent Medicare utilization will be met if in at least "2 of the 3 most recently audited cost reporting periods for which the Secretary has a settled cost report", at least 60 percent of the hospital's inpatient days or discharges were attributable to individuals receiving Medicare Part A benefits.

Hospitals that qualify under this provision are subject to the other provisions already in place for MDHs, that is, the payment methodology as defined in § 412.108(c) and the volume decrease provision as defined in § 412.108(d).

A hospital must notify its fiscal intermediary to be considered for MDH status under this new provision. Any hospital that believes it meets the criteria to qualify as an MDH, based on at least two of its three most recently settled cost reports, must submit a written request to its intermediary. The hospital's request must be submitted within 180 days from the date of the

notice of amount of program reimbursement for the cost reporting period in question. The intermediary will make its determination and notify the hospital within 180 days from the date it receives the hospital's request and all of the required documentation.

In the June 13 interim final rule with comment period, we revised § 412.108(a)(1)(iii) to reflect the additional option provided by section 212 of Public Law 106-554.

We received one comment on the proposed regulation change.

*Comment:* One commenter representing a state hospital association expressed concern regarding the MDH qualifying process outlined in the interim final rule. The commenter questioned the timing of the process, especially that the hospital would be required to apply within 180 days from the date of the notice of program reimbursement and that the fiscal intermediary would have up to 180 days in which to make its decision. The commenter believed that this would not allow hospitals to qualify by the first cost reporting period beginning on or after the April 1, 2001, effective date of the new provision. The commenter also believed that this process would result in a lengthy period of time, perhaps 2-4 years while the cost report settlement and this process plays out. The commenter also believed the determination of whether or not a hospital meets the requirements to become an MDH under this new provision should be handled in manner consistent with that already in place. That is, fiscal intermediaries should automatically determine, using the cost report information they have, whether or not any additional hospitals would now qualify as an MDH under this new criteria, rather than putting the burden on the hospitals to apply for MDH status. The commenter also stated that the fiscal intermediaries require instruction regarding the calculation of the payment rates in order to determine which would most benefit the MDHs. The commenter also believed that the impact analysis understates the number of newly eligible hospitals under the new MDH provision.

*Response:* We disagree with the commenter that the process for approval of new MDHs could take as long as 2 to 4 years. We do agree with this commenter that hospitals' requests for consideration under this provision need not be limited to requests submitted within 180 days of the issuance of a notice of amount of program reimbursement, and we are deleting this requirement from § 412.108(b). This will eliminate any unintended delay in the

time when hospitals could request MDH status. Therefore, hospitals are free to request MDH status at any time. We also are revising the time provided for fiscal intermediaries to make their determination, from 180 days to 90 days. We believe this will provide sufficient time for review while being responsive to the commenter's concern that the process not be too lengthy. Similar to the approval period for SCHs as described above, MDH status and the associated payment adjustment are effective 30 days after written notification to the MDH.

We believe it is most appropriate, and consistent with procedures for SCH and rural referral center designation, to require hospitals to request consideration as a MDH, rather than placing this requirement with the fiscal intermediaries. We will further clarify the MDH policy and process, including the change noted above, through future Program Memoranda.

With respect to the commenter's concern that our impact analysis underestimates the number of newly eligible hospitals under the new provision, we noted in the June 13, 2001 interim final rule with comment period that our most recent data available were 1998, and we were, therefore, unable to estimate the impacts using more recent data. Therefore, the actual impact of this provision may be different as the fiscal intermediaries evaluated hospitals' requests using more recent data.

#### *F. Reclassification of Certain Urban Hospitals as Rural Hospitals (Sections 401(a) and (b) of Public Law 106-113 and 42 CFR 412.63(b), 412.90(e), 412.102, and 412.103)*

##### 1. Permitting Reclassification of Certain Urban Hospitals as Rural Hospitals

Under Medicare law, the location of a hospital can affect its payment methodology as well as whether the facility qualifies for special treatment both for operating and for capital payments. Whether a facility is situated in an urban or a rural area will, for example, affect payments based on the wage index values and Federal standardized amounts specific to the area. Similarly, the percentage increase in payments made to hospitals that treat a disproportionate share of low-income patients is based, in part, on its urban/rural status, as are determinations regarding a hospital's qualification as an SCH, rural referral center, critical access hospital (CAH), or other special category of facility. Section 1886(d)(2)(D) of the Act defines an "urban area" as an area within a MSA as defined by the Office of Management and Budget. The same

provision defines a "large urban area," with respect to any fiscal year, as an urban area that the Secretary determines (in the publications described in section 1886(e)(5) of the Act before the fiscal year) has a population of more than 1 million as determined based on the most recent available published Census Bureau data. Section 1886(d)(2)(D) of the Act further defines a "rural area" as an area that is outside of a "large" urban area or "other" urban area. Since FY 1995, the average standardized amount for hospitals located in rural areas and "other" urban areas has been equal, as provided for in section 1886(b)(3)(B)(i)(X) of the Act.

Several provisions of the Act provide procedures under which a hospital can apply for reclassification from one geographic area to another. Section 1886(d)(8)(B) of the Act, which provides that if certain conditions are met, the Secretary shall treat a hospital located in a rural county adjacent to one or more urban areas as being located in the urban area to which the greatest number of workers in the county commute. Also, section 1886(d)(10) of the Act established the MGCRB to permit hospitals that are disadvantaged by their geographic classification to obtain a more appropriate classification to the area with which they have the most economic interaction.

In the August 1, 2000 interim final rule with comment period (65 FR 47029), we implemented section 401(a) of Public Law 106-113. Section 401(a) of Public Law 106-113, which amended section 1886(d)(8) by adding a new paragraph (E), directs the Secretary to treat any subsection (d) hospital located in an urban area as being located in the rural area of the State in which the hospital is located if the hospital files an application (in the form and manner determined by the Secretary) and meets one of the following criteria:

- The hospital is located in a rural census tract of an MSA (as determined under the most recent modification of the Goldsmith Modification, originally published in the **Federal Register** on February 27, 1992 (57 FR 6725));
- The hospital is located in an area designated by any law or regulation of the State as a rural area (or is designated by the State as a rural hospital);
- The hospital would qualify as a rural referral center, or as an SCH if the hospital were located in a rural area; or
- The hospital meets any other criteria specified by the Secretary.

The statutory effective date of this provision is January 1, 2000.

In the August 1, 2000 interim final rule with comment period, we provided a detailed discussion of the

development of the Goldsmith Modifications (65 FR 47029). The Goldsmith Modification evolved from an outreach grant program sponsored by the Office of Rural Health Policy of the Health Resources and Services Administration (HRSA) in order to establish an operational definition of rural populations lacking easy geographic access to health services. Using 1980 census data, Dr. Harold F. Goldsmith and his associates created a methodology for identification of rural census tracts that were located within a large metropolitan county of at least 1,225 miles but were so isolated from the metropolitan core by distance or physical features so as to be more rural than urban in character. We utilize data based on 1990 census data, reflecting the most recent Goldsmith modification.

We also included Appendix A of that interim final rule with comment period a listing of the identified urban counties with census tracts that may qualify as rural under the most recent Goldsmith Modification (January 1, 2000). The amendments made by section 401 of Public Law 106-113 enable a hospital located in one of the areas listed in Appendix A of the August 1, 2000 interim final rule with comment period to be treated as if it were situated in the rural area of the State in which it is located.

Additionally, section 401(a) of Public Law 106-113 includes hospitals " \* \* \* located in an area designated by any law or regulation of such State as a rural area (or is designated by such State as a rural hospital)." Since the concept of State "designation" referred to in the parenthetical clause was not explicit enough to provide a clear-cut rule for purposes of implementation, we required that a hospital's designation as rural be in the form of either State law or regulation if it is the basis for a hospital's request for urban to rural reclassification. We believe this will help ensure that the provision is implemented consistently among States.

Finally, a hospital also may seek to qualify for reclassification premised on the fact that, had it been located in a rural area, it would have qualified as a rural referral center or as an SCH. The hospital would need to satisfy the criteria set forth in section 1886(d)(5)(C) of the Act (as implemented in regulations at § 412.96) as a rural referral center, or the criteria set forth in section 1886(d)(5)(D) of the Act (as implemented in regulations at § 412.92) as an SCH.

Although the statute authorizes the Secretary to specify further qualifying criteria for a section 401 reclassification, we did not believe that additional

criteria were warranted at the time the August 1, 2002 interim final rule was published. However, we invited comment specifically on whether the criteria in the interim final rule are sufficient at this time, and if not, what additional criteria should be incorporated.

A hospital that is reclassified as rural under section 1886(d)(8)(E) of the Act, as added by section 401(a) of Public Law 106-113, is treated as rural for all purposes of payment under the Medicare inpatient hospital prospective payment system (section 1886(d) of the Act), including standardized amount (§§ 412.60 *et seq.*), wage index (§ 412.63), and the DSH payment adjustment calculations (§ 412.106) as of the effective date of the reclassification.

*Comment:* One commenter addressed policies discussed in the August 1, 2000 interim final rule with comment period. Other commenters addressed our policy to not permit hospitals that are redesignated as rural under section 1886(d)(8)(E) of the Act to be eligible for subsequent reclassifications by the MGCRB.

*Response:* These policies were addressed in the May 5, 2000 proposed rule (65 FR 26308) and the August 1, 2000 final rule (65 FR 47087) implementing the updates and policy changes to the prospective payment system for FY 2001. We responded to comments on the May 5, 2000 proposed rule in the August 1, 2000 final rule. Because we addressed these concerns in that final rule, we are not readdressing those comments in this final rule.

*Comment:* An association of physicians commented that the interim final rule with comment period stated that a hospital that is reclassified as rural under this provision must be treated as rural for all purposes of payment under the Medicare inpatient hospital prospective payment system, including standardized amount, wage index, and the DSH payment adjustment. However, the commenter pointed out, graduate medical education is not listed. The commenter urged that these hospitals also be considered rural for purposes of graduate medical education.

*Response:* Section 1886(d)(8)(E) of the Act provides that affected hospitals are considered rural for purposes of section 1886(d). Therefore, these reclassifications affect payments to a hospital under the IME adjustment, which are made under section 1886(d)(5)(B) of the Act, but not payments for direct GME, which are made under section 1886(h) of the Act.

## 2. Conforming Changes under Section 401(b) of Public Law 106-113

Section 401(b) of Public Law 106-113 sets forth conforming statutory changes relating to urban to rural reclassifications under section 401(a) of Public Law 106-113:

- Section 401(b)(1) provided that if a hospital is being treated as being located in a rural area under section 1886(d)(8)(E) of the Act (for purposes of section 1886(d) of the Act), the hospital will also be treated under section 1833(t) of the Act as being located in a rural area. This provision was addressed in the final rule for the hospital inpatient prospective payment system published in the **Federal Register** on August 1, 2000 (65 FR 47087).

- Section 401(b)(2) amended section 1820(c)(2)(B)(i) of the Act by extending the reclassification provisions of section 401(a) to the CAH program. A hospital that otherwise would have fulfilled the requirements for designation as a CAH had it been located in a rural area is now eligible for consideration as a CAH if it is treated as being located in a rural area under section 1886(d)(8)(E) of the Act, as added by section 401(a) of Public Law 106-113. (A list of certain existing hospitals that were identified as being located in Goldsmith areas was included in Appendix B of the August 1, 2000 interim final rule with comment period.) A more detailed discussion of the effect on the CAH program of this provision, as well as additional amendments to section 1820(c)(2)(B)(i) of the Act included in Public Law 106-113, is provided in section VI.B. of this preamble.

## 3. Application Procedures

The statute provides that a hospital seeking reclassification from urban to rural under section 1886(d)(8)(E) of the Act must submit an application "in a form and manner determined by the Secretary." In the August 1, 2000 interim final rule with comment period, we set forth procedures and requirements for the application for rural reclassification, including application submittal requirements, the filing and effective dates for the application, the procedures for withdrawal of applications, and cancellation of rural reclassification; and the qualifications through the Goldsmith Modification Criteria, by State designation and qualifications as a rural referral center or as an SCH. (See 65 FR 47030 through 47031 for a full discussion of these procedures and requirements.) As of early July 2001, 19 hospitals had taken advantage of this provision.

## 4. Changes in the Regulations

In the August 1, 2000 interim final rule with comment period, we added a new § 412.103 to incorporate the provisions on the urban to rural reclassification options set forth in section 1886(d)(8)(E) of the Act, as added by section 401(a) of Public Law 106-113, and the application procedures for requesting reclassification.

A formula for transition payments to hospitals located in an area that has undergone geographic reclassification from urban to rural is set forth in section 1886(d)(8)(A) of the Act and implemented in regulations at §§ 412.90 and 412.102. In the interim final rule with comment period, we revised existing §§ 412.63(b)(1) and 412.90(e) and the title of § 412.102 to clarify the distinction between hospital reclassification from urban to rural and the geographic reclassification (or redesignation) of an urban area to rural.

In addition, we revised § 485.610 by redesignating paragraph (b)(4) as paragraph (b)(5) and adding a new paragraph (b)(4) to reflect the conforming provision of section 401(b)(2) of Public Law 106-113.

We did not receive any comments on these changes in the regulations in the interim final rule with comment period and, therefore, are adopting them as final.

*G. Medicare Geographic Classification Review Board (MGCRB) (New § 412.235 and Existing §§ 412.256, 412.273, 412.274(b), and 412.276)*

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

As discussed in section III.F. of this final rule, section 304 of Public Law 106-554 contained several provisions related to the wage index and reclassification decisions made by the MGCRB. In summary, section 304 first establishes that hospital reclassification

decisions by the MGCRB for wage index purposes are effective for 3 years, beginning with reclassifications for FY 2001. Second, it provides that the MGCRB must use the 3 most recent years of average hourly wage data in evaluating a hospital's reclassification application for FY 2003 and subsequent years. Third, it provides that an appropriate statewide entity may apply to have all of the geographic areas in a State treated as a single geographic area for purposes of computing and applying the wage index, for reclassifications beginning in FY 2003. In the May 4, 2001 proposed rule, we presented a discussion of how we proposed to implement these three provisions. (Section III.F. of this preamble discusses the application of these policy changes to the development of the final FY 2002 and later wage indexes based on hospital reclassification under the provisions of section 304 of Public Law 106-554.)

## 1. Three-Year Reclassifications for Wage Index Purposes

Section 304(a) of Public Law 106-554 amended section 1886(d)(10)(D) of the Act by adding clause (v), which provides that, if a hospital is approved for reclassification by the MGCRB for purposes of the wage index, the reclassification is effective for 3 years. The amendment made by section 304(a) is effective for reclassifications for FY 2001 and subsequent years. In addition, the legislation specifies that the Secretary must establish a mechanism under which a hospital may elect to terminate such reclassification during the 3-year period.

Consistent with new section 1886(d)(10)(D)(v) of the Act, in the May 4 proposed rule, we proposed to revise § 412.274(b) to provide under new paragraph (b)(2) that any hospital that is reclassified for a particular fiscal year for purposes of receiving the wage index value of another area would receive that reclassification for 3 years beginning with discharges occurring on the first day (October 1) of the second Federal fiscal year in which a hospital files a complete application. This 3-year reclassification would remain in effect unless the hospital terminates the reclassification under revised procedures that we proposed to establish under new proposed § 412.273(b). The provision would apply to hospitals that are reclassified for purposes of the wage index only, as well as those that are reclassified for both the wage index and the standardized amount. However, in the latter case, only the wage index reclassification would be extended for 2 additional

years beyond the 1 year provided for in the existing regulations (3 years total). Hospitals seeking reclassification for purposes of the standardized amount must continue to reapply to the MGCRB on an annual basis.

a. Special Rule for a Hospital that was Reclassified for FY 2001 and FY 2002 to Different Areas

Because the 3-year effect of the amendment made by section 304(a) of Public Law 106-554 is applicable to reclassifications for FY 2001 (which had already taken place prior to the date of enactment of section 304(a) (December 21, 2000)), and because the application process for reclassifications for FY 2002 had already been completed by the date of enactment, we are establishing special procedures for hospitals that are reclassified for purposes of the wage index to one area for FY 2001, and are reclassified for purposes of the wage index or the standardized amount to another area for FY 2002. We are deeming such a hospital to be reclassified to the area for which it applied for FY 2002, unless the hospital elects to receive the wage index reclassification it was granted for FY 2001. Consistent with our procedures for withdrawing an application for reclassification (§ 412.273), we allowed a hospital that wished to receive the reclassification it was granted for FY 2001 to withdraw its FY 2002 application by making a written request to the MGCRB within 45 days of the publication date of the proposed rule (that is, by June 18, 2001). Again, only the wage index reclassification is extended for 2 additional years (3 years total). Hospitals seeking reclassification for purposes of the standardized amount must continue to reapply to the MGCRB on an annual basis.

(We note that, effective May 21, 2001, the new location and mailing address of the MGCRB and the Provider Reimbursement Review Board (PRRB) is: 2520 Lord Baltimore Drive, Suite L, Baltimore, MD 21244-2670. Please specify whether the mail is intended for the MGCRB or the PRRB.)

b. Overlapping Reclassifications Are Not Permitted

Under the broad authority delegated to the Secretary by section 1886(d)(10) of the Act, in the May 4 proposed rule, we proposed that a hospital that is reclassified to an area for purposes of the wage index may not extend the 3-year effect of the reclassification under section 304(a) of Public Law 106-554 by subsequently applying for reclassification to the same area for purposes of the wage index for a fiscal

year that would be within the 3-year period. For example, if a hospital is reclassified for purposes of the wage index to Area A for FY 2002, is approved to receive Area A's wage index for 3 years (FYs 2002, 2003, and 2004), and reapplies to be reclassified to Area A for FYs 2003, 2004, and 2005 (3 years) for purposes of the wage index, the hospital would not be permitted to receive Area A's wage index for FY 2005 as a result of the reapplication. Instead, we proposed that if the hospital wishes to extend the FY 2002 3-year reclassification for fiscal years beyond FY 2004, it would have to apply for reclassification for FY 2005.

We believe new section 1886(d)(10)(D)(v) of the Act replaces the current annual wage index reclassification cycle with a 3-year reclassification cycle. We believe this policy was intended to provide consistency and predictability in hospital reclassification and wage index data, as well as to alleviate the year-to-year fluctuations in the ability of some hospitals to qualify for reclassification. We do not believe it was intended to be used to extend reclassifications for which hospitals otherwise would not be eligible (by reapplying during the second year of a 3-year reclassification because a hospital fears it may not be eligible for reclassification after its current 3-year reclassification expires).

c. Withdrawals of Applications and Terminations of Approved Reclassifications

(1) General

Under § 412.273(a), a hospital, or group of hospitals, may withdraw its application for reclassification at any time before the MGCRB issues its decision or, if after the MGCRB issues its decision, within 45 days of publication of our annual notice of proposed rulemaking concerning changes to the inpatient hospital prospective payment system and proposed payment rates for the fiscal year for which the application was filed. In the May 4 proposed rule, we proposed that the withdrawal procedures and the applicable timeframes in the existing regulations would apply to hospitals that would receive 3-year reclassification for wage index purposes. For example, if a hospital applied for reclassification to Area A for purposes of the wage index for FY 2002, but wished to withdraw its application, it must have done so prior to the MGCRB issuing a decision on its application or, if the MGCRB issued such a decision, within 45 days of the publication date of the proposed rule

(that is, by June 18, 2001). Such a withdrawal, if effective, means that the hospital would not be reclassified to Area A for purposes of the wage index for FY 2002 (and would not receive continued reclassification for FYs 2003 and 2004), unless the hospital subsequently cancels its withdrawal (as discussed below). In other words, a withdrawal, if accepted, prevents a reclassification from ever becoming effective.

On the other hand, a reclassification decision that is terminated upon the request of the hospital has partial effect. Section 1886(d)(10)(D)(v) of the Act, as added by section 304(a) of Public Law 106-554, provides that a reclassification for purposes of the wage index is effective for 3 years "except that the Secretary shall establish procedures under which a . . . hospital may elect to terminate such reclassification before the end of such period." Consistent with section 1886(d)(10)(D)(v) of the Act, we proposed to allow a hospital to terminate its approved 3-year reclassification for 1 or 2 years of the 3-year effective period (§ 412.273(b)). This is a separate action from a reclassification withdrawal, which occurs following the initial decision by the MGCRB. A termination would occur during subsequent years. For example, a hospital that has been reclassified for purposes of the wage index for FY 2001 is also reclassified for FYs 2002 and 2003 (3 years). Such a hospital could terminate its approved reclassification so that the reclassification is effective only for FY 2001, or only for FYs 2001 and 2002. Consistent with the prospective nature of reclassifications, we proposed to not permit a hospital to terminate its approved 3-year reclassification for part of a fiscal year. A termination would be effective for the next fiscal year. In order to terminate an approved 3-year reclassification, we would require the hospital to notify the MGCRB in writing within 45 days of the publication date of the annual proposed rule for changes to the inpatient hospital prospective payment system. A termination, unless subsequently cancelled (as discussed below), is effective for the balance of the 3-year period.

We established a special procedural rule for handling FY 2001 reclassifications. As noted above, the amendments made by section 304(a) of Public Law 106-554 are effective for reclassifications for FYs 2001 and beyond, and reclassification decisions for FY 2001 had already been implemented prior to the date of enactment of section 304(a). We deemed those hospitals that were reclassified for

FY 2001 to be reclassified for FYs 2002 and 2003. Therefore, if a deemed hospital that was reclassified for purposes of the wage index for FY 2001 wished to terminate its reclassification for FY 2002 and FY 2003, the hospital had to notify the MGCRB in writing by June 18, 2001 (that is, within 45 days after the publication of the proposed rule).

(2) Cancellation of a Withdrawal of Application or a Termination of an Approved Reclassification

In the May 4 proposed rule, we proposed that if a hospital elects to withdraw its 3-year reclassification application after the MGCRB has issued its decision, it may cancel its withdrawal in a subsequent fiscal year and request the MGCRB to reinstate its reclassification for the remaining fiscal years of the 3-year reclassification period. (This proposal was consistent with our proposal that 3-year reclassification periods may not overlap, as discussed in section IV.G.1.b. of this preamble.) Alternatively, a hospital may apply for reclassification to a different area (that is, an area different from the one to which it was originally reclassified), and if successful, the reclassification effect would be for 3 years.

Similarly, and for the same reasons, we proposed that if a hospital elects to terminate its accepted 3-year reclassification prior to the second or third year of that reclassification, it may cancel that termination and have its original reclassification reinstated for the duration of the original 3-year period. Alternatively, a hospital could apply for reclassification to a different area after terminating a prior 3-year reclassification and receive a new 3-year period of reclassification.

*Example 1:* Hospital A files an application and the MGCRB issues a decision to reclassify it to Area B for purposes of wage index for FY 2002 through FY 2004 (3 years). Within 45 days after the publication of the proposed rule, Hospital A withdraws its application. Within the time for applying for a FY 2003 reclassification, Hospital A cancels its withdrawal for classification to Area B. Its reclassification to Area B is reinstated, but only for FYs 2003 and 2004.

*Example 2:* Hospital B files an application for reclassification for wage index purposes for FY 2002 through FY 2004 and the MGCRB issues a decision for reclassification to Area C. Within 45 days after publication of the proposed rule, Hospital B withdraws its application. Hospital B does not cancel its withdrawal of the application. Hospital B timely applies and is reclassified to Area D for 3 years, beginning with FY 2003. In this case, the reclassification to Area D would be for FYs 2003 through 2005.

*Example 3:* Hospital C is reclassified to Area A for purposes of the wage index for FY 2002, and terminates its 3-year reclassification effective for FYs 2003 and 2004. Within the timeframe for applying for FY 2004 reclassification, Hospital C cancels its termination. Its reclassification to Area A would be reinstated for FY 2004 only.

*Example 4:* Hospital D has the same circumstances as Hospital C in Example 3, except that instead of canceling its termination, Hospital D applies and is reclassified to Area B for FY 2004. In this case, the reclassification would be for FYs 2004 through 2006.

d. Special Rules for Group Reclassifications

Section 412.232 discusses situations where all hospitals in a rural county are seeking urban redesignation, and § 412.234 discusses criteria where all hospitals in an urban county are seeking redesignation to another urban county. In these cases, hospitals submit an application as a group, and all hospitals in the county must be a party to the application. The reclassification is effective both for purposes of the wage index and the standardized amount of the area to which the hospitals are reclassified.

Section 304(a) of Public Law 106-554 does not specifically address the group reclassification situations under §§ 412.232 and 412.234. However, we believe that, in the case of hospitals reclassified under these group reclassification procedures, it would be appropriate to extend the 3-year reclassification provision to these situations for the wage index only. In order to be reclassified for the standardized amount during the second and third years of a 3-year reclassification for the wage index, the hospitals located in these counties would have to reapply on an annual basis to the MGCRB either as a group or as individual hospitals and meet the criteria outlined in § 412.232, § 412.234, or § 412.230, as appropriate.

Hospitals that are part of a group reclassification would be able to terminate their 3-year wage index reclassifications in the same manner as described above. If one hospital within the group elects to terminate its 3-year wage index reclassification, the reclassification of other hospitals in the group would be unaffected. The same rules for withdrawing from a group reclassification that are in effect now would continue. That is, all of the hospitals that are party to a group reclassification application must consent for a withdrawal to be approved.

Under section 152(b) of Public Law 106-113, hospitals in certain counties

were deemed to be located in specified areas for purposes of payment under the hospital inpatient prospective payment system, for discharges occurring on or after October 1, 2000. For payment purposes, these hospitals are to be treated as though they were reclassified for purposes of both the standardized amount and the wage index. Section 152(b) also requires that these reclassifications be treated for FY 2001 as though they are reclassification decisions by the MGCRB. For purposes of applying the 3-year extension of wage index reclassifications, we proposed to extend section 1886(d)(10)(D)(v) to hospitals reclassified under section 152(b) of Public Law 106-113. These hospitals also would have to apply for the standardized amount on an annual basis to the MGCRB.

e. Administrator Authority to Cancel Inappropriate Reclassification Decisions

In the proposed rule we indicated that, under the provisions of § 412.278(g), the Administrator has the authority to review an inappropriate reclassification decision made by the MGCRB, as discovered by either the hospital or CMS, including 3-year reclassifications in the second and third years. The statement that this authority extended to the second and third years of 3-year reclassification was in error. Under the statute and our regulations, reclassification decisions are unreviewable once they become final. This principle applies to 3-year reclassification decisions. Once such a decision becomes final, it is unreviewable thereafter.

*Comment:* Several commenters expressed concern that we proposed that a hospital that is reclassified to an area for purposes of the wage index may not extend the 3-year effect of the reclassification under section 304(a) of Public Law 106-554, by subsequently applying for reclassification to the same area for purposes of the wage index for a fiscal year that would be within the 3-year period. These commenters argued that there is nothing in the statutory language that prohibits hospitals that are already approved for 3-year reclassifications from reapplying within that 3-year period to extend their reclassifications into future years. These commenters also pointed out that extending their wage index reclassifications in this way allows them to make budgetary commitments further into the future and fosters a more stable operating environment for their hospitals.

*Response:* Under section 1886(d)(10) of the Act, the Secretary has broad authority to establish policies and

criteria with respect to the evaluation and approval of applications for reclassification. As indicated in the proposed rule, we believe that new section 1886(d)(10)(D)(v) of the Act, as added by section 304(a) of Public Law 106-554, replaces the annual reclassification cycle with a 3-year reclassification cycle. We believe that, if a hospital is already reclassified to a given geographic area for a 3-year period, it is appropriate to avoid expending resources to evaluate an application for reclassification to that same area for the second and third years of the 3-year period. Thus, if a hospital is already reclassified for a given fiscal year, and submits an application for reclassification to the same area for the same year, that application will not be approved. We are adding language to § 412.230(a)(5)(v) in this final rule to specify that an application for reclassification will not be approved under these circumstances.

*Comment:* One commenter supported our proposal to reclassify a hospital based on its FY 2002 approval unless the hospital notified the MGCRB otherwise by June 18, 2001. This commenter questioned whether or not hospitals would have this same option in future years. In other words, if a hospital successfully sought reclassification to a different area for FY 2003 and then withdrew that reclassification, would that hospital have the option to fall back on the FY 2002 reclassification, or would it then not be reclassified.

*Response:* We appreciate the commenter's support of our proposal on this issue. This was specifically put in place because the new 3-year reclassification policy was not enacted until well after the reclassification process for FY 2002 was underway. Therefore, some hospitals may have sought reclassification to a different area or for a different purpose than they did for FY 2001, and the option to carry forward a FY 2001 wage index reclassification for 3 years may have changed their decisions.

This policy applies in future years as well. For example, a hospital that successfully seeks reclassification for the wage index for FY 2004 to Area A, then successfully seeks reclassification for FY 2005 for the wage index to Area B, has the option to withdraw its FY 2005 decision, thereby reinstating its FY 2004 decision. However, if the hospital successfully withdraws its FY 2005 decision, the hospital cannot return to its FY 2005 decision without reapplying at a later date.

*Comment:* Several commenters expressed uncertainty about the timing

of the extension of the wage index reclassification for 3 years. Some hospitals had successfully applied for FY 2001 as well as FY 2002 to the same area for the wage index, and it was not clear to these hospitals whether their wage index reclassifications were effective through FY 2003 or through FY 2004.

*Response:* As noted above, section 304(a) provides for 3-year wage index reclassifications effective with FY 2001 reclassifications. In the case of hospitals reclassified to the same area for both FY 2001 and FY 2002, because hospitals had already submitted their FY 2002 applications prior to enactment of Public Law 106-554, and the MGCRB had already issued its decision on these applications prior to publication of the May 4 proposed rule, we will consider FY 2002 to be the first year of the 3-year reclassification for these hospitals. Therefore, the reclassification period will extend through FY 2004. If a hospital was approved for FY 2001 for a wage index reclassification, but was unsuccessful in seeking a wage index reclassification for FY 2002, then its wage index reclassification would be effective for FY 2001, FY 2002, and FY 2003, and the hospital would have to reapply to seek reclassification for FY 2004.

*Comment:* One commenter supported our proposal that a hospital could cancel its withdrawal of an approved reclassification for the wage index in a future year in order to reinstate its original MGCRB approval.

*Response:* We appreciate the commenter's support of our proposal that hospitals reclassified for the wage index that then withdraw that approval have the ability to cancel the withdrawal, in effect reinstating the hospital's original reclassification approval for the wage index. We provided this option so that a hospital that later discovers that the withdrawal of its approved wage index reclassification was disadvantageous would have the ability to reinstate its MGCRB approval for the wage index for the remaining years in the 3-year term. However, a hospital is eligible to revert to its most recent MGCRB approval only.

In addition, the same process applies to cancellations of a withdrawal or termination as applies to requests for withdrawals and terminations. A hospital must request a cancellation of its withdrawal or termination within the 45-day period after the proposed rule is published, and that cancellation will become effective for the following Federal fiscal year.

*Comment:* Several commenters supported our proposal to extend the 3-year reclassification provision for the wage index to those hospitals that were reclassified for FY 2001 under section 152(b) of Public Law 106-113. While these hospitals did not successfully apply for reclassification through the MGCRB, they were effectively "reclassified" by this legislation, and the commenters believed that it would be correct to extend the 3-year wage index reclassification to this group of hospitals.

*Response:* We appreciate the commenters' support of our proposal. Section 152(b) of Public Law 106-113 required that the assignment of these hospitals to alternative geographic areas should be treated as if they were decisions of the MGCRB. As a result, these hospitals will be reclassified for the wage index to their designated areas for FY 2002 and FY 2003. They will be required to apply for reclassification to the MGCRB for FY 2004 if they wish to retain this reclassification for subsequent years.

## 2. Three-Year Average Hourly Wages

Section 304(a) of Public Law 106-554 amended section 1886(d)(10)(D) of the Act by adding clause (vi) which provides that the MGCRB must use the average of the 3 most recent years of hourly wage data for the hospital when evaluating a hospital's request for reclassification. Specifically, the MGCRB must base its evaluation on an average of the average hourly wage for the most recent years for the hospital seeking reclassification and the area to which the hospital seeks to reclassify. This provision is effective for reclassifications for FY 2003 and subsequent years. (Section III.F. of this preamble discusses the development and application of the hospital's 3-year average hourly wage data (Table 2 in the Addendum to this final rule) that the MGCRB will use to evaluate hospitals' applications for reclassifications for FY 2003; and the MSA and statewide rural 3-year average hourly wage data (Tables 3A and 3B in the Addendum to this final rule) for hospital reclassification applications for FY 2003.)

In the May 4, 2001 proposed rule, we proposed to revise §§ 412.230(e)(2) and 412.232(d)(2) to incorporate the provisions of section 1886(d)(10)(D)(vi) of the Act as added by section 304(a) of Public Law 106-554. Specifically, we provided that, for redesignations effective beginning FY 2003, for hospital-specific data, the hospital must provide a 3-year average of its average hourly wages using data from our hospital wage survey used to construct

the wage index in effect for prospective payment purposes. For data for other hospitals, we proposed to require hospitals to provide a 3-year average of the average hourly wage in the area in which the hospital is located and a 3-year average of the average hourly wage in the area to which the hospital seeks reclassification. The wage data would be taken from the CMS hospital wage survey used to construct the wage index for prospective payment purposes, as published in Tables 2, 3A, and 3B of this final rule (unless those data are subsequently changed by CMS). The 3-year averages are calculated by dividing the sum of the dollars (adjusted to a common reporting period using the method described in section III. of this final rule) across all 3 years, by the sum of the hours.

*Comment:* Several commenters responded positively to our proposal to use a 3-year average of the most recent 3 years of average hourly wages based on data from our hospital wage survey used to construct the wage index when evaluating a hospital's request for reclassification. Under the proposal, if data does not exist for all 3 years, the available data within the 3-year period will be used to construct the average.

While it was clear to these commenters that these data will be used to construct the average hourly wage for a hospital applying for reclassification, they noted it was not clear to them whether the 3-year average would also be used for the area in which that hospital is physically located as well as the area to which that hospital seeks reclassification.

*Response:* We appreciate the commenters' support of our proposal to calculate the 3-year average hourly wage based on the data available during the applicable 3-year period, even if a hospital does not have data in all 3 years.

As noted above, the MGRB will evaluate applications using the 3-year average hourly wages for hospitals and geographic areas as published in Tables 2, 3A, and 3B of this final rule (unless those data are subsequently changed by CMS).

*Comment:* One commenter requested that in cases of a change in ownership, a hospital be permitted the option of excluding prior years' wage data submitted by a previous owner for the purpose of calculating the average of the average hourly wages in order to qualify for reclassification. As a result, the average of the average hourly wages would be based on current and prior year data submitted by the new owner only.

*Response:* We believe we should treat these cases in a manner consistent with how we treat hospitals whose ownership has changed for other Medicare payment purposes. That is, where a hospital has simply changed ownership and the new owners have acquired the assets and liabilities of the previous owners, all of the applicable wage data associated with that hospital are included in the calculation of its 3-year average hourly wage. On the other hand, in the case of a new hospital, where there is no legal obligation to the operations of a predecessor hospital, the wage data associated with the previous hospital's provider number would not be used in calculating the new hospital's 3-year average hourly wage.

### 3. Statewide Wage Index

As stated earlier, section 304(b) of Public Law 106-554 provides for a process under which an appropriate statewide entity may apply to have all the geographic areas in the State treated as a single geographic area for purposes of computing and applying the area wage index for reclassifications beginning in FY 2003.

Section 304 does not indicate the duration of the application of these statewide wage indexes. However, it should be noted that the statutory language does refer to these applications as reclassifications. In the May 4, 2001 proposed rule, we proposed that these statewide wage index applications be processed similar to MGRB applications, with the same effective dates of the decisions and the withdrawal and termination process. Therefore, similar to wage index reclassification decisions under section 1886(d)(10)(D)(v) of the Act as added by section 304(a) of Public Law 106-554, the statewide wage index reclassification would be effective for a total of 3 years. The same deadlines and timetable applicable to MGRB reclassification applications would apply for statewide wage index applications.

We proposed to establish a new § 412.235 to include the requirements for statewide wage indexes. We proposed to apply the following criteria to determine whether hospitals would be approved for a statewide geographic wage index reclassification (§ 412.235(a)):

- There must be unanimous support for a statewide wage index among hospitals in the State in which the statewide wage index would be applied. We would require a signed affidavit on behalf of all the hospitals in the State of this support as part of the application for reclassification.

- All hospitals in the State must apply through a signed single application for the statewide wage index in order for the application to be considered by the MGRB. We believe this is necessary to ensure that every hospital in the State is included in the application, since the payment of every hospital would be affected by the statewide wage index.

- There must be unanimous support for the termination or withdrawal of a statewide wage index among hospitals in the State in which the statewide wage index would be applied. We would require a signed affidavit for this agreement.

- All hospitals in the State waive their rights to any wage index that they would otherwise receive absent the statewide wage index, including a wage index that any of the hospitals might have received through individual or group geographic reclassification under § 412.273(a).

An individual hospital within the State may receive a wage index that could be higher or lower under the statewide wage index reclassification in comparison to its wage index otherwise (§ 412.235(b)). Specifically, hospitals must be aware that there may be a reduction in the wage index as a result of participation on a statewide basis.

In addition, we proposed to consider statewide wage index applications under the same process we use for hospital reclassification applications, including the effective dates of the MGRB decision and the withdrawal and termination process (§ 412.235(c)). We proposed that applications for the statewide wage index would be effective for 3 years beginning with discharges occurring on the first day (October 1) of the second Federal fiscal year following the Federal fiscal year in which the hospitals file a complete application unless all of the participating hospitals withdraw their application or terminate their approved statewide wage index reclassification earlier, as discussed below. Once approved by the MGRB, an application for a statewide wage index can only be withdrawn or terminated as a result of a signed affidavit on behalf of all the hospitals in the State indicating their request that the statewide reclassification be withdrawn or terminated. A request for withdrawal or termination must be submitted within 45 days of the publication of the annual proposed rule for the inpatient hospital prospective payment system announcing the reclassification. New hospitals that open prior to the September 1 deadline for submitting an application for a statewide wage index, but after a group

application has been submitted, would be required to agree to the statewide wage index in order for the group application to remain viable. New hospitals that open after the deadline for submitting an application would receive the statewide wage index. The agreement of new hospitals would also be required in order to withdraw or terminate a statewide wage index reclassification. The rules discussed under section IV.G.1.c. of this preamble for withdrawals of applications and terminations of approved 3-year wage index reclassification decisions would apply to decisions regarding statewide wage index reclassifications.

*Comment:* Several commenters believed that Washington, DC should be recognized as a State for purposes of this statewide wage index reclassification policy. However, they were concerned that, while such a recognition may benefit hospitals located in Washington, DC, it may not benefit hospitals that are currently located outside of Washington, DC but within the Washington, D.C.–MD–VA–WV MSA. As a result, while these commenters believed that Washington, DC should be recognized as a State for this purpose, they also requested guidance about how the remainder of the hospitals in the current MSA would be treated.

One commenter did not believe that Washington, DC should be considered a State for this purpose. However, this commenter also stated that, should we decide that Washington, DC could be considered a State for this purpose, we should configure the criteria such that none of the hospitals that are currently located in the Washington, D.C.–MD–VA–WV MSA would be harmed.

*Response:* Section 304(b) of Public Law 106–554 directs the Secretary to establish a process “under which an appropriate statewide entity may apply to have all the geographic areas in a State treated as a single geographic area for purposes of computing and applying the area wage index under section 1886(d)(3)(E) of [the Social Security] Act. \* \* \*” Most States encompass multiple labor market areas (urban MSAs and rural areas) with differing wage indexes, and we believe that the intent of section 304(b) is to offer hospitals within a State the opportunity to eliminate the disparate wage indexes resulting from separate urban and rural labor market areas within the State. However, hospitals in Washington, DC are not subject to disparate wage indexes. Washington, DC is part of a larger labor market area where all the hospitals receive the wage index for that labor market area (subject to MGRB

reclassifications). Put another way, Washington, DC is *already* “treated as a single geographic area” for purposes of the hospital wage index.

If we treated Washington, DC as a separate distinct labor market area and applied the usual wage index methodology, Washington, DC hospitals might reap a significant windfall and the hospitals remaining in the MSA might be disadvantaged. Given the intended purpose of section 304(b), we believe that such results would be inappropriate. We believe that Congress did not intend for section 304(b) to address the type of situation presented by Washington, DC.

As indicated above, section 304(b) permits a State to be treated as a single geographic area “for purposes of computing and applying the area wage index under section 1886(d)(3)(E) of [the] Act.” Section 304(b) does not specify how to compute and apply the wage index for statewide geographic areas. Under section 1886(d)(3)(E) of the Act, the Secretary has broad authority to develop and apply the methodology for determining the wage index for labor market areas, and section 304(b) did not limit the agency’s authority. Thus, even if Washington, DC is a State for purposes of section 304(b), the Secretary has broad authority under section 1886(d)(3)(E) to determine the wage index for all affected hospitals. Given the purpose of section 304, and to avoid conferring an inappropriate and unintended windfall (or disadvantage) to hospitals, we are providing (pursuant to our broad authority under section 1886(d)(3)(E) of the Act) that, even if Washington, DC is a State for purposes of section 304(b) of Public Law 106–554, the wage index applicable to the Washington, DC “statewide” geographic area would be the same wage index that would apply to the Washington, DC–MD–VA–WV MSA as a whole (which would be calculated by including Washington, DC hospitals, in accordance with all applicable rules).

#### *H. Payment for Direct Costs of Graduate Medical Education (§ 413.86)*

##### 1. Background

Under section 1886(h) of the Act, Medicare pays hospitals for the direct costs of graduate medical education (GME). The payments are based in part on the number of residents trained by the hospital. Section 1886(h) of the Act, as amended by section 4623 of Public Law 105–33, caps the number of residents that hospitals may count for direct GME.

Section 1886(h)(2) of the Act, as amended by section 9202 of the

Consolidated Omnibus Reconciliation Act (COBRA) of 1985 (Public Law 99–272), and implemented in regulations at § 413.86(e), establishes a methodology for determining payments to hospitals for the costs of approved GME programs. Section 1886(h)(2) of the Act, as amended by COBRA, sets forth a payment methodology for the determination of a hospital-specific, base-period per resident amount (PRA) that is calculated by dividing a hospital’s allowable costs of GME for a base period by its number of residents in the base period. The base period is, for most hospitals, the hospital’s cost reporting period beginning in FY 1984 (that is, the period of October 1, 1983 through September 30, 1984). The PRA is multiplied by the number of FTE residents working in all areas of the hospital complex (or nonhospital sites, when applicable), and the hospital’s Medicare share of total inpatient days to determine Medicare’s direct GME payments. In addition, as specified in section 1886(h)(2)(D)(ii) of the Act, for cost reporting periods beginning on or after October 1, 1993, through September 30, 1995, each hospital’s PRA for the previous cost reporting period is not updated for inflation for any FTE residents who are not either a primary care or an obstetrics and gynecology resident. As a result, hospitals with both primary care and obstetrics and gynecology residents and nonprimary care residents have two separate PRAs beginning in FY 1994: one for primary care and obstetrics and gynecology and one for nonprimary care.

Section 1886(h)(2) of the Act was further amended by section 311 of Public Law 106–113 to establish a methodology for the use of a national average PRA in computing direct GME payments for cost reporting periods beginning on or after October 1, 2000, and on or before September 30, 2005. Generally, section 1886(h)(2) of the Act establishes a “floor” and a “ceiling” based on a locality-adjusted, updated, weighted average PRA. Each hospital’s PRA is compared to the floor and ceiling to determine whether its PRA should be revised. PRAs that are below the floor, that is, 70 percent of the locality-adjusted, updated, weighted average PRA, would be revised to equal 70 percent of the locality-adjusted, updated, weighted average PRA. PRAs that exceed the ceiling, that is, 140 percent of the locality-adjusted, updated, weighted average PRA, would, depending on the fiscal year, either be frozen and not increased for inflation, or increased by a reduced inflation factor.

We implemented section 311 of Public Law 106–113 in the hospital inpatient prospective payment system final rule published on August 1, 2000 (65 FR 47090). In that final rule, we set forth the methodology for calculating the weighted average PRA and outlined the steps for determining whether a hospital's PRA would be revised.

2. Amendments Made by Section 511 of Public Law 106–554  
(§ 413.86(e)(4)(ii)(C) and (e)(5)(iv))

Section 511 of Public Law 106–554 amended section 1886(h)(2)(D)(iii) of the Act by increasing the floor to 85 percent of the locality-adjusted national average PRA. In general, section 511 provides that, effective for cost reporting periods beginning on or after October 1, 2001, and before October 1, 2002, PRAs that are below 85 percent of the respective locality-adjusted national average PRA would be increased to equal 85 percent of that locality-adjusted national average PRA. Accordingly, we proposed to implement section 511 by revising § 413.86(e)(4)(ii)(C)(1) to incorporate this change and by outlining the methodology for determining whether a hospital's PRA(s) will be adjusted in FY 2002 relative to the increased floor of the locality-adjusted national average PRA.

In the August 1, 2000 final rule (65 FR 47091 and 47092), as implemented at § 413.86(e)(4), we determined, in accordance with section 311 of Public Law 106–113, that the weighted average PRA for cost reporting periods ending during FY 1997 is \$68,464. We described the procedures for updating the weighted average PRA of \$68,464 for inflation to FY 2001 and for adjusting this average for the locality of each individual hospital. We then outlined the steps for comparing each hospital's PRA(s) to the locality-adjusted national average PRA to determine if, for cost reporting periods beginning on or after October 1, 2000, and before October 1, 2001, the PRAs should be revised to equal the 70-percent floor.

In accordance with section 511 of Public Law 106–554, in the May 4 proposed rule, we proposed that, for cost reporting periods beginning during FY 2002, the FY 2002 PRAs of hospitals that are below 85 percent of the respective locality-adjusted national average PRA for FY 2002 be increased to equal 85 percent of that locality-adjusted national average PRA. Specifically, to determine which PRAs (primary care and nonprimary care separately) for each hospital are below the 85-percent floor, each hospital's locality-adjusted national average PRA

for FY 2002 is multiplied by 85 percent. This resulting number is then compared to each hospital's PRA that is updated for inflation to FY 2002. If the hospital's PRA would be less than 85 percent of the locality-adjusted national average PRA, the individual PRA is *replaced* with 85 percent of the locality-adjusted national average PRA for that cost reporting period, and in future years the new PRA would be updated for inflation by the Consumer Price Index for All Urban Consumers (CPI-U) as compiled by the Bureau of Labor Statistics.

There may be some hospitals with both primary care and nonprimary care PRAs that are below the floor, and both PRAs are, therefore, replaced with 85 percent of the locality-adjusted national average PRA. In these situations, the hospitals would receive a single PRA; a distinction between PRAs would no longer be made based on the different inflation adjustments (under § 413.86(e)(3)(ii)). On the other hand, hospitals may have primary care PRAs that are above the floor, and nonprimary care PRAs that are below the floor. In these situations, only the nonprimary care PRAs would be revised to equal 85 percent of the locality-adjusted national average PRA, and the prior year primary care PRAs would be updated for inflation by the CPI-U. An example of application of this provision appeared in the preamble of the May 4, 2001 proposed rule (66 FR 33697).

We note that section 511 of Public Law 106–554 only affects hospitals with PRAs below the 85-percent floor, and does not affect hospitals with PRAs that are either between the floor and ceiling or exceed the ceiling. Thus, with the exception of the change in the floor as provided by section 511, the policy regarding the use of a national average PRA for making direct GME payments remains as implemented in the regulations at § 413.86(e)(4).

We proposed to amend § 413.86(e)(4)(ii)(C)(1) to add the rules implementing section 1886(h)(2)(D)(iii) of the Act as amended by section 511 of Public Law 106–554.

We also proposed to amend § 413.86(e)(5) regarding the determination of base year PRAs for new teaching hospitals for cost reporting periods beginning during FYs 2001 through 2005. In the August 1, 2000 final rule, we made a conforming change to § 413.86(e)(5) to account for situations in which hospitals do not have a 1984 base year PRA and establish a PRA in a cost reporting period after the 1984 base year. Existing § 413.86(e)(5)(iv) specifies that the new base year PRAs of such hospitals are subject to the regulations regarding the

floor and the ceiling of the locality-adjusted national average PRA. Although the determination of new base year PRAs is subject to the national average methodology, it is not necessary to include this provision in the regulations. Therefore, we proposed to remove § 413.86(e)(5)(iv).

In the proposed rule, we clarified that, for purposes of calculating a base year PRA for a new teaching hospital, when calculating the weighted mean value of PRAs of hospitals located in the same geographic area or the weighted mean value of the PRAs in the hospital's census region (as defined in § 412.62(f)(1)(i)), the PRAs used in the weighted average calculation must not be less than the floors for cost reporting periods beginning during FY 2001 or FY 2002, or if they exceed the ceiling, they must either be frozen for FYs 2001 and 2002 or updated with the CPI-U minus 2 percent for FYs 2003 through 2005. In addition, existing § 413.86(e)(5) provides that the PRA for a new teaching hospital is based on the *lower* of the hospital's actual costs incurred in connection with the GME program or the weighted mean value of PRAs. If a hospital's actual costs of the GME program during its cost reporting period beginning during FY 2001 or FY 2002 are *less* than the floors, the hospital's PRA would *not* be based on the actual costs. Instead, it would be equal to 70 percent in FY 2001, or 85 percent during FY 2002, of the locality-adjusted national average PRA. The floor applies to hospitals with existing PRAs in FYs 2001 and 2002, or to hospitals that are establishing new base year PRAs in FYs 2001 and 2002. We proposed to clarify that if a hospital establishes a new base year PRA in a cost reporting period beginning *after* FY 2002, its PRA would *not* be increased to equal the floor if it is less than the floor. Similarly, the ceiling applies to hospitals with existing PRAs in FYs 2001 through 2005, or to hospitals that are establishing new base year PRAs in FYs 2001 through 2005.

*Comment:* One commenter believed that the provision to increase the PRA floor to 85 percent of the locality-adjusted national average will address many concerns about the fairness of GME payments. One commenter asked if the provisions of the proposed rule to increase PRAs that are less than 85 percent of the locality-adjusted national average PRA to equal 85 percent of the locality-adjusted national average PRA would provide relief to hospitals who do not have base year PRAs established in the 1984 base year and could not increase their PRAs because the appeal period has elapsed.

*Response:* Section 511 of the Public Law 106-554 amended section 1886(h)(2)(D)(iii) of the Act by increasing the floor to 85 percent of the locality adjusted national average PRA. Effective for cost reporting periods beginning on or after October 1, 2001 and before October 1, 2002, any PRAs that are below 85 percent of the respective locality-adjusted national average PRA would be increased to equal 85 percent of that locality-adjusted national average PRA. Accordingly, hospitals with PRAs (primary care and/or nonprimary care) that are less than 85 percent of the respective locality-adjusted national average PRA for the hospital's cost reporting period beginning on or after October 1, 2001 and before October 1, 2002, will have those PRAs increased to equal 85 percent of that locality-adjusted national average PRA. This provision sets the floor on per resident amounts for cost reporting periods beginning during FY 2002, regardless of the base year used to establish the hospital's PRA.

*Comment:* One commenter requested that we clarify the references in the preamble stating that the national average PRA methodology is applicable for "cost reporting periods beginning on

or after October 1, 2000 and on or before September 30, 2005." The commenter believed that the PRA changes authorized in the law were meant to be permanent, and therefore, did not understand the basis for the September 30, 2005 endpoint.

*Response:* The changes made to a hospital's PRA as a result of section 311 of Public Law 106-113 and section 511 of Public Law 106-554 are permanent. However, this *new methodology* for determining whether or not a hospital's PRA is *revised*, as described in the statute, is only effective for cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2005. For cost reporting periods beginning on or after October 1, 2005, a hospital's PRA, *whether or not it was revised by the new methodology*, is updated with the full CPI-U, using the procedures in place prior to October 1, 2000. If a hospital's PRAs are below the floors, they will be revised accordingly in FYs 2001 or 2002, or both. After FY 2002, that hospital's revised PRA will be updated for inflation as usual, that is, using the procedures in place for all PRAs prior to October 1, 2000. If a hospital's PRAs exceed the ceiling, the PRAs would be frozen in FYs 2001 and 2002, and

updated with a reduced inflation factor in FYs 2003, 2004, and 2005. Thus, after September 30, 2005, although any changes made to a hospital's PRAs as a result of the new methodology would remain in place, the procedure for updating PRAs reverts back to the procedure in place prior to October 1, 2000, that is, updating for inflation with the full CPI-U.

*Comment:* One commenter requested that we publish in the final rule the CPI-U factors that must be used to update the 1997 national average PRA to the midpoint of a hospital's cost reporting period beginning in FY 2001.

*Response:* As the commenter requested, we are including below the CPI-U factors. For cost reporting periods beginning on or after October 1, 2000 and before October 1, 2001, the following update factors should be used when implementing section 311 of Public Law 106-113. Specific instructions for applying these factors can be found in the hospital inpatient prospective payment system final rule published on August 1, 2000 (65 FR 47091). (Refer to the bottom of the middle column and the right column on page 47091 for "Step 1: Update the weighted average PRA for inflation".)

**GME UPDATE FACTORS FOR MIDPOINT OF PERIODS ENDING IN FY 1997 TO COST REPORTING PERIODS BEGINNING IN FY 2001 USING THE CPI (U)—ALL ITEMS**

Update weighted average PRA from:	To midpoint of cost reporting period beginning:	Use update factor of: *
October 1, 1996 .....	October 1, 2000 .....	1.11200
October 1, 1996 .....	November 1, 2000 .....	1.11389
October 1, 1996 .....	December 1, 2000 .....	1.11579
October 1, 1996 .....	January 1, 2001 .....	1.11800
October 1, 1996 .....	February 1, 2001 .....	1.12053
October 1, 1996 .....	March 1, 2001 .....	1.12307
October 1, 1996 .....	April 1, 2001 .....	1.12465
October 1, 1996 .....	May 1, 2001 .....	1.12528
October 1, 1996 .....	June 1, 2001 .....	1.12591
October 1, 1996 .....	July 1, 2001 .....	1.12780
October 1, 1996 .....	August 1, 2001 .....	1.13097
October 1, 1996 .....	September 1, 2001 .....	1.13414

\* Source: Forecast by Standard and Poor's DRI; Historical Data through August 2000.

**3. Determining the 3-Year Rolling Average for Direct GME Payments (§ 413.86(g)(4) and (g)(5))**

Section 1886(h)(4)(G)(iii) of the Act, as added by section 4623 of Public Law 106-33, provides that for the hospital's first cost reporting period beginning on or after October 1, 1997, the hospital's weighted FTE count for direct GME payment purposes equals the average of the weighted FTE count for that cost reporting period and the preceding cost reporting period. For cost reporting periods beginning on or after October 1,

1998, section 1886(h)(4)(G) of the Act requires that hospitals' direct medical education weighted FTE count for payment purposes equal the average of the actual weighted FTE count for the payment year cost reporting period and the preceding two cost reporting periods (rolling average). This provision phases in the associated reduction in payment over a 3-year period for hospitals that are reducing their number of residents.

In the August 29, 1997 final rule with comment period (62 FR 46004), we revised § 413.86(g)(5) accordingly, and outlined the methodology for

determining a hospital's direct GME payment. Based on what we explained in the 1997 final rule, for cost reporting periods beginning on or after October 1, 1997, we would determine a hospital's direct GME payment as follows:

*Step 1.* Determine the average of the weighted FTE counts for the payment year cost reporting period and the prior two immediately preceding cost reporting periods (with exception of the hospital's first cost reporting period beginning on or after October 1, 1997, which will be based on the average of the weighted average for that cost

reporting period and the immediately preceding cost reporting period).

*Step 2.* Determine the hospital's direct GME amount without regard to the FTE cap (before determining Medicare's share). That is, take the sum of (a) the product of the primary care PRA and the primary care weighted FTE count in the current payment year, and (b) the product of the nonprimary care PRA and the nonprimary care weighted FTE count in the current payment year.

*Step 3.* Divide the hospital's direct GME amount by the total number of FTE residents (including the effect of weighting factors) for the cost reporting period to determine the weighted average PRA (this amount reflects the FTE weighted average of the primary and nonprimary care PRAs) for the cost reporting period.

*Step 4.* Multiply the weighted average PRA for the cost reporting period by the 3-year average weighted count to determine the hospital's allowable direct GME costs. This product is then multiplied by the hospital's Medicare patient load for the cost reporting period to determine Medicare's direct GME payment to the hospital.

Steps 2 and 3 above describe the methodology for combining a hospital's primary care PRA and nonprimary care PRA to determine the hospital's single weighted average PRA for the payment year cost reporting period. (This step accounts for hospitals that were training residents in both primary care and nonprimary care residency programs in FYs 1994 and 1995, when, as described in § 413.86(e)(3)(ii), each hospital's PRA for the previous cost reporting period was not adjusted for any resident FTEs who were not either a primary care resident or an obstetrics and a gynecology resident. As a result, such hospitals have two PRAs for direct GME payment; one for primary care and obstetrics and gynecology residents, and one for all other, or nonprimary care, residents. Hospitals that train either only primary care (including obstetrics and gynecology) residents or only nonprimary care residents follow the methodology described above, with the exception of combining two PRAs. Step 4 then dictates that the resulting average PRA is multiplied by the 3-year rolling average, which, in turn, is multiplied by the hospital's Medicare patient load in the current year to determine Medicare's direct GME payment to the hospital for that cost reporting period.

In implementing this provision in the August 29, 1997 final rule with comment period, we believed that the methodology described above was appropriate because it was consistent with the methodology described under

section 1886(h)(3)(B) of the Act. This section specifies that, in order to arrive at the average PRA, or "aggregate approved amount," the Secretary must multiply a hospital's PRA by the "weighted average number of [FTE] residents \* \* \* in the hospital's approved medical residency training programs *in that period*" (emphasis added).

We also believed the methodology outlined above and in the August 29, 1997 rule was appropriate because it was consistent with the intent of the statute that, after October 1, 1997, direct GME payments should be based on a rolling average. Specifically, section 4623 of Public Law 106-33 provides that, "For cost reporting periods beginning on or after October 1, 1997 \* \* \* *the total number of full-time equivalent residents for determining a hospital's graduate medical education payment shall equal the average of the actual full-time equivalent resident counts for the cost reporting period and the preceding two cost reporting periods*" (emphasis added). Thus, while the statute does not include a specific methodology for computing the direct GME payments, it clearly indicates that the payment should be based on a 3-year average of the weighted number of residents, *not* the weighted number of residents in the current payment year cost reporting period.

As stated above, Congress provided that the direct GME payments should be made based on a 3-year average of the weighted number of residents in order to phase in the associated reduction in payment over a 3-year period for hospitals that are reducing the number of residents they are training. However, in steps 2 and 3 above, when combining a hospital's primary care PRA and nonprimary care PRA, we weight the respective PRAs by *current year* residents. This introduces the number of residents that a hospital is training in the *current cost reporting period* into the payment formula. A payment formula that incorporates the number of current year residents "dilutes" the effect of the rolling average as related to direct GME payments. After further consideration, we believe that, consistent with the statute, the formula should be based on rolling average counts of residents. We proposed an alternative methodology which would replace the current methodology in which the direct GME payment would be the sum of (a) the product of the primary care PRA and the primary care and obstetrics and gynecology rolling average, and (b) the product of the nonprimary care PRA and the nonprimary care rolling average. (This

sum would then be multiplied by the Medicare patient load.) The new methodology would only be used for determining direct GME payments because there is no distinction between primary care and nonprimary care residents for IME payment purposes.

The new methodology is effective for cost reporting periods beginning on or after October 1, 2001. The methodology for determining a hospital's direct GME payment is as follows:

*Step 1.* Determine that the hospital's total unweighted FTE counts in the payment year cost reporting period and the prior two immediately preceding cost reporting periods for all residents in allopathic and osteopathic medicine do not exceed the hospital's FTE cap for these residents in accordance with § 413.86(g)(4). If the hospital's total unweighted FTE count in a cost reporting period exceeds its cap, the hospital's weighted FTE count, for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced in the same proportion that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. The proportional reduction is calculated for *primary care and obstetrics and gynecology residents and nonprimary care residents separately* in the following manner:

(FTE cap/unweighted total FTEs in the cost reporting period) × (weighted primary care and obstetrics and gynecology FTEs in the cost reporting period)

plus

(FTE cap/unweighted total FTEs in the cost reporting period) × (weighted nonprimary care FTEs in the cost reporting period).

Add the two products to determine the hospital's reduced cap.

*Step 2.* Determine the 3-year average of the weighted FTE count for primary care and obstetrics and gynecology residents in the payment year cost reporting period and the two immediately preceding cost reporting periods. Determine the 3-year average of the weighted FTE count for nonprimary care residents in the payment year cost reporting period and the two immediately preceding cost reporting periods.

*Step 3.* Determine the product of the primary care PRA and the primary care and obstetrics and gynecology 3-year average from step 2. Determine the product of the nonprimary care PRA and the nonprimary care 3-year average from step 2.

*Step 4.* Sum the products of step 3.

*Step 5.* Multiply the sum from step 4 by the hospital's Medicare patient load

for the cost reporting period to determine Medicare's direct GME payment to the hospital.

Existing § 413.86(g)(5) specifies that residents in new programs are excluded from the rolling average calculation for a period of years equal to the minimum accredited length for the type of program, and are added to the payment formula after applying the averaging rules. Accordingly, for hospitals that qualify for an adjustment to their FTE caps for residents training in new programs under § 413.86(g)(6), primary care and obstetrics and gynecology residents in new programs would be added to the quotient of the primary care and obstetrics and gynecology 3-year average, and nonprimary care residents in new programs would be added to the quotient of the nonprimary care 3-year average. The sums of the respective 3-year averages and new residents would then be multiplied by the respective PRAs.

The following example illustrates the determination of direct GME payment under the proposed rolling average methodology for an existing teaching hospital with no new programs:

*Example:* Assume a hospital with a cost reporting period ending September 30, 1996 (beginning October 1, 1995) had 100 unweighted FTE residents and 90 weighted FTE residents. The hospital's FTE cap is 100 unweighted residents.

*Step 1.* In its cost reporting period beginning in FY 2000, it had 100 unweighted residents and 90 weighted residents (50 primary care and 40 nonprimary care).

- The hospital had 90 unweighted residents and 85 weighted residents (50 primary care and 35 nonprimary care) for its cost reporting period beginning in FY 2001.

- In its cost reporting period beginning in FY 2002, the hospital had 80 unweighted residents and 80 weighted residents (50 primary care and 30 nonprimary care).

*Step 2.* The 3-year average of weighted primary care and obstetrics and gynecology residents is  $(50 + 50 + 50)/3 = 50$ . The 3-year average of weighted nonprimary care residents is  $(40 + 35 + 30)/3 = 35$ .

*Step 3.* Primary care:  $\$80,000 \text{ PRA} \times 50 \text{ weighted primary care and obstetrics and gynecology FTEs} = \$4,000,000$ . Nonprimary care:  $\$78,000 \times 35 \text{ weighted nonprimary care FTEs} = \$2,730,000$ .

*Step 4.*  $\$4,000,000 + \$2,730,000 = \$6,730,000$ .

*Step 5.* If the hospital's Medicare patient load for the payment cost reporting period is .20, Medicare's direct GME payment would be  $\$6,730,000 \times .20 = \$1,346,000$ .

Whether the proposed methodology results in a payment difference for a hospital is dependent upon whether or not the number and mix (primary care and nonprimary care) of FTEs changes in a 3-year period. If the number and mix of FTEs does not change in a 3-year period, there would be no difference in a direct GME payment amount derived using the proposed methodology versus the existing methodology. For example, if a hospital has 90 weighted FTEs (50 primary care and 40 nonprimary care) in the current year and the 2 previous years (using the PRAs and the Medicare patient load from the example above), the payment amounts derived from the existing methodology and the proposed methodology would be equal.

If the number and mix of FTEs varies from year to year, there will be a difference in the results of the two methodologies. In some instances the existing methodology would result in a higher payment, and in other instances the proposed methodology would result in a higher payment. In the example above, the hospital has reduced its number of weighted residents by 5 FTEs in FYs 2001 and 2002. Calculating this hospital's direct GME payment amount using the existing methodology (using the PRAs and the Medicare patient load from the example) would result in a payment of \$1,347,250, which is \$1,250 more than \$1,346,000, the amount calculated in the example using the proposed methodology.

In a scenario where a hospital makes larger reductions to the number of FTEs, the proposed methodology may be more beneficial. For example, using the PRAs and the Medicare patient load from the example above, assume a hospital has 90 weighted FTEs (50 primary care and 40 nonprimary care) in FY 2000, 85 weighted FTEs (50 primary care and 35 nonprimary care) in FY 2001, and 70 weighted FTEs (35 primary care and 35 nonprimary care) in FY 2002. If the proposed methodology is used, the payment amount of \$1,292,050 would be calculated, which is \$1,666 more than \$1,290,386, the amount calculated if the existing methodology is used.

We proposed to revise § 413.86(g)(4) to specify that, effective for cost reporting periods beginning on or after October 1, 2001, if the hospital's total unweighted FTE count in a cost reporting period exceeds its cap, the hospital's weighted FTE count, for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced in the same proportion that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. We

also proposed to revise § 413.86(g)(5) to specify that, effective for cost reporting periods beginning on or after October 1, 2001, the direct GME payment will be calculated using two separate rolling averages, one for primary care and obstetrics and gynecology residents and one for nonprimary care residents.

*Comment:* Two commenters asked whether or not the proposed new methodology for calculating direct GME payment using two separate rolling averages for primary care and nonprimary care residents is truly an "alternative," or, if finalized, would it replace the present methodology.

*Response:* The proposed new methodology would *replace* the existing rolling average methodology effective for cost reporting periods beginning on or after October 1, 2001 (the effective date of this final rule). Hospitals training both primary care and nonprimary care residents would determine two separate rolling average counts; one for primary care and one for nonprimary residents.

*Comment:* One commenter stated: "although the new rolling average methodology is difficult and complex, its impact on GME programs is far from clear." The commenter asked how much change in resident number and mix is necessary before this new methodology has an effect on payment, and stated that more examples would be helpful in determining this effect. The commenter also expressed hope that, if this change is finalized, we will revisit this issue after implementation and fully examine and analyze its impact on teaching program payment.

*Response:* As we explained in the proposed rule, whether the new methodology results in a payment difference for a hospital is dependent upon whether or not the ratio of primary care to nonprimary care FTEs changes in a 3-year period. If the ratio of the FTEs does not change over the 3-year period, there would be no difference in a direct GME payment amount derived using the new methodology versus the existing methodology. In particular, there would be an increase in direct GME payment under the revised methodology, where a hospital's proportion of primary care residents to nonprimary care residents over the last 3 years is higher than the hospital's proportion of primary care residents to nonprimary care residents in the current year. As this new rolling average methodology is implemented, we intend to evaluate hospitals' direct GME payments to further analyze the impact of using this methodology.

*Comment:* One commenter asked how many hospitals would still be "at risk"

for changes in payment because they retain different primary care and nonprimary care PRAs, given the implementation of the 85 percent floor.

*Response:* As described in the impact section of this final rule in Appendix A, we estimated that, of 1,231 teaching hospitals included in the analysis, approximately 562 hospitals have PRAs that will be increased to equal 85 percent of the national average PRA. This leaves 669 hospitals with PRAs that exceed the 85 percent floor. However, not all of these hospitals will be using the new methodology because not all of them have both primary care and nonprimary care PRAs.

*Comment:* One commenter noted that, in order to implement the new rolling average methodology, significant changes must be made to Worksheet E, Part A, the worksheet on the Medicare cost report used for calculating a hospital's IME adjustment. The commenter also stated that past cost reports using the current cost reporting forms would have to be reopened.

*Response:* As we explained in the preamble to the proposed rule and above in this final rule, we have decided to institute a separate rolling average for primary care and nonprimary care residents due to an issue with respect to the current payment methodology for *direct GME only*. That is, when combining a hospital's primary care PRA and nonprimary care PRA on Worksheet E-3, Part IV of the Medicare cost report, we currently weight the respective PRAs by *current* year residents. As a result, although Congress provided that the direct GME payments should be made based on a 3-year rolling average count of weighted residents, the current methodology introduces the number of residents that a hospital is training in the *current cost reporting period* into the payment formula. A payment formula that incorporates the number of current year residents "dilutes" the effect of the rolling average as related to direct GME payments. However, in regard to the IME payments, we also noted that, although they are also based on a rolling average, no change in the existing methodology is needed because there is no distinction between primary care and nonprimary care residents for IME payment purposes. Therefore, while two separate rolling averages will be used for direct GME payments (one for primary care and one for nonprimary care), a single rolling average will continue to be used for IME payments under the existing methodology. We will make the necessary changes to the Medicare cost report on Worksheet E-3, Part IV, which is used for calculating a

hospital's direct GME payment, to accommodate two separate rolling average calculations.

The commenter also stated that affected cost reports in which the current rolling average methodology was used would need to be reopened. However, the effective date of this change in the methodology is *prospective*, and will only affect cost reporting periods beginning on or after October 1, 2001. We will not be reopening past cost reports to change direct GME payment because of the new methodology.

*Comment:* One commenter indicated that the separation of the 3-year rolling average between primary care and nonprimary care FTEs will be difficult because the prior year FTEs were not separated into primary care and nonprimary care FTEs. The commenter asked how a provider could obtain the information from prior years if the same methodology was not used.

*Response:* We do not believe it will be difficult for a hospital to obtain the weighted FTE counts of its primary care and nonprimary care residents separately. This is because, in fact, although the rolling average was computed based on total residents, there are lines on Worksheet E-3, Part IV (lines 3.07 and 3.08) in which the current year weighted count of primary care and nonprimary care residents are reported separately. Therefore, the hospital and the fiscal intermediary can easily refer to these lines on prior year cost reports to determine a 3-year average for primary care and nonprimary care residents, respectively.

#### 4. Counting Research Time as Direct and Indirect GME Costs (§§ 412.105 and 413.86)

It has come to our attention that there appears to be some confusion in the provider community as to whether the time that residents spend performing research is countable for the purposes of direct and indirect GME reimbursement. Although we did not propose to make any policy changes in the May 4 proposed rule, we did reiterate our longstanding policy regarding time that residents spend in research and proposed to incorporate this policy in the IME regulations.

Section 413.86(f) specifies that, for the purposes of determining the total number of FTE residents for the direct GME payment, residents in an approved program working in all areas of the hospital complex may be counted. Accordingly, the time the residents spend performing research as part of an approved program anywhere in the hospital complex may be counted for

direct GME payment purposes. If the requirements listed at §§ 413.86(f)(3) and (f)(4) are met, a hospital may also count the time residents spend doing research in nonhospital settings for direct GME payment.

For purposes of determining the IME payment, § 412.105(f)(1)(ii) specifies that the time residents spend training in parts of the hospital that are subject to the inpatient prospective payment system, in the outpatient departments, or (effective on or after October 1, 1997, in accordance with § 413.86(f)(3) or (f)(4), as applicable) in nonhospital settings, may be counted. Section 2405.3.F.2. of the Provider Reimbursement Manual (PRM) further states that a resident must not be counted for the IME adjustment if the resident is engaged exclusively in research. Resident time spent "exclusively" in research means that the research is not associated with the treatment or diagnosis of a particular patient of the hospital. Therefore, although the research component may be part of an approved program, *the time that residents devote specifically to performing research that is not related to delivering patient care*, whether it occurs in the hospital complex or in non-hospital settings, *may not be counted for IME payment purposes*. "Exclusively research" time is not allowable for IME purposes irrespective of whether the resident is engaged only in research or spends only part of his or her time on research. Accordingly, time spent exclusively in research over the course of a program year should be subtracted from the total FTE count for that year. For example, if a resident is required to spend 3 months in a particular program year engaged in research activities unrelated to delivering patient care, that amount of time should be subtracted from the total FTE count, whether or not the research time is fulfilled in one block of time, or is distributed throughout the training year.

We note that in order to count residents for both direct GME and IME payment purposes, the residents' training must be part of an approved program. *This applies whether or not the residents are doing work that is clinical in nature*. There are situations where residents have completed their residency program requirements but remain for an additional period of time to continue their training (that is, to conduct research or other activities) outside the context of a formally organized approved program. As we explained in the September 29, 1989 final rule (54 FR 40306), these residents are *not* countable for direct GME or IME

reimbursement. Rather, patient care services provided by these residents should be paid as Part B services.

We proposed to amend § 412.105(f)(1)(iii) to add a paragraph (B) to incorporate language that reflects this policy.

We received several comments disagreeing with our clarification of longstanding policy on whether the time that residents spend performing research may be included in the FTE count for the purpose of determining direct and indirect GME reimbursement.

*Comment:* One commenter stated that the proposed revised IME regulations at § 412.105 do not mention any requirement that residents counted for purposes of the IME adjustment and assigned to a hospital's inpatient prospective payment system or outpatient area be involved in "patient care activities." Instead, that requirement is only mentioned with reference to residents assigned to nonprovider settings. Therefore, the commenter believed that a patient care requirement in reference to counting residents in nonprovider settings implies the exclusion of the same requirement when counting residents in the hospital (specifically as it applies to counting research time for IME purposes).

*Response:* The clarification in the proposed rule addresses our longstanding interpretation of existing regulations and reflects longstanding general Medicare reimbursement principles. Under general Medicare reimbursement principles, as reflected in § 413.9, costs incurred by a hospital generally must be related to patient care in order to be reimbursed by Medicare.

The purpose of the IME payments is to address the additional costs that hospitals incur in treating patients. In our May 6, 1986 interim final rule (51 FR 16775), we stated: "Section 1886(d)(5)(B) of the Act provides that prospective payment hospitals receive an additional payment for the indirect costs of medical education computed in the same manner as the adjustments for those costs under regulations in effect as of January 1, 1983. Under those regulations, we provided that the indirect costs of medical education incurred by teaching hospitals are the increased operating costs (*that is, patient care costs*) that are associated with approved intern and resident programs" (emphasis added). In addition, in our September 29, 1989 final rule (54 FR 40286), we specifically state: "As used in section 1886(d)(5)(B) of the Act, 'indirect medical education' means those additional costs (*that is, patient care costs*) incurred by hospitals

with graduate medical education programs. The indirect costs of medical education might, for example, include added costs resulting from an increased number of tests ordered by residents as compared to the number of tests normally ordered by more experienced physicians" (emphasis added).

Thus, payments for IME address the additional operating costs that teaching hospitals incur in furnishing patient care. Accordingly, consistent with the purpose of IME payments and general Medicare reimbursement principles, in determining the FTE count with respect to the IME adjustment, it has been our longstanding policy that we do not include residents to the extent that the residents are not involved in furnishing patient care but are instead engaged exclusively in research.

*Comment:* One commenter disagreed with our use of the Provider Reimbursement Manual (PRM), section 2405.3.F.2, in support of our policy on excluding residents from the IME count if the resident is "engaged exclusively in research." The commenter stated that the reference to exclusion from the resident count for residents engaged "exclusively in research" must be read in the context of the Manual provision, and not in a regulatory vacuum. The commenter believed that PRM section 2405.3.F.2 is addressing situations outside of the traditional residency program—where the resident time at issue is not part of an approved medical education program. The commenter believed that the phrase "engaged exclusively in research" refers to persons who are research scientists and not engaged in research as part of a clinical residency program.

In addition, this commenter stated that our interpretation of the word "exclusively" in this context is not reasonable and is contrary to the clear meaning of the term. The commenter argued that our interpretation practically eliminates the word "exclusively," effectively saying that a resident is "exclusively engaged in research" if that resident participates in any research at all.

*Response:* Section 2405.3.F.2 of the PRM (published in August 1988) was written to address "Questionable situations" for the IME FTE count. Indeed, in the introductory paragraph in this section we state: "It is recognized that situations arise in which it may be unclear whether an individual is counted as an intern or resident in an approved program for the purposes of the indirect medical education adjustment." Thus, the point of section 2405.3.F.2 of the PRM was to clarify situations for counting resident FTEs in

approved programs for IME purposes. As the commenter suggested, *some* of the situations listed under this section address situations where the resident FTE time at issue is not part of the approved medical education program (for example, that a resident must not be counted for the IME adjustment if "the individual's services in provider settings are payable as physician services (situations in which it is clear that the otherwise eligible resident is 'moonlighting')".) (Section 2405.3.F.2. of the PRM). However, this section in the PRM was written to clarify counting rules for IME purposes in various situations. In addition to clarifying situations where resident time is spent in an unapproved program, this section in the PRM certainly also clarifies the rules for determining resident time spent in an approved program—such as time the resident is "engaged exclusively in research" (as cited in the proposed rule) and that "any portion of the individual's salary is subject to reasonable compensation equivalency limits." (Section 2405.3.F.2. of the PRM)

Therefore, we do not agree with the commenter that we have read this manual provision in a "regulatory vacuum". The phrase "engaged exclusively in research" is *not* meant only to refer to persons who are research scientists and not engaged in research as part of an approved clinical residency program, since as explained above, there is *nothing* in the manual provision that limits the research provision to research performed outside of an approved program.

In the proposed rule, we stated that resident time spent "exclusively" in research "means that the research is not associated with the treatment or diagnosis of a particular patient of the hospital." (66 FR 22700). The commenter argued that this interpretation of the word "exclusively" in the context of the manual provision is unreasonable and contrary to the clear meaning of the term, that under our policy, a resident would be "engaged exclusively in research" if that resident participates in any research at all. We do not agree.

Resident time spent "engaged exclusively in research" means time *not* associated with the care of a particular patient (see proposed § 412.105(f)(1)(iii)(B)); thus, *any* research time that *is* associated with the treatment or diagnosis of a particular hospital patient or, effective on or after October 1, 1997, of patients in nonhospital settings, that is, usual patient care, is countable for IME payment purposes. We note that this distinction between activities that are

“usual patient care” and research activities is, again, longstanding Medicare policy. In April 1975, at section 500 of the PRM, we stated the principle that “Costs incurred for research purposes, over and above usual patient care, are not included as allowable costs.” Indeed, since the inception of Medicare, we have distinguished between activities that are “usual patient care” and activities that are outside this scope, such as research activities.

*Comment:* One commenter stated that “by its very nature as a regression analysis, or statistical measure, the IME formula is not intended to be dependent on ‘the treatment or diagnosis of a particular patient of the hospital.’” Another commenter stated: “our understanding of the development of the adjustment is that statistical analyses showed that the use of an intern/resident-to-bed ratio (IRB) was (and continues to be) the best proxy for the patient care cost differences between teaching and non-teaching hospitals. Given that the IRB is only a proxy, the relevance of a requirement that residents themselves must be engaged in activities related to patient care in order for their training time to be counted in the IRB is unclear.”

*Response:* Generally, the statistical analyses used in the development of the statutory IME adjustment measured the differences between teaching and nonteaching hospitals with respect to the additional costs associated with patient care. Inpatient hospital care that involves the use of residents is costlier than inpatient hospital care that does not involve the use of residents. As the comments and the statute reflect, the hospital’s ratio of interns and residents to beds is one factor in measuring the additional costs that a hospital incurs due to the use of residents in furnishing patient care. While a resident is engaged exclusively in research, the hospital is not incurring additional patient care costs due to that resident. Accordingly, we believe that the measure of additional patient care costs is more accurate if it excludes residents engaged exclusively in research.

Suppose, for example, that a teaching hospital has a total of 20 FTE residents training in prospective payment system sections of the hospital who are all involved in furnishing patient care. The amount of the IME payment to the hospital would reflect 20 FTE residents, reflecting the additional operating costs arising from the use of 20 FTE residents in furnishing patient care. Now suppose that the same hospital has the same 20 residents involved in furnishing patient care but it also has 4 additional FTE

residents engaged exclusively in research. The 4 residents engaged exclusively in research do not contribute to higher operating costs and, therefore, as our longstanding policy reflects, we believe it is appropriate not to count them for purposes of the IME adjustment. Thus, in both situations, the hospital’s FTE count for purposes of IME is 20. If we did make higher payments in the second situation, then the hospital would receive higher payments even though the hospital did not incur higher patient care costs.

*Comment:* One commenter stated that our regulations at § 413.86(e)(1)(i)(B) clearly allow research time to be counted for direct GME purposes. This commenter asserted that “it cannot be reasonably argued that research time should be counted differently for IME than direct GME based on a new, very specific definition of patient care that applies solely to IME”. Another commenter stated the proposed rule is “unduly burdensome” by requiring hospitals to maintain different counts for direct GME and IME based on research activity or rotations. A third commenter stated that there is an alternative to distinguishing between direct GME and IME as it relates to research—“lawyers, often when faced with conflicting sections of the law, attempt to reconcile a common policy out of these conflicts, rather than further complicating things. You could do the same here.”

*Response:* As we have stated above and in the proposed rule, the clarification we made concerning the counting of FTEs for research time related to the diagnosis and treatment of a particular patient for IME purposes is *longstanding* Medicare reimbursement policy. We were *not* proposing a change in Medicare policy.

We are not introducing unnecessary complexity to the direct and indirect medical education counts, since it has *always* been Medicare policy to require the hospital to distinguish between time spent by residents involved exclusively in research and time spent on patient care. Further, the IME and direct GME FTE counts have and will continue to differ for several reasons. Hospitals have always been able to count residents in all areas of the hospital complex for direct GME but cannot count residents working in units exempt from the prospective payment system for IME. In addition, each resident included in the hospital’s direct GME FTE count is counted as 0.5 FTE if they have trained beyond the number of years required to become eligible in the specialty in which they first began training. These same residents are counted as 1.0 FTE

in the hospital’s IME FTE count. We reiterate that we are *not* making a change in policy, but merely clarifying our policy with respect to counting residents involved in GME.

With respect to research, our policies for direct GME payment are consistent with our policies for IME payment. In both contexts, we do not pay for the costs of time spent by residents engaged exclusively in research. In making payments for IME and direct GME for a given year, it is true that we treat research *time* differently for purposes of the IME FTE count and the direct GME FTE count, but, as explained below, this difference arises from the direct GME base year methodology and does not mean that we pay for research *costs* in the direct GME payment.

In the September 29, 1989 final rule implementing the direct GME base year payment methodology, we described the calculation of the per resident amounts (PRAs). Each hospital’s PRA is determined by taking the hospital’s total allowable graduate medical education costs (which do not include costs allocated to the nursery cost center, *research*, and other nonreimbursable cost centers) in a base year and dividing the costs by the number of FTE residents working in all areas of the hospital complex in the base year. (§ 413.86(e)(1)(i)) In the case of research and other nonreimbursable cost centers, costs were excluded from the PRA calculation because they were nonreimbursable in the base year, consistent with longstanding Medicare policy on Medicare cost reimbursement to teaching hospitals. Ideally, residents engaged exclusively in research would also have been excluded from the base year FTE count used in the PRA calculation. However, for a number of hospitals, the FTE count for the base year *did include* residents engaged exclusively in research because the 1984 base year information available when the PRAs were determined in 1990 did not distinguish between residents involved in furnishing patient care services and residents exclusively engaged in research.

In order to avoid disadvantaging these hospitals, in making direct GME payments for a given year, we have included and continue to include residents exclusively engaged in research in the direct GME FTE count both in the base year PRA calculation and in the FTE count in subsequent payment year calculations. Doing so “offsets” the effects of the inclusion of such residents in the direct GME base year FTE count (no such “offset” is necessary in the context of IME). However, because the *costs* were

excluded in calculating the PRA, the end result is that the direct GME payment does *not* encompass the costs of residents engaged exclusively in research. Therefore, as with the IME payment, Medicare is not and has not been reimbursing teaching hospitals under direct GME for costs the hospital incurs associated with resident time spent in research unrelated to usual patient care.

*Comment:* One commenter stated that our policy on counting research time is well stated and clear. However, this commenter stated that there is much research that is done outside any funding source, but is an essential part of the resident's training. The commenter further stated that the hospital does assume these costs, and they are not part of the direct GME component, and so represent valid hospital expenditures due to the presence of residents.

*Response:* We certainly acknowledge that hospitals incur research costs associated with the training of interns and residents. We understand that many specialties require a research component to be completed as part of the specialties' board eligibility requirements. The question as far as IME payments are concerned is whether or not the research is associated with the diagnosis and treatment of a particular patient. As explained above, teaching hospitals receive Medicare IME payments to pay hospitals for Medicare's share of the additional costs these hospitals incur associated with patient care costs; if the research is not associated with usual patient care costs, then the resident research time is not reimbursable.

*Comment:* Two commenters stated that they are concerned that clarifications on the exclusion of resident FTEs from the IME payment for trainees engaged in activities that are purely research would be extended to include those individuals in an approved program that requires research activities at the same time as the delivery of patient care.

*Response:* As stated above, where the residents are engaged exclusively in research, it is appropriate to exclude that time from the IME payment calculation. However, consistent with longstanding policy, in the situation where residents are in an approved program participating in research activities that are associated with the diagnosis and treatment of a particular patient, we believe it is appropriate to include that time in the IME payment calculation.

#### 5. Temporary Adjustments to FTE Cap to Reflect Residents Affected by Residency Program Closure

In the July 30, 1999 hospital inpatient prospective payment system final rule (64 FR 41522), we indicated that we would allow a temporary adjustment to a hospital's FTE resident cap under limited circumstances and if certain criteria are met when a hospital assumes the training of additional residents because of another hospital's closure. We made this change because hospitals had indicated a reluctance to accept additional residents from a closed hospital without a temporary adjustment to their caps. When we proposed this change 2 years ago, we received several comments suggesting that we include lost accreditation of a program (that is, a program's closure) in the temporary adjustment policy. We explained in our response to these comments (64 FR 41522) that we did not believe it was appropriate to expand our policy to cover any acts other than a hospital's closure. We made this decision because, unless the hospital terminates its Medicare agreement, the hospital would retain its statutory FTE cap and could affiliate with other hospitals to enable the residents to finish their training.

It has come to our attention that, despite a hospital's ability to affiliate with other hospitals when it shuts down a residency program, some hospitals for various reasons do not affiliate before their programs close, particularly when the program closes abruptly towards the end of the program year (the deadline to submit Medicare affiliation agreements is July 1 of the upcoming program year). Therefore, in the May 4 proposed rule, we proposed that if a hospital that closes its residency training program agrees to temporarily reduce its FTE cap, another hospital(s) may receive a temporary adjustment to its FTE cap to reflect residents added because of the closure of the former hospital's residency training program. For purposes of this policy on closed programs, we proposed to define "closure of a hospital residency training program" as when the hospital ceases to offer training for residents in a particular approved medical residency training program (proposed § 413.86(g)(8)(i)(B)). The methodology for adjusting the caps for the "receiving hospital" and the "hospital that closed its program" is described below.

a. *Receiving hospital.* We proposed that a hospital(s) may receive a temporary adjustment to its (or their) FTE cap to reflect residents added because of the closure of another

hospital's residency training program if—

- The hospital is training additional residents from the residency training program of a hospital that closed its program; and
- 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 the hospital 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 cap reduction statement by the hospital closing the program, as specified in paragraph (g)(8)(iii)(B)(2).

In general, the proposed temporary adjustment criteria are reflective of the temporary adjustment criteria for taking on the training of displaced residents from closed hospitals. We note that we proposed that more than one hospital would be eligible to apply for the temporary adjustment, because residents from one closed program may go to different hospitals, or they may finish their training at more than one hospital. We also noted that only to the extent a hospital would exceed its FTE cap by training displaced residents would it be eligible for the temporary adjustment.

Finally, we proposed that hospitals that meet the proposed criteria would be eligible to receive temporary adjustments (for cost reporting periods beginning on or after October 1, 2001, for direct GME and with discharges beginning on or after October 1, 2001 for IME) for training the displaced residents from programs that closed even before the effective date of this policy. We mentioned this because hospitals may have closed programs in the recent past and the residents from the closed programs may not have completed their training as of the effective date of this policy. For instance, if a 5-year residency program, such as surgery, closed on July 1, 1997, the 5th program year residents may still be training during this residency year (2001). We proposed that if both the receiving hospital(s) and the hospital that closed the program in this example follow the criteria described in this preamble, the receiving hospital may receive a temporary adjustment to its FTE cap for 9 months (October 1, 2001 through June 30, 2002) to accommodate the 5th year surgery residents. However, we noted that hospitals would not be eligible to receive a temporary adjustment for

training the residents until the effective date of this rule (that is, October 1, 2001).

b. *Hospital that closed its program(s).* We proposed that 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(s)—

- Temporarily reduces its FTE cap by the number of FTE residents in each program year training in the program at the time of the program's closure. The yearly reduction would be determined by deducting the number of those residents who would have been training in the program year during each year had the program not closed; and
- No later than 60 days after the residents who were in the closed program begin training at another hospital, submits 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 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.

Unlike the closed hospital policy at § 413.86(g)(8), we proposed under this closed program policy (which we proposed to amend § 413.86(g)(8) to include), that in order for the receiving hospital(s) to qualify for a temporary adjustment to its FTE cap, the hospitals that are closing their programs would need to reduce their FTE cap for the duration of time the displaced residents would need to finish their training. We proposed this change because, as explained below, the hospital that closes the program still has the FTE slots in its cap, even if the hospital chooses not to fill the slots with residents. We believe it is inappropriate to allow an increase to the receiving hospital's cap without an attendant temporary decrease to the cap of the hospital with the closed program, even if the increase is only temporary. We noted that even under the proposed closed program policy, the hospital that closes its program may choose instead to affiliate with another hospital by July 1 of the next residency year so that the residents can more easily finish their training.

We proposed that the cap reduction for the hospital with the closed program would be based on the number of FTE

residents in each program year who were in the program at the program's closure, and who began training at another hospital, rather than the count of residents each year at the hospital(s) receiving the temporary adjustment(s). We believe it would be too burdensome administratively to require the hospital closing the program to keep track of the status of the residents when they are training at other hospitals. For instance, Joe Smith, a resident who is a PGY 1 when Hospital X closes its pathology residency program, may then finish his training at Hospital Y. The resident trains for one year at Hospital Y as a PGY 2, but decides to drop out of the program before finishing. It would be burdensome to require Hospital X to keep track of Joe Smith's status while he is training at Hospital Y for purposes of the reduction in Hospital X's cap. Therefore, we proposed to "freeze" the basis for the reduction of the FTE cap of the hospital that closed the program based on the count and status of the residents when the hospital closes the program.

*Example:* Hospital A, which has a direct GME FTE cap of 20 FTEs and an IME FTE cap of 18 FTEs, is experiencing financial difficulties and decides to close down its internal medicine residency training program effective June 30, 2002. As of June 30, 2002, Hospital A is training 2 PGY 1s, 4 PGY 2s, and 6 PGY 3s in its internal medicine program. Hospitals B, C, and D take on the training of the displaced residents. These hospitals are eligible to receive temporary adjustments to their FTE caps if they follow the proposed criteria stated above. In order for Hospitals B, C, and D to receive the temporary adjustments, however, Hospital A must agree to reduce its FTE cap. According to the proposed criteria stated above, Hospital A's reduction would be:

*July 1, 2002 through June 30, 2003*

Direct GME FTE cap: 14 FTEs, (20 FTEs cap—2 PGY 2s—4 PGY 3s)

IME FTE cap: 12 FTEs (18 FTEs—2 PGY 2s—4 PGY 3s)

We note that no downward adjustment for the 6 PGY 3s for either cap is necessary since these residents will have completed their training in that program by the July 1, 2000 through June 30, 2003 program year.

*July 1, 2003 through June 30, 2004*

Direct GME FTE cap: 18 FTEs (20 FTEs cap—2 PGY 3s)

IME FTE cap: 16 FTEs (18 FTEs cap—2 PGY 3s)

*July 1, 2004 through June 30, 2005*

Direct GME FTE cap: 20 FTEs

IME FTE cap: 18 FTEs

We also proposed to revise § 412.105(f)(1)(ix) to make the provision relating to the adjustment to FTE caps to reflect residents affected by closure of hospitals' medical residency training programs applicable to determining the IME payment.

*Comment:* Several commenters commended us for extending payment of IME and direct GME to situations of program closure, explaining that this change will help stabilize the GME system and ensure that residents can continue their training without imposing financial hardship on the institutions that accept them into their programs. One commenter also noted that the tradeoff in the FTE resident cap between a hospital closing its residency program and the hospital receiving the displaced residents seems reasonable. Another commenter stated that while the proposed rule more than adequately described the requirements and procedures for allowing a hospital to receive a temporary adjustment to its FTE caps to reflect residents added because of the closure of another hospital's program, the receiving hospital is penalized because the 3-year rolling average applies to these residents. The commenter noted that, in the first and second year, the receiving hospital will be paid one third and two thirds of the costs of these displaced FTE residents because of the rolling average, although the receiving hospital is paying for these FTE residents at full cost. The commenter suggested that a temporary exception should be granted to receiving hospitals from the 3-year rolling average in the same manner as residents in new programs under § 413.86(g)(5) are excluded from the rolling average. The commenter also asked that temporary relief should be granted in the IME adjustment with regard to the application of the resident-to-bed ratio cap, wherein the relief from this cap should be an adjustment to the prior year's resident FTEs equal to the increase in the current year's FTEs which is attributable to the transferred residents.

*Response:* We understand the commenter's concern regarding the inclusion of the resident FTEs displaced by the closure of another hospital's program in the receiving hospital's rolling average count of residents, for both direct GME and IME purposes. In addition, we believe that a similar concern also exists in regard to the inclusion of residents in the receiving hospital's rolling average calculation for residents displaced by the closure of another hospital. Therefore, we are revising proposed § 412.105(f)(1)(v) for IME and adding a paragraph (vi) to proposed § 413.86(g)(5) for direct GME to specify that FTE residents that are displaced by the closure of either another hospital or another hospital's program are added after the calculation of the rolling average for the receiving

hospital for the duration of time that those displaced FTE residents are training at the receiving hospital.

In regard to providing temporary relief to the receiving hospital's IME resident-to-bed ratio cap for the displaced residents, while we understand the commenter's concern about this issue as well, at this time we have decided not to allow the exclusion of these displaced residents in applying the resident-to-bed ratio cap. Under existing IME policy, the receiving hospital may be held to a lower cap in the first year of training the displaced residents. However, the receiving hospital may benefit from the higher cap in the year following the final year of the displaced residents' training. Effective in the first year that the receiving hospital takes on the displaced residents, it will be capped by the prior year's lower resident-to-bed ratio because the displaced residents will not be included in the prior year FTE count. However, an increase in the current year's ratio will establish a higher cap for the following year. Furthermore, in the last year that the receiving hospital is training the displaced residents, a higher cap will be established for the following year in which all the displaced residents will have left the hospital since they have completed their training. Therefore, we believe it is unnecessary to exclude displaced residents in applying the resident-to-bed ratio cap. While we are not making any changes to address this issue at this time, we will consider suggestions for possible changes in the future, if warranted.

*Comment:* One commenter stated that it is unclear at what rate the payments for IME and direct GME will be made for the hospital receiving the displaced residents. The commenter asked if Medicare would pay that hospital at the same rate that the hospital with the closed program was paid for its residents, or would the receiving hospital receive Medicare payment at the same rate it currently is paid.

*Response:* The receiving hospital will receive payment for the displaced residents using its own rates—that is, the same rates as those used for residents in its own programs. The receiving hospital will use its own bed count for IME payment purposes, and its own PRA and Medicare patient load for direct GME payment purposes.

*Comment:* One commenter stated that, although the commenter supports the proposal for allowing temporary adjustments for residents coming from a closed program, the commenter believed that a mechanism should be established to "permanently preserve resident

positions, as opposed to individual residents," so long as there is no increase in the total number of FTE residents for which Medicare payment is made.

*Response:* In proposing § 413.86(g)(8)(iii), which allows a hospital to receive a temporary adjustment to its FTE caps to reflect residents added because of the closure of another hospital's program, we have attempted to make these regulations consistent with the existing regulations at § 413.86(g)(8). These existing regulations allow a hospital to receive a temporary adjustment to its FTE caps to reflect residents added because of the closure of another hospital. Therefore, because the regulations only allow for a temporary cap adjustment in situations involving hospital closure, we believe that it is appropriate to only allow for a temporary adjustment in situations involving program closure, as well.

#### 6. Conforming Change to Regulations Governing Payment to Federally Qualified Health Centers (§ 405.2468(f))

We have discovered a technical error in the regulations at § 405.2468(f) regarding payment to federally qualified health centers (FQHCs) and rural health centers (RHCs) for the costs of graduate medical education. Specifically, § 405.2468(f)(6)(ii)(D) provides that "The costs associated with activities described in § 413.85(d) of this chapter" are not allowable graduate medical education costs. We recently amended § 413.85 in a final rule (66 FR 3358, January 12, 2001) regarding Medicare pass-through payment for approved nursing and allied health education programs. However, we inadvertently did not make a conforming change to § 405.2468(f)(6)(ii)(D). Section 405.2468(f)(6)(ii)(D) should read "The costs associated with activities described in § 413.85(h) of this chapter." We proposed to revise § 405.2468(f)(6)(ii)(D) to reflect this change.

#### 7. Provisions of the August 1, 2000 Interim Final Rule With Comment Period

The following provisions were included in the August 1, 2000 interim final rule with comment period. We are presenting a discussion of these provisions here in order to respond to the public comments received on the provisions and to finalize the rule.

Section 1886(h) of the Act, as revised by Public Law 105–33, caps the number of residents a hospital may count for direct GME and IME. In general, the total number of residents in the fields of allopathic or osteopathic medicine in a

hospital may not exceed the number of such FTE residents in the hospital with respect to the hospital's most recent cost reporting period ending on or before December 31, 1996. In the regulations we published on August 29, 1997 (62 FR 46003), May 12, 1998 (63 FR 26327), July 31, 1998 (63 FR 40986), and July 30, 1999 (64 FR 41517), we established special rules for adjusting the FTE resident caps for indirect and direct GME for new medical residency programs. Public Law 106–113 further revised sections 1886(d) and 1886(h) of the Act to allow a hospital's caps to be adjusted if certain additional criteria are met.

#### a. Counting Primary Care Residents on Certain Approved Leaves of Absence in Base-Year FTE Count (Section 407(a)(1) of Public Law 106–113 and New 42 CFR 412.105(f)(1)(xi) and 413.86(g)(9))

The limit that was placed on the number of residents that a hospital may count for purposes of direct GME and IME is based on the number of residents in the hospital's most recent cost reporting period ending on or before December 31, 1996. In the situation where a primary care resident was previously training in a hospital's residency program, but was on an approved leave of absence during the hospital's most recent cost reporting period ending on or before December 31, 1996, the hospital's FTE cap may be lower than it would have been had the resident not been on an approved leave of absence. Section 407(a) of Public Law 106–113 amended section 1886(h)(4)(F) of the Act to direct the Secretary to count an individual for purposes of determining a hospital's FTE cap, to the extent that the individual would have been counted as a primary care resident for purposes of the FTE cap but for the fact that the individual was on maternity or disability leave or a similar approved leave of absence.

The statute allows a hospital to receive an adjustment for those residents to its individual FTE cap of up to three additional FTE residents. We provided that, in order for a hospital to receive this adjustment, the leave of absence must have been approved by the residency program director to allow the residents to be absent from the program and return to the program after the absence. We required that no later than 6 months after the date of publication of this interim final rule, the hospital must submit a request to the fiscal intermediary for an adjustment to its FTE cap and must provide contemporaneous documentation of the approval of the leave of absence by the residency program director, specific to

each additional resident that is to be counted for purposes of the adjustment. For example, a letter to the resident by the residency program director before the resident takes the leave would be sufficient documentation of prior approval of the leave of absence.

Under section 407(a)(3) of Public Law 106-113, this provision is effective for direct GME FTE counts with cost reporting periods beginning on or after November 29, 1999, and for IME FTE counts, with discharges occurring in cost reporting periods beginning on or after November 29, 1999.

We added §§ 412.105(f)(1)(xi) and 413.86(g)(9) to our regulations to incorporate the provisions of section 407(a) of Public Law 106-113.

We received one comment concerning section 407(a)(1) of Public Law 106-113, as implemented at §§ 412.105(f)(1)(xi) and 413.86(g)(9), concerning the counting of primary care residents in certain approved leaves of absence in base-year FTE counts.

*Comment:* One commenter asked us to consider allowing hospitals to count FTE residents for residents who had been training in an approved residency program at a hospital but then left the hospital during the 1996 base-year and never returned. The commenter stated that the FTE slot in which the "abandoning" resident vacated sometime in 1996 was filled by another resident in 1997 and thereafter, but the hospital has never received any direct or indirect GME payment for this FTE slot.

*Response:* Section 407(a) of Public Law 106-113 amended section 1886(h)(4)(F) of the Act to direct the Secretary to count an individual for purposes of determining a hospital's FTE cap to the extent that the individual would have been counted as a primary care resident for purposes of the FTE cap but for the fact that the individual "was on maternity or disability leave or a similar approved leave of absence." We believe that this provision was *not* intended to apply to residents who leave the program in the base-year and never return. The statutory language is quite clear that in order for a hospital to count residents in this provision, the resident must have been on an "approved leave of absence." A "leave of absence" necessarily translates to a resident being away and then *returning* to the hospital at which the resident had been training.

b. Adjustments to the FTE Cap for Rural Hospitals (Section 407(b)(1) of Public Law 106-113 and 42 CFR 412.105(f)(1)(iv) and 413.86(g)(4))

Public Law 105-33 included several provisions with the intent of

encouraging physician training and practice in rural areas. Section 1886(h)(4)(H)(i) of the Act, as added by section 4623 of Public Law 105-33, directed the Secretary, in promulgating rules for the purpose of the FTE cap, to give special consideration to facilities that meet the needs of underserved rural areas. Consistent with the intent of this provision, section 407(b) of Public Law 106-113 provides a 30-percent expansion of a rural hospital's direct and indirect FTE count for purposes of establishing the hospital's individual FTE cap. Specifically, section 407(b) provided that, effective for direct GME with cost reporting periods beginning on or after April 1, 2000, and for IME, with discharges occurring on or after April 1, 2000, the FTE count may equal 130 percent of the number of unweighted residents the rural hospital counted in its most recent cost reporting period ending on or before December 31, 1996.

For example, if a hospital located in a rural area had 10 unweighted FTEs for its count for both direct GME and IME in its most recent cost reporting period ending on or before December 31, 1996, under this new provision the hospital would have a FTE cap of 13 unweighted FTEs, instead of 10 unweighted FTEs, because the hospital is located in a rural area. The revised FTE cap is equal to 130 percent of the number of unweighted residents in its most recent cost reporting period ending on or before December 31, 1996. The rural hospital's new FTE cap, effective April 1, 2000, is now 13 FTEs. However, if a hospital located in a rural area had zero unweighted FTEs for its count for both direct GME and IME in its most recent cost reporting period ending on or before December 31, 1996, under this new provision, this hospital would receive no adjustment to its FTE cap (130 percent of zero is zero FTEs).

We incorporated the provision of section 407(b) of Public Law 106-113 in §§ 412.105(f)(1)(iv) and 413.86(g)(4). We did not receive any comments on this provision.

c. Rural Track FTE Limitation for Purposes of GME and IME for Urban Hospitals that Establish Separately Accredited Approved Medical Programs in a Rural Area (Section 407(c) of Public Law 106-113 and new 42 CFR 412.105(f)(1)(x) and 413.86(g)(11))

In order to encourage the training of physicians in rural areas, section 407(c) of Public Law 106-113 amended section 1886(h)(4)(H) of the Act to add a provision that in the case of a hospital that is not located in a rural area but establishes separately accredited

approved medical residency training programs (or rural tracks) in a rural area or has an accredited training program with an integrated rural track, an adjustment may be made to the hospital's cap on the number of residents. For direct GME, the amendment applies to payments to hospitals for cost reporting periods beginning on or after April 1, 2000; for IME, the amendment applies to discharges occurring on or after April 1, 2000.

Section 407(c) of Public Law 106-113 did not define "rural tracks" or an "integrated rural track," nor are these terms defined elsewhere in the Social Security Act or in any applicable Federal regulations. Currently, there are a number of accredited residency programs, particularly 3-year primary care residency programs, in which residents train for 1 year of the program at an urban hospital and are then rotated for training for the other 2 years of the 3-year program to a rural facility. These separately accredited "rural track" programs are identified by the Accreditation Council of Graduate Medical Education (ACGME) as "1-2" rural track programs. Accordingly, we implemented section 407(c) to address these "1-2" programs. In addition, we implemented section 407(c) to account for other programs that are not "1-2" programs but which include rural training portions.

As stated above, since there is no existing definition of "rural track" or "integrated rural track," we defined at § 413.86(b) a "rural track" and an "integrated rural track" as an approved medical residency training program established by an urban hospital in which residents train for a portion of the program at the urban hospital and then rotate for a portion of the program to a rural hospital(s) or to a rural nonhospital site(s). We noted that "rural track" and "integrated rural track," for purposes of this definition, are synonymous.

We amended § 413.86 to add paragraph (g)(11) (and amended § 412.105 to add paragraph (f)(1)(x)) to specify that, for direct GME, for cost reporting periods beginning on or after April 1, 2000, (or, for IME, for discharges occurring on or after April 1, 2000), an urban hospital that establishes a new residency program, or has an existing residency program, with a rural track (or an integrated rural track) may include in its FTE count residents in those rural tracks, in addition to the residents subject to the FTE cap at § 413.86(g)(4). An urban hospital may count the residents in the rural track up to a "rural track FTE limitation" for that

hospital. We defined this rural track FTE limitation at § 413.86(b) as the maximum number of residents training in a rural track residency program that an urban hospital may include in its FTE count, that is in addition to the number of FTE residents already included in the hospital's FTE cap.

Generally, the rural track policy is divided into two categories: Rural track programs in which residents are rotated to a rural area for at least two-thirds of the duration of the program; and rural track programs in which residents are rotated to a rural area for less than two-thirds of the duration of the program. These two categories are then subdivided according to where the residents are training in the rural area; the residents may be trained in a rural hospital or the residents may be trained in a rural nonhospital site. To account for rural track residency programs with rural rotations that have program lengths greater than or less than 3 years, or that are not "1-2" programs, we specified "two-thirds of the length of the program," instead of "2 out of 3 program years," as a qualification to count FTEs in the rural track.

In the interim final rule with comment period, we specified that urban hospitals that wish to count FTE residents in rural tracks, up to a rural track FTE limitation, must comply with the conditions discussed below:

(1) Rotating Residents for at Least Two-Thirds of the Program to a Rural Hospital(s)

In the August 1, 2000 interim final rule with comment period, we specified at § 413.86(g)(11)(i) that if an urban hospital rotates residents in the rural track program to a rural hospital(s) for at least two-thirds of the duration of the program, 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:

- 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 training in the rural track at the urban hospital.
- Beginning with the fourth year of the rural track's existence, the rural track FTE limitation is equal to the product of: (1) The highest number of residents in any program year who, during the third year of the rural track's existence, are training in the rural track at the 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; and (2) the number of years those residents are training at the urban hospital.

We utilized the term "designated" at § 413.86(g)(11)(i) (as well as at §§ 413.86(g)(11)(ii) and (iv)) to refer to the calculation of the rural track FTE limitation. "Designated" means that the residents must actually have enrolled in that rural track program to rotate for a portion of the rural track program to a rural area (either rural hospital(s) or rural nonhospital site(s)). To be counted as an FTE in this first scenario, these enrolled residents must actually rotate for at least two-thirds of the duration of the program to a rural hospital(s). If a resident, at the beginning of his or her training, intends to train in the rural area for at least two-thirds of the duration of the program, but ultimately never does so, this resident would be proportionately excluded from the urban hospital's rural track FTE limitation.

We noted that if the residents in the rural track are rotating to a rural hospital(s), the rural hospital(s) may be eligible to count the residents as part of its FTE count. If the rural track residency program is a new residency program as specified in redesignated § 413.86(g)(12), the rural hospital may be eligible to receive an FTE cap adjustment for those residents training in the rural track for the time those residents are training at the rural hospital(s), in accordance with the provisions of existing § 413.86(g)(6)(iii). If the rural track residency program is an existing residency program, a rural hospital may be eligible to count the FTE residents training in the rural track at the rural hospital(s), in accordance with the provisions of § 413.86(g)(4), as amended in the interim final rule with comment period to implement section 407(b)(1) of Public Law 106-113.

(2) Rotating Residents for at Least Two-Thirds of the Program to a Rural Nonhospital Site

In the August 1, 2000 interim final rule with comment period, we specified at § 413.86(g)(11)(ii) that if an urban hospital rotates residents in the rural track program to a rural nonhospital site(s) for at least two-thirds of the duration of the program, the urban hospital may include those residents in its FTE count, subject to the requirements under existing § 413.86(f)(4). 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:

- 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 training in the rural track at the urban hospital and the rural nonhospital site.
- Beginning with the fourth year of the rural track's existence, the rural track FTE limitation is equal to the product of: (1) The highest number of residents in any program year who, during the third year of the rural track's existence, are training in the rural track at the 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 and the rural nonhospital site(s); and, (2) 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.

We note that we specified at § 413.86(g)(11)(ii) that an urban hospital may include in its FTE count those residents in the rural track rotating to a rural nonhospital site, subject to the requirements under existing § 413.86(f)(4). Section 413.86(f)(4) provides, in part, that a hospital that incurs "all or substantially all" of the costs of training residents in a nonhospital site may include those residents in determining the number of FTE residents (not to exceed the FTE cap) for that hospital. Under this rural track policy, where the urban hospital rotates residents for at least two-thirds of the residency program to a rural nonhospital site, the urban hospital would be eligible to include in its FTE count residents training in the rural track up to its rural track FTE limitation, but the urban hospital must still reimburse the rural nonhospital site for the costs of training those residents, as specified under § 413.86(f)(4). In the August 1, 2000 interim final rule with comment period (66 FR 47034), we included an example of application of this policy.

(3) Rotating Residents for Less Than Two-Thirds of the Program to a Rural Hospital(s)

In the August 1, 2000 interim final rule with comment period, we specified at § 413.86(g)(11)(iii) that if an urban hospital rotates residents in the rural track program to a rural hospital(s) for periods of time that are less than two-thirds of the duration of the program, the urban hospital may not include those residents in its FTE count, nor may the urban hospital include those residents as part of its rural track FTE

limitation. However, we noted that, in this scenario, if the rural track residency program is a new residency program as specified in redesignated § 413.86(g)(12), the rural hospital may be eligible to receive an FTE cap adjustment for those residents training in the rural track, in accordance with the provisions of existing § 413.86(g)(6)(iii). If the rural track residency program is an existing residency program, a rural hospital may count the FTE residents training in the rural track at the rural hospital(s), in accordance with the provisions of § 413.86(g)(4), as amended, to incorporate the provisions of section 407(b)(1) of Public Law 106-113.

We are not permitting an urban hospital to count the time of residents training at the urban hospital in a rural track rotating to a rural hospital(s) for less than two-thirds the duration of the program (either as part of the urban hospital's FTE count or as part of its rural track FTE limitation), because to do so would inappropriately allow the urban hospital to circumvent the FTE caps by creating a new program with minimal training in a rural track. However, in this situation, like the other three provisions that concern the training of residents in rural areas, we indicated that we will allow Medicare payment for the rural portion of the training to the rural hospital.

#### (4) Rotating Residents for Less Than Two-Thirds of the Program to a Rural Nonhospital Site

In the August 1, 2000 interim final rule with comment period, we specified at § 413.86(g)(11)(iv) that if an urban hospital rotates residents in the rural track program to a rural nonhospital site(s) for periods of time that are less than two-thirds of the duration of the program, the urban hospital may include those residents in its FTE count, subject to the requirements under existing § 413.86(f)(4). 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:

- 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 training in the rural track at the rural nonhospital site.
- 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); and (b)

the length of time in which the residents are being trained at the rural nonhospital site(s).

We noted that, in this situation, an urban hospital would not be able to count the FTE for the rural track resident while the resident is training at the urban hospital. The rural track FTE count and the rural track FTE limitation for the urban hospital would be limited to account for the residents training at the rural nonhospital site.

As in the second scenario at § 413.86(g)(11)(ii), we specified at § 413.86(g)(11)(iv) that an urban hospital may include in its FTE count those residents in the rural track rotating to a rural nonhospital site, subject to the requirements under § 413.86(f)(4). Under the rural track policy, where the urban hospital rotates residents for less than two-thirds of the residency program to a rural nonhospital site, the urban hospital would be eligible to include in its FTE count residents training in the rural track up to its rural track FTE limitation, but the urban hospital must still reimburse the rural nonhospital site for the costs of training those residents, as specified under § 413.86(f)(4).

We noted that, in this last scenario, we are allowing the urban hospital to receive a rural track FTE limitation even in situations where it is rotating residents to a rural area for a minimal period of time (less than two-thirds the duration of the program). However, we believe that this last scenario can be distinguished from the third scenario in which the urban hospital is again rotating residents to a rural area for a minimal portion of the program but to a rural hospital instead of a rural nonhospital site. In the third scenario, we allow Medicare payment to go to the rural hospital for the portion of the urban hospital program that involves rural training (but not to the urban hospital, if the rural hospital is receiving an FTE cap adjustment for that training). However, in the last scenario, we allow the urban hospital to include the rural track residents in its FTE count (and as part of its rural track FTE limitation), based on how long it rotates the residents to the rural nonhospital site (and also incurs all or substantially all of the training costs). We do not believe that the urban hospital can circumvent its FTE cap in this last scenario because it will only count the rural track residents based on the portion of training in the rural nonhospital site. In the interim final rule with comment period (66 FR 47035), we included an example of the last scenario.

#### (5) Conditions That Apply to All Urban Hospitals

In the August 1, 2000 interim final rule with comment period, we specified that all urban hospitals that wish to count FTE residents in rural tracks, not to exceed their respective rural track FTE limitations, must also comply with each of the following conditions, as stated at §§ 413.86(g)(11)(v) and (vi):

- A hospital may not include in its FTE count residents who are training in a rural track residency program that were already included as part of the hospital's FTE cap (if the rural track program was in existence during the hospital's most recent cost reporting period ending on or before FY 1996).
- A 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 urban hospital intends to rotate for a portion of the residency program to a rural area. For example, written contemporaneous documentation might be a letter of intent signed and dated by the rural track residency program director and the resident at the time of the resident's entrance into the rural track program as a PGY 1.

- All residents who are included by the hospital as part of its FTE count (not to exceed its rural track FTE limitation) must ultimately train in the rural area.

- If we find 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, we will reopen the urban hospital's cost report within the 3-year reopening period (as specified in § 405.1885) and adjust the hospital's Medicare GME payments (and, where applicable, the hospital's rural track FTE limitation).

We received several comments regarding the provisions of section 407 of Public Law 106-113 implemented in the August 1, 2000 interim final rule with comment period.

*Comment:* One commenter cited studies that found that more than half of residents with as little as 3 months of rural training became rural physicians, and, therefore, to best serve the intent of the legislation and significantly increase the number of rural physicians, we should fully fund FTEs with less than two-thirds total training in rural areas.

*Response:* Section 1886(h)(4)(H)(iv) of the Act, as added by section 407(c) of Public Law 106-113, provides for adjustments to the FTE cap "[i]n the case of a hospital that is not located in a rural area but establishes *separately accredited* approved medical residency training programs (or rural tracks) in a[]

rural area \* \* \*.” Thus, in order for a hospital to receive an adjustment under this provision, the training program must be *separately accredited*. The ACGME has established criteria to separately accredit programs that involve training in rural areas; under these criteria, a training program may be separately accredited if residents in the program train for at least 2 years of the 3-year program at a rural facility. Currently, the ACGME does *not* separately accredit a program as a rural track program or a program in a rural area unless it meets this “1–2” condition. We make an adjustment to the FTE cap under the rural track provision only if a program is separately accredited, and in order to be separately accredited, the program must meet ACGME’s “1–2” criteria. We are amending the regulations at § 413.86 by adding paragraph (g)(11) to reflect this policy.

Furthermore, we believe that incorporating the ACGME’s criteria reasonably identifies the situations in which an adjustment to the FTE cap under the rural track provision is warranted. We believe that it is important to limit adjustments under this provision to situations in which residents receive a significant amount of training in rural areas. While we certainly agree that post-residency physician retention in rural areas is important, we believe that it is also important to prevent hospitals from receiving adjustments to the FTE cap in situations when an adjustment is not warranted. We believe that, if an urban hospital could receive an adjustment to its FTE cap by providing only a nominal amount of training in a rural area, then hospitals might be able to inappropriately circumvent the FTE caps. Thus, our policy reflects the requirements of the statute as well as a balancing of considerations (permitting adjustments for hospitals that establish programs that provide a significant amount of training in rural areas, and preventing adjustments for hospitals that do not warrant an adjustment).

*Comment:* One commenter noted that, for cost reporting periods beginning on or after April 1, 2000, section 407 of Public Law 106–113 allows rural hospitals to increase their FTE resident caps by 30 percent and urban hospitals with rural training tracks to count those residents in rural tracks. The commenter had two concerns: (1) What happens to rural track programs that were in existence between January 1, 1997 and April 1, 2000; and (2) if the intent of the rural track provision is to encourage training in rural areas, then rural track programs in existence between January

1, 1997 and April 1, 2000 should also be permitted to expand by 30 percent.

*Response:* Section 1886(h)(4)(F) of the Act, as added by section 407(b) of Public Law 106–113, and as implemented at §§ 413.86(g)(4) and 412.105(f)(1)(iv), provides for a 30-percent expansion to a *rural* hospital’s direct and indirect FTE counts for purposes of establishing the hospital’s individual FTE cap. Section 407(c) provides for an adjustment to the FTE cap of *urban* hospitals for training residents in rural areas. Section 407(b) clearly only applies to *rural* hospitals, and not to urban hospitals, regardless of whether or not the urban hospitals train residents in rural areas. Therefore, while the general intent of the provisions at section 407 is to encourage training in rural areas, only those rural hospitals that have a FTE resident cap based on the count of residents in the hospital’s cost reporting period ending on or before December 31, 1996, may qualify for a 30-percent increase to that FTE cap under the amendments made by section 407(b).

To address the commenter’s uncertainty concerning what happens to rural track programs that were in existence between January 1, 1997 and April 1, 2000, we point to our language at §§ 413.86(g)(11) and 412.105(f)(1)(x) which states that for cost reporting periods beginning on or after April 1, 2000, “an urban hospital that establishes a new residency program, *or has an existing residency program*, with a rural track (or an integrated rural track) may include in its FTE count residents in those tracks \* \* \*” (emphasis added). Thus, urban hospitals with rural tracks that were in existence between January 1, 1997 and April 1, 2000, and continue to be in existence after April 1, 2000, may be eligible for Medicare payment under this provision. We note that urban hospitals with rural tracks that were established *before* January 1, 1997, and continued to exist after April 1, 2000, may be eligible for payment under this rural track provision, as well.

We note that we have received questions from the provider industry regarding the application of the rural track FTE limitation and rural track FTE count to hospitals with rural track programs that have already been in existence before April 1, 2000. Generally, the methodology at § 413.86(g)(11) states that the actual count of residents for the first 3 years of the rural track’s existence is to be used as the hospital’s rural track FTE limitation, and beginning with the fourth year, the rural track FTE limitation is determined based on the

number of residents training in the rural track in the third year of the program’s existence. However, if a rural track program has been in existence for at least 3 years prior to April 1, 2000, the provision regarding using the actual count of residents in the first 3 years of the program would not apply. Rather, for such a program, the rural track FTE limitation would take effect immediately on April 1, 2000. The limitation would be based on the highest number of residents in any program year training in the rural track in the third year of the program, depending on the amount of time the residents spent in the rural area, subject to the regulations at § 413.85(g)(11)(i) through (iv). It would be the responsibility of the hospital to provide the necessary information regarding the third year of the program to the fiscal intermediary. For example, if the third year of the rural track’s existence is July 1, 1997 to June 30, 1998, the rural track FTE limitation would be based on the highest number of residents in any program year in 1997–1998 training year. The urban hospital may begin to count the additional FTEs up to its rural track FTE limitation in its cost reporting period beginning on or after April 1, 2000 for direct GME, and for discharges occurring on or after April 1, 2000 for IME.

*Comment:* One commenter noted that the interim final rule with comment period states that “all residents that are included by the hospital as part of its FTE count must ultimately train in the rural area.” The commenter expressed concern that we are requiring hospitals to designate specific *individuals*, rather than *FTEs*, and that basing payment on individuals rather than FTEs would set a poor precedent. The commenter further stated that, while specific individuals may not remain in a program, hospitals should be permitted to fill these slots with FTEs and receive payment.

*Response:* The commenter is concerned with the provision at § 413.86(g)(11)(v)(C), which states that all residents that are included by the hospital as part of its FTE count under this provision must ultimately train in the rural area. As the commenter correctly assesses, this particular provision would link the rural track policy to specific individual residents, rather than FTEs. We made this link to individuals rather than FTEs because we believe the additional provision at § 413.86(g)(11)(v)(C) (as well as the provision at §§ 413.86(g)(11)(v)(B)) was necessary in order to ensure that urban hospitals did not count additional FTE

residents who did not actually rotate at any time to a rural area.

However, we understand the commenter's concern about permitting hospitals to fill slots with FTEs that are open because individuals did not remain in the program. We agree that where a hospital fills a vacated FTE slot in a rural 1-2 program with another resident, it would be consistent with the intent of the rural track provision to allow the urban hospital to count the time of the resident who left the training program. Accordingly, we are amending the regulations at § 413.86(g)(11)(v)(C) to allow for the counting of the resident's time at the urban hospital where, for example, a resident who just completed her PGY1 year at the urban hospital decides to drop out of the program, and then the urban hospital fills the vacated FTE slot with another PGY2 resident who then continues and completes the rural portion of the rural track program. We note that we would *not* allow for the counting of the time at the urban hospital for the first year of training for that resident who left the program where the urban hospital fills the vacated FTE slot with another PGY1 resident who first begins to train in the urban hospital, since, in effect, this would result in double counting one FTE at the urban hospital without the required amount of training occurring in the rural area.

*Comment:* One commenter expressed concern with the provision at § 413.86(g)(11)(v)(A) that states "an urban hospital may not include in its rural track FTE limitation or FTE count residents who are training in a rural track residency program that were already included as part of the hospital's FTE cap." The commenter stated that this provision fails to account for the fact that many hospitals may have "backed out" residents training time in rural sites from their base year FTE cost reports. The commenter stated further that this provision may be interpreted by cost report accountants to mean that appeals to include FTEs that were excluded by Public Law 105-33 are prohibited.

*Response:* We believe the commenter is confusing the provision at § 413.86(g)(11)(v)(A), that an urban hospital may not include in its rural track FTE limitation or rural track FTE count residents who are training in a rural track residency program that were already included as part of the hospital's FTE cap, and the policy contained in section 4623 of Public Law 105-33, as implemented at §§ 412.105(f)(1)(iv) and 413.86(g)(4), which places a limit on the count of residents, or hospitals' FTE caps. The

intent of the provision at § 413.86(g)(11)(v)(A) is to encourage more residency training in rural areas by providing for Medicare payment to an urban hospital for FTE residents who are training in a rural area and are not already included as part of the hospital's FTE cap. Whether or not there are many hospitals that have "backed out" resident training time in rural sites from their base year FTE cost reports is irrelevant to this rural track requirement. The possible mistaken exclusion of the count of resident FTEs spent in rural settings is an issue relevant to the determination of a hospital's initial FTE cap as provided for at §§ 412.105(f)(1)(iv) and 413.86(g)(4). The rural track requirement at § 413.86(g)(11)(v)(A) was not intended to provide for adjustments to reflect FTEs that were excluded from the FTE cap.

With regard to rural training, generally, and the determination of a hospital's FTE cap under §§ 412.105(f)(1)(iv) and 413.86(g)(4), a FTE resident should not have been included in the hospital's FTE cap to the extent that, in that cost reporting year, the resident was rotating to another rural hospital, or if the resident was rotating to a rural nonhospital to which the urban hospital was not paying all or substantially all of the costs of training (see § 413.86(f)(3)).

To clarify the intent of the requirement that "an urban hospital may not include in its rural track FTE limitation or FTE count residents who are training in a rural track residency program that were already included as part of the hospital's FTE cap," we are providing the following example:

- Assume there are 10 unweighted FTE residents training at an urban Hospital A in the hospital's most recent cost reporting period ending on or before December 31, 1996, thereby establishing Hospital A's FTE cap at 10.

- In July 2002, Hospital A starts a rural training track program. In addition to devoting 2 out of its 10 FTE slots to the rural track, Hospital A recruits an additional 2 FTEs to participate in the rural track, for a total of 12 FTEs to be trained in that cost reporting year.

- These 4 FTEs will complete 1 year of training at Hospital A and 2 years of training at a rural nonhospital site. This type of program is modeled after the scenario outlined at § 413.86(g)(11)(ii), where the urban hospital may include in its FTE count the FTEs in the rural track at the urban hospital and at the rural nonhospital site. (Hospital A is complying with the requirements at § 413.86(f)(4) regarding the counting of residents in nonhospital sites).

However, when calculating the rural track FTE limitation in the fourth year of the rural track's existence, Hospital A may not include in its rural track FTE limitation *those FTEs that were already included as part of the hospital's initial FTE cap*. Two of the hospital's four FTEs training in the rural track were already included in the hospital's FTE cap. Therefore, beginning July 2002, only two FTEs may be included to determine the hospital's rural track FTE limitation, as well as its rural track FTE count. Since it is the two FTEs that Hospital A added when it started the rural track that have caused the hospital to exceed its FTE cap, only two FTEs may be counted above the FTE cap for the hospital's rural track FTE count and limitation. However, we note that the other two FTEs training in the rural track that were not included as part of the hospital's *rural* FTE count and limitation because they had already been included as part of the hospital's FTE cap, may still be counted by the hospital in its *general* FTE count, according to §§ 412.105(f) and 413.86(f).

*Comment:* One commenter requested that, since rural hospitals often do not have the resources or infrastructure to claim their GME costs on a Medicare cost report, we should revise the regulations to allow urban hospitals to claim the resident FTEs training at the rural hospitals, as long as the urban hospitals are providing "adequate funding" to the rural hospital, similar to our Medicare policy on nonhospital settings.

*Response:* In regard to the request to allow urban hospitals to claim the FTEs training in rural hospitals, while we understand that it is not uncommon for urban hospitals to incur the costs of training residents in rural hospitals because the rural hospitals cannot incur the costs themselves, there is longstanding policy that prohibits one hospital from claiming the training time of FTEs training at another hospital. First, section 1886(h)(4)(B) of the Act states that the rules governing the direct GME computation of count of the number of FTE residents "shall take into account individuals who serve as residents for only a portion of a period with a hospital or simultaneously with more than one hospital." Accordingly, the September 4, 1990 **Federal Register** (55 FR 36065) states that "\* \* \* the other hospital is required to include the portion of time the resident spent at its facility in its FTE count consistent with § 413.86(f)." Further, the regulations at § 413.86(f)(2) state that "No individual may be counted as more than one FTE \* \* \*. [I]f a resident spends time in more than one hospital \* \* \* the

resident counts as partial FTE based on the proportion of time worked at the hospital to the total time worked \* \* \*." Therefore, even though the urban hospital incurs the training costs and the rural hospital does not claim the FTEs for Medicare direct GME and IME payment purposes, the urban hospital is precluded from claiming any FTEs training at the rural hospital (or any other hospital, for that matter). The commenter is correct in stating that a hospital may count the time residents spend in *nonhospital* settings if they comply with the criteria at § 413.86(f)(4). However, this regulation implements *statutory* provisions (sections 1886(d)(5)(B)(iv) and 1886(h)(4)(E) of the Act), which specifically provide for Medicare direct GME and IME payment to be made to hospitals for training residents in nonhospital settings.

*Comment:* One commenter objected to the policy in the interim final rule with comment period that the terms "rural track" and "integrated rural track" are synonymous. The commenter (a hospital) believed that we have the authority to develop a new definition for "integrated rural track" based on our interpretations of congressional intent, and we should not wait for further clarification from Congress at the expense of the commenter's particular allopathic family practice residency program. The commenter described this program as one in which the residents train in the rural setting for approximately 7 months out of a 3-year program, and for the remainder of the program when the residents spend training in the urban setting, the residents treat rural patients. The commenter proposed the following new definition for integrated rural track: "*Accredited Training Program with an Integrated Rural Track*—refers to an accredited program that provides at least 6 months of training at a rural location in addition to 2 years of rural training at an urban location. The 6 months of rural training should be conducted as part of all 3 years of training. The program should also establish a continuity of care with patients in a rural area for at least one program year."

*Response:* When we implemented this provision on August 1, 2000, we did so based on discussions with the Accreditation Council for Graduate Medical Education (ACGME), which accredits rural track programs. The ACGME specifically identifies and separately accredits programs with 1 year of training in an urban hospital and 2 years of training in a rural facility as "rural tracks." However, the ACGME

explained that it did not have a separate definition of "integrated rural track" and, in particular, did not separately classify programs with portions of rural training of less than 2 years as "integrated rural tracks". In response to questions raised on this provision, we have followed up with the ACGME to confirm whether a definition of, or criteria for identifying programs with, "integrated rural tracks" had been established. We were informed that the term "integrated rural track" is not, and never was, a term that is used by the ACGME in accrediting its programs. Other than the 1–2 programs that specifically incorporate 2 years of rural training, the ACGME does not grant unique accreditation to programs with a rural focus, nor do any of the other accreditation organizations listed at § 415.152.

In addition, we do not believe it is administratively feasible for us to review documentation and confirm that the training at the urban hospital, as suggested by the commenter, is rural in nature, based on the patient load treated by the residents at the urban hospital. We currently do not have a way of tying patient data to the residents that treat them. Accordingly, for purposes of this policy, until we believe we can appropriately categorize and define rural tracks and integrated rural tracks separately, we will continue to define these terms synonymously. We remain open to adopting another definition of a separately accredited training program, and we welcome suggestions for definitions that would be administratively feasible to apply.

*Comment:* One commenter suggested that we add a fifth scenario to those already described at § 413.86(g)(11). The commenter proposed the following regulation text:

*Rotating Residents of an Accredited Training Program with an Integrated Rural Track to a Rural Nonhospital Site*—If an urban hospital rotates residents in an accredited training program with an integrated rural track to a rural nonhospital site throughout all 3 years of training, the urban hospital may include those residents in its FTE count, subject to the requirements under existing § 413.86(g)(4). The urban hospital may include in its FTE count those residents in the rural track, not to exceed its rural track FTE limitation, determined as follows:

(A) For the first 3 years of the integrated rural track's existence, the rural track FTE limitation for each urban hospital will be the actual number of FTE residents training in the rural track at the urban hospital and the rural nonhospital site.

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

(1) The highest number of residents in any program year who, during the third year of the integrated rural track's existence, are training in the integrated rural track at the urban hospital and are designated at the beginning of their training to be rotated to a rural nonhospital site throughout all 3 years of training, and

(2) 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.

(C) This would apply to accredited training programs with integrated rural tracks that were in existence prior to 1997.

The commenter explained that this language is designed to address the unique program at the commenter's hospital, and it also is date sensitive so that newer programs would be required to comply with the existing criteria in the existing regulations.

*Response:* We have concerns about the commenter's proposal. First, the commenter assumes a separate definition of "integrated rural track," which, as explained above, we currently do not have. Even if we were to adopt such a change in policy, the cut-off date of 1997 in paragraph (C) of the commenter's proposed changes seems arbitrary; there is nothing in the statute that would serve as a basis to simply grandfather existing "integrated rural track" programs and not provide for new ones post-1997. Accordingly, we are not adopting such a change in our rural track policy as the one described by the commenter.

*Comment:* One commenter thought that if a hospital's rural track program has been in existence since 1993, then the 4th program year is 1997. The commenter explained that when the FTE cap went into effect, the hospital was capped at 15 FTEs. The hospital subsequently added another three residents at its own expense. The commenter stated that it interprets § 413.86(g)(11)(v)(A) to mean that the hospital would only be able to count the additional three FTE residents for the rural track count. The commenter urged us to reconsider this language as it relates to hospitals with only one residency program, because the commenter was unsure whether or not all the residents in the program count toward the rural track FTE count. The commenter believed that for hospitals with only one residency program that existed prior to 1996, all rural track residents included in the original hospital FTE cap should be counted toward the rural FTE count.

*Response:* The commenter correctly interprets the intent of the regulation at § 413.86(g)(11)(v)(A), which states that only those FTEs in the rural track that were not already counted as part of the

hospital's FTE cap may be considered when calculating the hospital's rural track FTE limitation and count. In the scenario the commenter outlined above, if the first program year of the rural track program began on July 1, 1993, then the fourth program year would begin on July 1, 1996, not in 1997. Because 15 FTEs were already included in the hospital's FTE cap, assuming the urban hospital qualifies to count the FTEs, only 3 out of the 18 FTE residents training in the program may be considered in determining the hospital's rural track FTE limitation and counts (the specific rural FTE limitation and count are dependent upon which scenario the hospital's program fits under § 413.86(g)(11)).

We do not believe it is necessary to revise this policy for hospitals whose only GME program is the rural track program that was in existence prior to 1996, as the commenter suggested. Hospitals that had rural track programs in existence in 1996 were able to count those residents training at the urban hospital at that time as part of their initial FTE caps. Our existing policy on rural tracks at § 413.86(g)(11) provides additional assistance to these hospitals by allowing them to count separately in their rural track FTE limitations, FTE residents not included in the FTE cap but participating in a rural track.

Accordingly, we are adopting the provisions in the August 1, 2000 interim final rule with comment period implementing section 407(c) of Public Law 106-113 as final.

In addition, we are making a technical correction. The regulations at § 413.86(g)(6) currently state, "If a hospital established a new medical residency training program as defined in paragraph (g)(9) of this section \* \* \*." When we revised the regulations at § 413.86(g)(9) to redesignate the paragraph as § 413.86(g)(12) in the August 1, interim final rule with comment period, we inadvertently did not make a corresponding revision at § 413.86(g)(6). Therefore, we are revising § 413.86(g)(6) to read "If a hospital established a new medical residency training program as defined in paragraph (g)(12) of this section \* \* \*." We are making the same revision to the regulations for IME at § 412.105(f)(vii).

d. Not Counting Against Numerical Limitation Certain Residents Transferred from a Department of Veterans Affairs Hospital's Residency Program That Loses Accreditation (Section 407(d) of Public Law 106-113 and new 42 CFR 412.105(f)(1)(xii) and 413.86(g)(10))

Section 407(d) of Public Law 106-113 addressed the situation where residents were training in a residency training program at a Veterans Affairs (VA) hospital and then were transferred on or after January 1, 1997, and before July 31, 1998, to a non-VA hospital because the program in which the residents were training would lose its accreditation by the ACGME if the residents continued to train at the VA hospital. In this situation, the non-VA hospital may receive a temporary adjustment to its FTE cap to reflect those residents who were transferred to the non-VA hospital for the duration that those transferred residents were training at the non-VA hospital. In the August 1, 2000 interim final rule with comment period, we specified that, in order to receive this adjustment, the non-VA hospital must submit a request to its fiscal intermediary for a temporary adjustment to its FTE cap, document that the hospital is eligible for this temporary adjustment by identifying the residents who have come from the VA hospital, and specify the length of time the adjustment is needed.

We noted that section 407(d) of Public Law 106-113 only refers to programs that would lose their accreditation by the ACGME. This provision does not apply to accreditation by the American Osteopathy Association (AOA), the American Podiatry Association (APA), or the American Dental Association (ADA).

Under section 407(d)(3) of Public Law 106-113, this policy is effective as if included in the enactment of Public Law 105-33, that is, for direct GME, with cost reporting periods beginning on or after October 1, 1997, and for IME, discharges occurring on or after October 1, 1997. If a hospital is owed payments as a result of this provision, payments must be made immediately.

We added §§ 412.105(f)(1)(xii) and 413.86(g)(10) to incorporate the provisions of section 407(d) of Public Law 106-113.

We did not receive any comments on this provision and are adopting it as final.

e. Initial Residency Period for Child Neurology Residency Programs (Section 312 of Public Law 106-113 and 42 CFR 413.86(g)(1))

Generally, section 1886(h)(5)(F) of the Act defines the term "initial residency period" to mean the "period of board eligibility." The period of board eligibility is defined in section 1886(h)(5)(G) of the Act as the period recognized by ACGME as specified in the *Graduate Medical Education Directory* which is published by the American Medical Association. The initial residency period limitation was designed to limit full Medicare payment for direct GME to the time required to train in a single specialty. Therefore, the initial residency period is determined based on the minimum time required for a resident to become board eligible in a specialty and the published periods included in the *Graduate Medical Education Directory*. During the initial residency period, the residents are weighted at 1.0 FTE for purposes of Medicare payment. Residents seeking additional specialty or subspecialty training are weighted at 0.5 FTE.

In order to become board eligible in child neurology, residents must complete training in more than one specialty. Thus, for example, before the effective date of section 312 of Public Law 106-113, if a resident enrolled in a child neurology residency program by first completing 2 years of training in pediatrics (which is associated with a 3-year initial residency period), followed by 3 years of training in child neurology, the resident would be limited by the initial residency period of pediatrics. Section 312 of Public Law 106-113 amended section 1886(h)(5) of the Act by adding at the end a clause (v) which states that "in the case of a resident enrolled in a child neurology residency training program, the period of board eligibility and the initial residency period shall be the period of board eligibility for pediatrics plus 2 years." (The initial residency period for pediatrics is currently 3 years). The policy under section 312(b) of Public Law 106-113 applies to future child neurology residents and to child neurology residents who have already begun their training (for whom an initial residency period was already established). However, it does not apply to residents who have completed their child neurology training before July 1, 2000.

In the August 1, 2000 interim final rule with comment period, we revised § 413.86(g)(1) to reflect that, effective on or after 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 child neurology is now the period of board eligibility for pediatrics plus 2 years. We noted that the initial residency period is the same for all child neurology residents, regardless of whether or not the resident completes the first year of training in pediatrics or neurology.

We did not receive any comments on this provision and are adopting it as final.

#### f. Technical Amendment

In the August 1, 2000 interim final rule with comment period, we indicated that it had come to our attention that the first sentence of the then existing § 413.86(g)(1) contains a technical error. The first sentence of this paragraph reads "For purposes of this section, an initial residency period is the number of years necessary to satisfy the minimum requirements for certification in a specialty or subspecialty, plus one year." This section of the regulation was revised as a result of section 13563(b) of Public Law 103-66, and was effective only until June 30, 1995. Generally, effective July 1, 1995, an initial residency period is defined as the minimum number of years required for board eligibility. Therefore, we revised the first sentence of paragraph (g)(1) of § 413.86 accordingly. The remainder of paragraph (g)(1) of § 413.86 was unchanged.

We did not receive any comments on this provision and are adopting it as final.

#### *I. Additional Payment to Hospitals that Operate Approved Nursing and Allied Health Education Programs*

Under sections 1861(v) and 1886(a) of the Act, hospitals that operate approved nursing or allied health education programs may be eligible for the reimbursement of their reasonable costs of operating such programs. Section 1886(h) of the Act establishes the methodology for determining payments to hospitals for the direct costs of GME programs. Section 1886(h) of the Act, as implemented in regulations at 42 CFR 413.86, specifies that Medicare payments for direct costs of GME are based on a prospectively determined per resident amount (PRA). The PRA is multiplied by the number of full-time equivalent residents working in all areas of the hospital complex (and nonhospital sites, where applicable), and the product is then multiplied by the hospital's Medicare share of total inpatient days to determine Medicare's direct GME payment.

Section 1886(h)(3)(D) of the Act, as added by section 4624 of Public Law 105-33, provides a 5-year phase-in of payments to teaching hospitals for direct costs of GME associated with services to Medicare+Choice (managed care) enrollees for portions of cost reporting periods occurring on or after January 1, 1998. The amount of payment for direct GME is calculated by (1) multiplying the aggregate approved amount (that is, the product of the PRA and the number of FTE residents working in all areas of the hospital (and nonhospital sites, if applicable)), by the ratio of the number of inpatient bed days that are attributable to Medicare+Choice enrollees to total inpatient bed days, and (2) multiplying the result by an applicable percentage.

The applicable percentages are 20 percent for portions of cost reporting periods occurring in calendar year 1998, 40 percent in calendar year 1999, 60 percent in calendar year 2000, 80 percent in calendar year 2001, and 100 percent in calendar year 2002 and subsequent years. (Section 1886(d)(11) of the Act, as added by section 4622 of Public Law 105-33, provides a 5-year phase-in of payments to teaching hospitals for IME associated with services to Medicare+Choice enrollees for portions of cost reporting periods occurring on or after January 1, 1998, as well. However, the Medicare+Choice IME payments are irrelevant for the purposes of this section of the interim final rule with comment period, because although section 541 of Public Law 106-113 affects the payments for Medicare+Choice direct GME, it in no way affects the payments for Medicare+Choice IME.)

#### 1. Provisions of the August 1, 2000 Interim Final Rule with Comment Period (Section 541 of Public Law 106-113 and 42 CFR 413.86(d) and 413.87)

Section 541 of Public Law 106-113 further amended section 1886 of the Act by adding subsection (l) and amending section 1886(h)(3)(D) to provide for additional payments to hospitals for nursing and allied health education programs associated with services to Medicare+Choice enrollees. Hospitals that operate approved nursing or allied health education programs, as defined under the regulations at 42 CFR 413.85, and receive Medicare reasonable cost reimbursement for these programs, would receive additional payments. This provision is effective for portions of cost reporting periods occurring in a calendar year, beginning with calendar year 2000.

Section 1886(l) of the Act, as added by section 541 of Public Law 106-113,

specifies the methodology to be used to calculate these additional payments and places a limitation, that is, \$60 million, on the total amount that is projected to be expended in any calendar year. We refer to the total amount of \$60 million or less as the payment "pool." We emphasize that we use the term "pool" solely for ease of reference; the term reflects an estimated dollar figure, a number that is plugged into a formula to calculate the amount of additional payments. The term "pool" does not refer to a discrete fund of money that is set aside in order to make the additional payments (thus, for example, if the estimated "pool" is \$50 million, we use the number \$50 million to calculate the amount of additional payments, but this does not mean that we set aside \$50 million in a separate fund from which we make the additional payments). The total amount of additional payments is based on the ratio of estimated total direct GME payments for Medicare+Choice enrollees to estimated total Medicare direct GME payments, multiplied by the total Medicare nursing and allied health education payments. Under section 541 of Public Law 106-113, a hospital would receive its share of these additional payments in proportion to the amount of Medicare nursing and allied health education payments received in the cost reporting period that ended in the fiscal year that is 2 years prior to the current calendar year, to the total amount of nursing and allied health payments made to all hospitals in that cost reporting period. Section 541(b) of Public Law 106-113 amended section 1886(h)(3) of the Act to provide that direct GME payments for Medicare+Choice utilization will be reduced to account for the additional payments that are made for nursing and allied health education programs under the provisions of section 1886(l) of the Act.

In the August 1, 2000 interim final rule with comment period, we implemented section 541 by establishing regulations at 42 CFR 413.87 to incorporate the provisions of section 1886(l) of the Act. We specified the rules for a hospital's eligibility to receive the additional payment under section 1886(l), the requirements for determining the additional payment to each eligible hospital, and the methodologies for calculating each additional payment and for calculating the payment "pool." The preamble language regarding § 413.87 can be found in the August 1, 2000 interim final rule with comment period (65 FR 47036 through 47039).

We also made a conforming change to §§ 413.86(d)(4) through (d)(6) to account

for the revised methodology in determining a hospital's Medicare+Choice direct GME payments.

2. Provisions of the June 13, 2001 Interim Final Rule with Comment Period

a. Additional Payment to Hospitals That Operate Approved Nursing and Allied Health Programs (Section 512 of Public Law 106-554 and 42 CFR 413.87)

Public Law 106-554 further amended section 1886(l)(2)(C) of the Act. Specifically, section 512 of Public Law 106-554 changed the formula for determining the additional amounts to be paid to hospitals for Medicare+Choice nursing and allied health costs. Under Public Law 106-113, as described above, the additional payment amount was determined based on the proportion of each individual hospital's nursing and allied health education payments to total nursing and allied health education payments made across all hospitals. This formula does not account for a hospital's specific Medicare+Choice utilization. Section 512 of Public Law 106-554 revised this payment formula to specifically account for each hospital's Medicare+Choice utilization. Accordingly, we made conforming changes at § 413.87 to reflect this change. The changes are effective for portions of cost reporting periods occurring on or after January 1, 2001. We refer the reader to the preamble of the June 13 interim final rule with comment period for a detailed description of the revised methodology for calculating the additional payments (66 FR 32178).

We revised § 413.87 to incorporate the provisions of section 512 of Public Law 106-554.

b. Technical Amendment

In the June 13, 2001 interim final rule with comment period, we indicated that it had come to our attention that the regulations at § 413.86(d)(4) and § 413.87(d) contained errors. The regulations at § 413.86(d)(4) had read, "Effective for cost reporting periods beginning on or after January 1, 2000, the product derived from step three is reduced in accordance with the provisions of § 413.87(f)." Consistent with the statutory effective date and to clarify the intent of the reference to § 413.87(f), we revised § 413.86(d)(4) to state that, "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." We also made a conforming change to § 413.87(d), which had read, "Subject to the provisions of paragraph (f) of this section \* \* \*." Instead, we revised this language to state, "Subject to the provisions of § 413.86(d)(4) \* \* \*."

*J. Payment for Bad Debts (Section 541 of Public Law 106-554 and 42 CFR 413.80)*

Section 4451 of Public Law 105-33 required that allowable bad debt reimbursement for hospitals be reduced by 25 percent for cost reporting periods beginning during FY 1998, by 40 percent for cost reporting periods beginning during FY 1999, and by 45 percent for cost reporting periods beginning during a subsequent fiscal year.

In the June 13, 2001 interim final rule with comment period (66 FR 32183), we implemented section 541 of Public Law 106-554. Section 541 amended section 1861(v)(1)(T) of the Act, thereby modifying the reduction in payment for Medicare beneficiary bad debt for hospitals made by section 4451 of Public Law 105-33. Specifically, this provision reduced the amount of bad debts otherwise treated as allowable reductions in revenue, attributable to the deductibles and coinsurance amounts, by 30 percent for cost reporting periods beginning during FY 2001 and later. Therefore, for cost reporting periods beginning during the year 2001 and later, hospital bad debt amounts otherwise allowable will be reimbursed at 70 percent of the total allowable amount. In the June 13 interim final rule with comment period, we revised § 413.80 to implement this change.

We did not receive any comments on this provision and, therefore, are adopting the proposed revision to § 413.80 as final.

**V. Changes to the Prospective Payment System for Capital-Related Costs**

*A. End of the Transition Period*

Federal fiscal year (FY) 2001 is the last year of the 10-year transition period established to phase in the prospective payment system for hospital capital-related costs. For the readers' benefit, we are providing a summary of the statutory basis for the system, the development and evolution of the system, the methodology used to determine capital-related payments to hospitals, and the policy for providing exceptions payments during the transition period.

Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of inpatient hospital services "in accordance with a prospective payment system established by the Secretary." Under the statute, the Secretary has broad authority in establishing and implementing the capital prospective payment system. We initially implemented the capital prospective payment system in the August 30, 1991 final rule (56 FR 43409), in which we established a 10-year transition period to change the payment methodology for Medicare inpatient capital-related costs from a reasonable cost-based methodology to a prospective methodology (based fully on the Federal rate).

The 10-year transition period established to phase-in the prospective payment system for capital-related costs is effective for cost reporting periods beginning on or after October 1, 1991 (FY 1992) and before October 1, 2001 (FY 2002). Beginning in FY 2001, the last year of the 10-year transition period for the prospective payment system for hospital capital-related costs, capital prospective payment system payments are based solely on the Federal rate for the vast majority of hospitals. Since FY 2001 is the final year of the capital transition period, we will no longer determine a hospital-specific rate for FY 2002 in section III. of the Addendum of this final rule. For cost reporting periods beginning on or after October 1, 2001, payment for capital-related costs for all hospitals, except those defined as new hospitals under § 412.324(b), will be determined based solely on the capital standard Federal rate.

Generally, during the transition period, inpatient capital-related costs are paid on a per discharge basis, and the amount of payment depends on the relationship between the hospital-specific rate and the Federal rate during the hospital's base year. A hospital with a base year hospital-specific rate lower than the Federal rate is paid under the fully prospective payment methodology during the transition period. This method is based on a dynamic blend percentage of the hospital's hospital-specific rate and the applicable Federal rate for each year during the transition period. A hospital with a base period hospital-specific rate greater than the Federal rate is paid under the hold-harmless payment methodology during the transition period.

During the transition period, a hospital paid under the hold-harmless payment methodology receives the higher of (1) a blended payment of 85 percent of reasonable cost for old capital plus an amount for new capital based on

a portion of the Federal rate; or (2) a payment based on 100 percent of the adjusted Federal rate. The amount recognized as old capital is generally limited to the allowable Medicare capital-related costs that were in use for patient care as of December 31, 1990. Under limited circumstances, capital-related costs for assets obligated as of December 31, 1990, but put in use for patient care after December 31, 1990, also may be recognized as old capital if certain conditions were met. These costs are known as obligated capital costs. New capital costs are generally defined as allowable Medicare capital-related costs for assets put in use for patient care after December 31, 1990.

Hospitals that are defined as "new" for the purposes of capital payments during the transition period (see § 412.300(b)) will continue to be paid according to the applicable payment methodology outlined in § 412.324. During the transition period, new hospitals are exempt from the prospective payment system for capital-related costs for their first 2 years of operation and are paid 85 percent of their reasonable capital-related costs during that period. The hospital's first 12-month cost reporting period (or combination of cost reporting periods covering at least 12 months), beginning at least 1 year after the hospital accepts its first patient, serves as the hospital's base period. Those base year costs qualify as old capital and are used to establish its hospital-specific rate used to determine its payment methodology under the capital prospective payment system. Effective with the third year of operation and through the remainder of the transition period, the hospital will be paid under either the fully prospective methodology or the hold-harmless methodology. If the fully prospective methodology is applicable, the hospital is paid using the appropriate transition blend of its hospital-specific rate and the Federal rate for that fiscal year until the conclusion of the transition period, at which time the hospital will be paid based on 100 percent of the Federal rate. If the hold-harmless methodology is applicable, the hospital will receive hold-harmless payment for assets in use during the base period for 8 years, which may extend beyond the 10-year transition period.

The basic methodology for determining capital prospective payments based on the Federal rate is set forth in § 412.312. For the purpose of calculating payments for each discharge, the standard Federal rate is adjusted as follows:

$$(\text{Standard Federal Rate}) \times (\text{DRG Weight}) \times (\text{GAF}) \times (\text{Large Urban Add-on, if applicable}) \times (\text{COLA Adjustment for Hospitals Located in Alaska and Hawaii}) \times (1 + \text{DSH Adjustment Factor} + \text{IME Adjustment Factor})$$

Hospitals may also 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.

In accordance with section 1886(d)(9)(A) of the Act, under the prospective payment system for inpatient operating costs, hospitals located in Puerto Rico are paid for operating costs under a special payment formula. Prior to FY 1998, hospitals in Puerto Rico were paid a blended rate that consisted of 75 percent of the applicable standardized amount specific to Puerto Rico hospitals and 25 percent of the applicable national average standardized amount. However, effective October 1, 1997, under amendments to the Act enacted by section 4406 of Public Law 105-33, operating payments to hospitals in Puerto Rico are based on a blend of 50 percent of the applicable standardized amount specific to Puerto Rico hospitals and 50 percent of the applicable national average standardized amount. In conjunction with this change to the operating blend percentage, effective with discharges on or after October 1, 1997, we compute capital payments to hospitals in Puerto Rico based on a blend of 50 percent of the Puerto Rico rate and 50 percent of the Federal rate as specified in the regulations at § 412.374. For capital-related costs, we compute a separate payment rate specific to Puerto Rico hospitals using the same methodology used to compute the national Federal rate for capital-related costs.

In the August 30, 1991 final rule (56 FR 43409), we established a capital exceptions policy, which provided for exceptions payments during the transition period (§ 412.348). Section 412.348 provides that during the transition period, a hospital may receive additional payment under the exceptions process when its regular payments are less than a minimum percentage, established by class of hospital, of the hospital's reasonable capital-related costs. The amount of the exceptions payment is the difference between the hospital's minimum payment level and the payments the hospital would have received under the capital prospective payment system in

the absence of an exceptions payment. The comparison is made on a cumulative basis for all cost reporting periods during which the hospital has been subject to the capital prospective payment transition rules. The minimum payment percentages throughout the transition period for regular capital exceptions payments by class of hospitals are:

- For sole community hospitals, 90 percent;
- For urban hospitals with at least 100 beds that have a disproportionate share patient percentage of at least 20.2 percent or that received more than 30 percent of their net inpatient care revenues from State or local governments for indigent care, 80 percent;
- For all other hospitals, 70 percent of the hospital's reasonable inpatient capital-related costs.

The provision for "regular" exceptions payments expires at the end of the transition period, that is, for cost reporting periods beginning after September 30, 2001. Capital prospective payment system payments are no longer adjusted to reflect regular exceptions payments at § 412.348 after that date. Accordingly, for cost reporting periods beginning on or after October 1, 2001, all hospitals other than those defined as "new" under § 412.324(b) will receive only the per discharge payment based on the Federal rate for capital costs (plus any applicable DSH or IME and outlier adjustments) unless a hospital qualifies for a special exceptions payment under § 412.348(g).

#### B. Special Exceptions Process

In the August 30, 1991 final rule (56 FR 43409), we established a capital exceptions policy at § 412.348, which provided for *regular* exception payments during the transition period. In the September 1, 1994 final rule (59 FR 45385), we added the *special* exceptions process, describing it as " \* \* \* narrowly defined, focusing on a small group of hospitals who found themselves in a disadvantaged position. The target hospitals were those who had an immediate and imperative need to begin major renovations or replacements just after the beginning of the capital prospective payment system. These hospitals would not be eligible for protection under the old capital and obligated capital provisions, and would not have been allowed any time to accrue excess capital prospective payments to fund these projects."

Under the special exceptions provisions at § 412.348(g), an additional payment may be made through the 10th year beyond the end of the capital

prospective payment system transition period for eligible hospitals that meet (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; and (2) a project size requirement as described at § 412.348(g)(5). Eligible hospitals include sole community hospitals, urban hospitals with at least 100 beds that have a disproportionate share patient percentage of at least 20.2 percent, and hospitals with a combined Medicare and Medicaid inpatient utilization of at least 70 percent.

When we established the special exceptions process, we selected the hospital's cost reporting period beginning before October 1, 2001, as the project completion date in order to limit cost-based exceptions payments to a period of not more than 10 years beyond the end of the 10-year transition to the fully Federal capital prospective payment system. Therefore, hospitals are eligible to receive special exceptions payments for the 10 years after the cost reporting year in which they complete their project. Generally, if a project is completed in the hospital cost reporting period ending September 29, 2002, exceptions payments would continue through September 29, 2012. In addition, we believe that, for projects completed after the deadline, hospitals would have had the opportunity to reserve their prior years' capital prospective payment system payments for financing projects. We note that the August 1, 2000 final rule (65 FR 47095) incorrectly stated that special exceptions payments could extend through September 30, 2011; the date should have been September 29, 2012.

For each cost reporting period, the amount of the special exceptions payment is determined by comparing the cumulative payments made to the hospital under the capital payment system to the cumulative minimum payment levels applicable to the hospital for each cost reporting period subject to the prospective payment system. This comparison is offset or reduced by (1) any amount by which the hospital's cumulative payments exceed its cumulative minimum payments under the regular exceptions process for all cost reporting periods during which the hospital has been subject to the capital prospective payment system; and (2) any amount by which the hospital's current year Medicare inpatient operating and capital prospective payment system payments (excluding 75 percent of its operating DSH payments) exceed its Medicare inpatient operating and capital costs (or its Medicare inpatient margin). During

the capital prospective payment system transition period, the minimum payment level under the regular exceptions process varied by class of hospital as set forth in § 412.348(c) and described in section V.A. of this preamble. After the transition period and for the duration of the special exceptions provision, the minimum payment level is 70 percent as set forth in § 412.348(g)(6).

As we indicated in the July 30, 1999 final rule (64 FR 41526), we have little information about the number of hospitals that may qualify for special exceptions payments or the projected dollar amount of special exception payments, because no hospitals are currently being paid under the special exceptions process. Until FY 2002, the special exceptions provision pays either the same as the regular exceptions process or less for high DSH and sole community hospitals. In accordance with § 412.348(g)(7), a qualifying hospital may receive additional payments for up to 10 years from the year in which it completes a project that meets the project need and project size requirements of the special exception provision in §§ 412.348(g)(2) through (g)(5). Because a qualifying project under the special exceptions provision at § 412.348(g) must be completed (put into use for patient care) by the end of the hospital's last cost reporting period beginning before the end of the transition period (September 30, 2001), a hospital may receive special exception payments for 10 years through September 30, 2012. For example, an eligible hospital that completes a qualifying project in October 1993 (FY 1994) will be eligible to receive special exception payments up through FY 2003 (September 30, 2003).

In order to assist our fiscal intermediaries in determining the end of the 10-year period in which an eligible hospital will no longer be entitled to receive special exception payments, in the May 4, 2001 proposed rule, we proposed to add a new § 412.348(g)(9) to require that hospitals eligible for special exception payments under § 412.348(g) submit documentation to the intermediary indicating the completion date of their project (the date the project was put in use for patient care) that meets the project need and project size requirements outlined in §§ 412.348(g)(2) through (g)(5). We proposed that, in order for an eligible hospital to receive special exception payments, this documentation would have to be submitted in writing to the intermediary by the later of October 1, 2001, or within 3 months of the end of the hospital's last cost reporting period

beginning before October 1, 2001, during which a qualifying project was completed. For example, if a hospital completed a qualifying project in March 1995, it would be required to submit documentation to the intermediary by October 1, 2001. If a hospital with a 12-month cost reporting period beginning on July 1 completed a qualifying project in November 2001, it would be required to submit documentation to the intermediary no later than September 30, 2002, which is 3 months after the end of its 12-month cost reporting period that began on July 1, 2001.

We did not receive any comments on our proposed revision to § 412.348 to add paragraph (g)(9). Accordingly, we are adopting the proposed revision as final without change.

#### *C. Exceptions Minimum Payment Level*

Section 412.348(h) limits the estimated aggregate amount of exceptions payments under both the regular exceptions and special exceptions process to no more than 10 percent of the total estimated capital prospective payment system payments in a given fiscal year. Consistent with the requirements for regular exceptions at § 412.348(c), in the May 4, 2001 proposed rule, we proposed that if we estimate that special exception payments would exceed 10 percent of total capital prospective payment system payments for a given fiscal year, we will adjust the minimum payment level of 70 percent by one percentage point increments until the estimated payments are within the 10-percent limit. For example, we could set the minimum payment level at 69 percent to ensure that estimated aggregate special exceptions payments do not exceed 10 percent of estimated total capital prospective payment system payments. If the estimate of aggregate special exceptions payments were still projected to exceed 10 percent of total capital prospective payment system payments, we would continue reducing the minimum payment level by one percentage point increments until the requirements in § 412.348(h) were satisfied. We proposed to revise § 412.348(g)(6) accordingly to reflect this policy.

We received no comments on this proposed change. Thus, we are revising § 412.348(g)(6) accordingly.

#### *D. Exceptions Adjustment Factor*

Section 412.308(c)(3) requires that the standard capital Federal rate be reduced by an adjustment factor equal to the estimated proportion of additional payments for both regular exceptions and special exceptions under § 412.348

relative to total capital prospective payment system payments. In estimating the proportion of regular exceptions payments to total capital prospective payment system payments during the transition period, we used the model originally developed for determining budget neutrality (described in Appendix B of this final rule) to determine the exception adjustment factor, which was applied to both the Federal and hospital-specific rates. In the May 4, 2001 proposed rule, we described our proposed methodology for determining the special exceptions adjustment used in establishing the Federal capital rate as follows:

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 patient 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 exception 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; (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).

In order to determine the estimated proportion of special exceptions payments to total capital payments, we attempted to identify the universe of eligible hospitals that may potentially qualify for special exception payments. First, we identified hospitals that met the eligibility requirements at § 412.348(g)(1). Then we determined each hospital's average fixed asset age in the earliest available cost report starting in FY 1992 and later. For each of those hospitals, we calculated the average fixed asset age by dividing the accumulated depreciation by the current year's depreciation. In accordance with § 412.348(g)(3), a hospital must have an average age of buildings and fixed assets above the 75th percentile of all hospitals in the first year of capital prospective payment system. In the September 1, 1994 final rule (59 FR 45385), we stated

that, based on the June 1994 update of the cost report files in HCRIS, the 75th percentile for buildings and fixed assets for FY 1992 was 16.4 years. However, we noted that we would make a final determination of that value on the basis of more complete cost report information at a later date. In the August 29, 1997 final rule (62 FR 46012), based on the December 1996 update of HCRIS and the removal of outliers, we finalized the 75th percentile for buildings and fixed assets for FY 1992 as 15.4 years. Thus, for the proposed rule, we eliminated any hospitals from the potential universe of hospitals that may qualify for special exception payments if its average age of fixed assets did not exceed 15.4 years.

For the hospitals remaining in the potential universe, we proposed to estimate the project-size by using the fixed capital acquisitions shown on Worksheet A7 from the following HCRIS cost reports updated through December 2000.

PPS Year	Cost reports periods beginning in . . .
IX .....	FY 1992
X .....	FY 1993
XI .....	FY 1994
XII .....	FY 1995
XIII .....	FY 1996
XIV .....	FY 1997
XV .....	FY 1998
XVI .....	FY 1999

Because the project phase-in may overlap 2 cost reporting years, we proposed to add together the fixed acquisitions from sequential pairs of cost reports to determine project size. Under § 412.348(g)(5), the project-size must meet the following requirements: (1) \$200 million; or (2) 100 percent of its operating cost during the first 12-month cost reporting period beginning on or after October 1, 1991. We proposed to calculate the operating costs from the earliest available cost report starting in FY 1992 and later by subtracting inpatient capital costs from inpatient costs (for all payers). We proposed not to subtract the direct medical education costs as those costs are not available on every update of the HCRIS minimum data set. If the hospital met the project size requirement, we

assumed that it also met the project need requirements at § 412.348(g)(2) and the excess capacity test for urban hospitals at § 412.348(g)(4).

Because we estimate that so few hospitals will qualify for special exceptions, projecting costs, payments, and margins would result in high statistical variance. Consequently, we modeled the effects of special exceptions using historical data based on hospitals' actual cost experiences. If we determined that a hospital may qualify for special exceptions, we modeled special exceptions payments from the project start date through the last available cost report (FY 1999). For purposes of modeling, we used the cost and payment data on the cost reports from HCRIS assuming that special exceptions would begin at the start of the qualifying project. In other words, when modeling costs and payment data we proposed to ignore any regular exception payments that these hospitals may otherwise have received as if there had not been regular exceptions during the transition period. In projecting an eligible hospital's special exception payments, we applied the 70-percent minimum payment level, the cumulative comparison of current year capital prospective payment system payments and costs, and the cumulative operating margin offset (excluding 75 percent of operating DSH payments).

Because hospitals may receive regular exceptions payments up through the end of their last cost reporting period beginning before October 1, 2001, hospitals with cost reporting periods beginning on a day other than October 1 will continue to receive regular exception payments until the end of their FY 2002 cost reporting period. Therefore, these hospitals will only receive special exception payments for the remainder of Federal FY 2002. Consequently, the special exceptions payments made in FY 2002 will be less than for subsequent years since they are only being paid a special exception payment for a portion of FY 2002.

Based on more recent data and HCRIS cost reports updated through March 2001, our modeling of special exception payments produced the following results:

Cost report	Number of hospitals eligible for special exceptions	Special exceptions as a fraction of capital payments to all hospitals	Special exceptions as a fraction of capital payments to all hospitals weighted by portion of FY 2002 for which special exceptions are paid
PPS IX .....	.....	.....	.....
PPS X .....	.....	.....	.....
PPS XI .....	3	.....	.....
PPS XII .....	6	0.0001	0.0001
PPS XIII .....	7	0.0001	0.0000
PPS XIV .....	14	0.0002	0.0001
PPX XV .....	17	0.0009	0.0002
PPS XVI .....	23	0.0009	0.0007

Currently, the PPS XVI cost reports in HCRIS are incomplete because there is a 2-year lag time between the end of a hospital's cost reporting period and the submission and processing of the cost reports for HCRIS. In particular, we have not received all the cost reports for hospitals whose cost reporting periods begin in July. We expect that more hospitals may qualify for special exceptions once data from later HCRIS updates are available. In addition, hospitals still have two more cost reporting periods (PPS XVII and PPS XVIII) to complete their projects in order to be eligible for special exceptions.

In the May 4, 2001 proposed rule (66 FR 22705), we estimated that about 30 additional hospitals could qualify for special exceptions. Based on more recent data, we still estimate that about 30 additional hospitals could qualify for special exceptions. Thus, we project that special exception payments as a fraction of capital payments to all hospitals is approximately 0.0025. However, after weighting this amount to account for the FY 2002 phase-in of special exception payments, we project that this factor is approximately 0.0012. These projections have not changed since the publication of the May 4, 2001 proposed rule (66 FR 22706). We received no comments on our proposed methodology for determining the special exceptions adjustment used in establishing the capital Federal rate. Because special exceptions are budget neutral, we will offset the Federal capital rate by 0.12 percent for special exceptions for FY 2002. Therefore, the final special exceptions adjustment factor is equal to 0.9988 (1-0.0012) to account for special exception payments in FY 2002.

*E. Provisions Relating to Capital Prospective Payments in the June 13, 2001 Interim Final Rule With Comment Period*

In the June 13, 2001 interim final rule with comment period, we implemented section 301(b) of Public Law 106-554 (66 FR 32176). Section 301(b) provides for a special rule for payment for the operating standardized amounts for hospitals other than SCHs for FY 2001. For discharges occurring on or after April 1, 2001, and before October 1, 2001, the update to the operating standardized amounts for hospitals other than SCHs is equal to the market basket percentage increase plus 1.1 percentage points. This provision amends the prior statutory 1.1 percent reduction to the update to the FY 2001 operating standardized amounts for hospitals other than SCHs as provided by section 4401(a)(1) of Public Law 105-33 and 406 of Public Law 106-113.

Section 1886(d)(3)(B) of the Act directs the Secretary to adjust the inpatient operating national standardized amounts to account for the estimated proportion of operating DRG payments made to payments in outlier cases. Accordingly, as a result of this change to the update to the operating standardized amounts for discharges occurring on or after April 1, 2001 and before October 1, 2001, we revised the fixed-loss outlier threshold. The regulations at § 412.312(c) establish a unified outlier methodology for inpatient operating and inpatient capital-related costs, which utilizes a single set of thresholds to identify outlier cases for both inpatient operating and inpatient capital prospective payment system payments.

Because operating DRG payments increased as a result of implementing section 301 of Public Law 106-554, the fixed-loss outlier threshold decreased, which resulted in an increase in

estimated outlier payments. Thus, the capital national outlier adjustment factor was revised. Since the revision to the fixed-loss outlier threshold also affected total capital payments, the exceptions adjustment factor was also revised in order to maintain budget neutrality. The exceptions adjustment factor is determined based on an estimate of the ratio of exception payments to total capital payments. The GAF/DRG budget neutrality factor was also revised. We discuss the impact of changes to the rates and payments under the capital prospective payment system that result from implementation of section 301 of Public Law 106-554 in further detail in the Addendum of this final rule.

We did not receive any comments on the revised FY 2001 capital Federal rate for discharges occurring on or after April 1, 2001 and before October 1, 2001 as a result of implementing section 301(b) of Public Law 106-554.

**VI. Changes for Hospitals and Hospital Units Excluded From the Prospective Payment System**

*A. Limits on and Adjustments to the Target Amounts for Excluded Hospitals and Units (§§ 413.40(b)(4) and (g))*

**1. Updated Caps for Existing Hospitals and Units**

Section 1886(b)(3) of the Act (as amended by section 4414 of Public Law 105-33) established caps on the target amounts for certain existing hospitals and units excluded from the prospective payment system for cost reporting periods beginning on or after October 1, 1997 through September 30, 2002. The caps on the target amounts apply to the following three classes of excluded hospitals: psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals.

In addition, section 4416 of Public Law 105-33 limited payments for

psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals that first received payments on or after October 1, 1997. Payment for these hospitals and units is limited to the lesser of the hospital's operating costs per case or 110 percent of the national median of target amounts for the same class of hospitals for cost reporting periods ending during FY 1996, updated and adjusted for differences in area wage levels.

A discussion of how the caps on the target amounts and the payment limitation were calculated can be found in the August 29, 1997 final rule with comment period (62 FR 46018); 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). For purposes of calculating the caps for existing facilities, the statute required the Secretary to estimate the national 75th percentile of the target amounts for each class of hospital (psychiatric, rehabilitation, or long-term care) for cost reporting periods ending during FY 1996 without adjusting for differences in area wage levels. Under section 1886(b)(3)(H)(iii) of the Act, the resulting amounts are updated by the market basket percentage to the applicable fiscal year.

Section 121 of Public Law 106-113 amended section 1886(b)(3)(H) of the Act to also provide for an appropriate wage adjustment to the caps on the target amounts for existing psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals, effective for cost reporting periods beginning on or after October 1, 1999, through September 30, 2002. On August 1, 2000, we published an interim final rule with comment period that implemented this provision for cost reporting periods beginning on or after October 1, 1999 and before October 1, 2000 (65 FR 47026) and a final rule that implemented this provision for cost reporting periods beginning on or after October 1, 2000 (65 FR 47054). This final rule addresses the wage adjustment to the caps and payment limitations for cost reporting periods beginning on or after October 1, 2001 as proposed in the May 4, 2001 proposed rule.

For purposes of calculating the caps, section 1886(b)(3)(H)(ii) of the Act requires the Secretary to first "estimate the 75th percentile of the target amounts for such hospitals within such class for cost reporting periods ending during fiscal year 1996." Furthermore, section 1886(b)(3)(H)(iii), as added by Public Law 106-113, requires the Secretary to also provide for existing hospitals "an appropriate adjustment to the labor-

related portion of the amount determined under such subparagraph to take into account the differences between average wage-related costs in the area of the hospital and the national average of such costs within the same class of hospital."

Consistent with the broad authority conferred on the Secretary by section 1886(b)(3)(H)(iii) of the Act to determine the appropriate wage adjustment, we account for differences in wage-related costs by adjusting the caps to account for the following:

First, as stated in the May 4 proposed rule, we adjust each hospital's target amount to account for area differences in wage-related costs. For each class of hospitals (psychiatric, rehabilitation, and long-term care), we determine the labor-related portion of each hospital's FY 1996 target amount by multiplying its target amount by the actuarial estimate of the labor-related portion of costs (or 0.71553). Similarly, we determine the nonlabor-related portion of each hospital's FY 1996 target amount by multiplying its target amount by the actuarial estimate of the nonlabor-related portion of costs (or 0.28447).

Next, as we stated in the May 4 proposed rule, we account for wage differences among hospitals within each class by dividing the labor-related portion of each hospital's target amount by the hospital's wage index under the hospital inpatient prospective payment system. Within each class, each hospital's wage-neutralized target amount was calculated by adding the wage-neutralized labor-related portion of its target amount and the nonlabor-related portion of its target amount. Then, the wage-neutralized target amounts for hospitals within each class were arrayed in order to determine the national 75th percentile caps on the target amounts for each class.

Taking into account the national 75th percentile of the target amounts for cost reporting periods ending during FY 1996 (wage-neutralized using the FY 2000 acute care wage index), the wage adjustment provided for under Public Law 106-113, and the applicable update factor based on the market basket percentage increase for FY 2001, in the August 1, 2000 final rule (65 FR 47096), we established the FY 2001 caps on the target amounts as follows:

Class of excluded hospital or unit	FY 2001 labor-related share	FY 2001 nonlabor-related share
Psychiatric .....	\$8,131	\$3,233
Rehabilitation ....	15,164	6,029

Class of excluded hospital or unit	FY 2001 labor-related share	FY 2001 nonlabor-related share
Long Term Care	29,284	11,642

In reviewing our methodology for wage neutralizing the hospital specific target amounts, it appears that we incorrectly used the FY 2000 hospital inpatient prospective payment system wage index published in Tables 4A and 4B of the July 30, 1999 final rule (64 FR 41585 through 41593), which is based on wage data after taking into account geographic reclassification under section 1886(d)(8) of the Act. As stated in the May 4 proposed rule, we are revising the methodology of wage neutralizing the hospital-specific target amounts using pre-reclassified wage data. We recalculate the limit for new excluded hospitals and units, as well as calculate the cap for existing excluded hospitals and units, using the pre-reclassification wage index. The pre-reclassification wage index is the same wage index used under the prospective payment system for skilled nursing facilities (SNFs) and was included in Table 7 of the July 30, 1999 SNF final rule (64 FR 41690). (We note that both SNFs and ambulatory surgical centers use the prospective payment system inpatient wage index without regard to the prospective payment system reclassification as a proxy for variations in local costs.)

As we stated in the August 1, 2000 final rule, long-term care hospitals, rehabilitation hospitals and units, and psychiatric hospitals and units that are exempt from the prospective payment system are not subject to the prospective payment system hospital reclassification system under section 1886(d)(10)(A) of the Act. This section establishes the MGCRB for the purpose of evaluating applications from short-term, acute care providers. There is no equivalent statutory mandate for HCFA to develop an alternative board for long-term care hospitals, psychiatric hospitals and units, and rehabilitation hospitals and units. In addition, while it would be feasible to allow units physically located in prospective payment system hospitals that have been reclassified by the MGCRB to use the wage index for the area to which that hospital has been reclassified, at the present time there is no process in place to make reclassification determinations for freestanding excluded providers. There are approximately 1,000 freestanding excluded providers. Therefore, in the interest of equity, we believe that, in determining a hospital's wage-adjusted

cap on its target amount, it is appropriate for excluded hospitals and units to use the wage index associated with the area in which they are physically located (MSA or rural area) and the prospective payment system reclassification under section 1886(d)(10) of the Act is not applicable. This policy is also consistent with the policy for SNFs and ambulatory surgical centers that use the acute care, inpatient hospital prospective payment system wage index and that does not allow for reclassifications since there is no analogous determinations process to the MGCRB. The MGCRB only has authority over the prospective payment system for acute care hospitals.

Therefore, based on the broad authority conferred on the Secretary by section 1886(b)(3)(H)(iii) of the Act to determine the appropriate wage adjustment to the caps, we have determined the labor-related and nonlabor-related portions of the caps on the target amounts for FY 2002 using the methodology outlined above.

Class of excluded hospital or unit	FY 2001 labor-related share	FY 2001 nonlabor-related share
Psychiatric .....	\$8,429	\$3,351
Rehabilitation ....	\$15,736	\$6,256
Long-Term Care	\$31,490	\$12,519

These labor-related and nonlabor-related portions of the caps on the target amounts for FY 2002 are based on the current estimate of the market basket increase for excluded hospitals and units for FY 2002 of 3.3 percent and reflect the change in applying the pre-reclassified hospital inpatient prospective payment system wage index as discussed above. Furthermore, in accordance with section 307(a) of Public Law 106-554, which amended section 1886(b)(3) of the Act, the labor-related and nonlabor-related portions of the cap for long-term care hospitals for FY 2002 are increased by 2 percent. A further discussion of this provision as it appeared in the June 13, 2001 interim final rule with comment period (66 FR 32181) that will implement provisions of Public Law 106-554 for FY 2001 and for periods in FY 2001 from April 1, 2001 through September 30, 2001, appears in section VI.A.4. of this preamble.

Finally, to determine payments described in § 413.40(c), the cap on the hospital's target amount per discharge is determined by adding the hospital's nonlabor-related portion of the national 75th percentile cap to its wage-adjusted, labor-related portion of the national 75th percentile cap. A hospital's wage-

adjusted, labor-related portion of the target amount is calculated by multiplying the labor-related portion of the national 75th percentile cap for the hospital's class by the hospital's applicable wage index. For FY 2002, a hospital's applicable wage index is the pre-reclassified wage index under the hospital inpatient prospective payment system (see § 412.63). The wage index values are computed based on the same data used to compute the FY 2002 wage index values for the hospital inpatient prospective payment system without taking into account changes in geographic reclassification under the following: Section 1886(d)(8)(B) of the Act for certain rural hospitals; section 401 of Public Law 106-113; reclassifications based on MGCRB decisions; or the Secretary's decisions under sections 1886(d)(8) through (d)(10) of the Act. For cost reporting periods beginning on or after October 1, 2001 and before October 1, 2002, the pre-reclassified wage index is in Tables 4G and 4H of this final rule. A hospital's applicable wage index corresponds to the area in which the hospital or unit is physically located (MSA or rural area).

2. New Excluded Hospitals and Units

a. Updated Caps (§ 413.40(f))

Section 1886(b)(7) of the Act establishes a payment methodology for new psychiatric hospitals and units, new rehabilitation hospitals and units, and new long-term care hospitals. Under the statutory methodology, for a hospital that is within a class of hospitals specified in the statute and first receives payments as a hospital or unit excluded from the prospective payment system on or after October 1, 1997, the amount of payment will be determined as follows: For the first two 12-month cost reporting periods, the amount of payment is the lesser of (1) the operating costs per case; or (2) 110 percent of the national median of target amounts for the same class of hospitals for cost reporting periods ending during FY 1996, updated to the first cost reporting period in which the hospital receives payments as adjusted for differences in area wage levels.

As discussed earlier, in reviewing our methodology for wage neutralizing the hospital-specific target amounts, it appears we incorrectly used the FY 2000 hospital inpatient prospective payment system wage index published in Tables 4A and 4B of the July 30, 1999 final rule, which is based on wage data after taking into account geographic reclassifications under section 1886(d)(8) of the Act. Therefore, as we proposed in the May 4 proposed rule,

we also are revising the methodology of wage neutralizing the hospital-specific target amounts using pre-reclassified wage data in our calculation of the limit for new excluded hospitals and units.

The amounts included in the following table reflect the updated and recalculated 110 percent of the wage neutralized national median target amounts for each class of excluded hospitals and units for cost reporting periods beginning during FY 2002. These figures are updated to reflect the projected market basket increase of 3.3 percent. For a new provider, the labor-related share of the target amount is multiplied by the appropriate geographic area wage index, without regard to prospective payment system 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 2002 labor-related share	FY 2002 nonlabor-related share
Psychiatric .....	\$6,815	\$2,709
Rehabilitation ....	\$13,465	\$5,353
Long-Term Care	\$16,701	\$6,640

b. Changes in Type of Hospital Classification (§§ 412.23 and 412.25)

Section 1886(b)(3) of the Act (as amended by section 4414 of Public Law 105-33) establishes caps on the target amounts for existing psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals for cost reporting periods beginning on or after October 1, 1997 through September 30, 2002. Section 4416 of Public Law 105-33 amended section 1886(b)(7) of the Act to provide for a limitation on payment for new excluded psychiatric hospitals and units, new rehabilitation hospitals and units, and new long-term care hospitals. Since the establishment of the caps on target amounts and the payment limitations, there has been an increase in the number of hospitals requesting a change from one classification type to another (for example, from rehabilitation to long-term care). Regulations at § 412.22(d) state that "For purposes of exclusion from the prospective payment systems under this subpart, the status of each currently participating hospital (excluded or not excluded) is determined at the beginning of each cost reporting period and is effective for the entire cost reporting period. Any changes in the status of the hospital are made only at the start of a cost reporting period."

Even though the existing regulations directly address only a hospital that changes from a prospective payment system hospital to an excluded hospital, our longstanding policy has been that a change of any classification type can be effective only at the beginning of the provider's cost reporting period. As we stated in the May 4 proposed rule, although the existing regulations do not directly address changes in a classification type of excluded hospital, we believe that a change from one classification type of excluded hospital to another type of excluded hospital is analogous to a change from a prospective payment system hospital to an excluded hospital. Therefore, based on our belief that it would be consistent with our longstanding policy, we proposed to amend our regulations to specify that a change from one excluded hospital classification type to another type is allowed only at the beginning of the hospital's cost reporting period.

The rationale underlying our present policy of requiring that these types of changes should only be effective at the beginning of the cost reporting period is the need to avoid any undue (and possibly significant) administrative burden that could result from doing otherwise (for example, cost allocation, cost reporting requirements, certification issues). If we were to accept changes in an excluded hospital's classification type from one type of classification to another, other than at the beginning of the cost reporting period, the hospital would need to file a terminating cost report with respect to its original classification as well as file a separate cost report for the remainder of the cost reporting period with respect to its new classification. Filing these cost reports would involve gathering the appropriate cost data, allocating the data, and apportioning the data between the two hospital classes. Additionally, we would have to validate the cost reports. To allow these types of changes in the middle of a cost reporting period would result in a significant administrative burden. We point out that this burden is applicable equally for either a change from a prospective payment system hospital to an excluded hospital, or a change from one excluded hospital classification type to another classification type. Therefore, as we proposed in the May 4 proposed rule, we are amending the regulations to provide that the effective date of any of these classification changes is only at the beginning of a provider's cost reporting period (§ 412.23(i), for excluded hospitals, and § 412.25(f), for excluded units).

We did not receive any public comments on our proposed revisions of §§ 412.23(i) and 412.25(f). Therefore, we are adopting the proposed revisions as final.

### 3. Effective Date of Exclusion of Long-Term Care Hospitals

Existing regulations at § 412.23(e) require a newly established long-term care hospital to operate for at least 6 months with an average length of stay in excess of 25 days in order to qualify for exclusion from the inpatient hospital prospective payment system as a long-term care hospital. Other regulations at § 412.22(d) allow changes in a hospital's status from not excluded to excluded to occur only at the start of a cost reporting period. These two regulations, taken together, typically require a hospital to operate for at least 6 months under the prospective payment system before becoming eligible for payment at the more favorable rate under section 1886(b)(3) of the Act.

These regulations were challenged in litigation by a chain organization that operates a large number of long-term care hospitals (*Transitional Hospitals Corporation of Louisiana, Inc. v. Shalala*, 222 F.3d 1019 (D.C. Cir. 2000) (*THC*)). Although the court of appeals in this case found that the Secretary has ample authority to adopt current regulatory provisions, it also concluded that the Secretary could have considered other policy options. Consequently, it remanded the case to the agency for the agency to consider whether it wanted to continue its existing policy or adopt a policy of either "self-certification" or "retroactive adjustment." Generally, under a self-certification approach, hospitals that have not yet demonstrated the required average length of stay would be excluded from the prospective payment system based on a commitment to maintain such a length of stay. Under a retroactive adjustment approach, a hospital's long-term care classification would be made effective with the beginning of the 6-month period in which it demonstrated the required average length of stay. Payments for that period initially would be made under the prospective payment system and then adjusted retroactively to amounts payable for an excluded long-term care hospital once length of stay was successfully established.

As directed by the court of appeals, we reviewed the issues raised in this case in light of the court's decision, and specifically considered the options of self-certification and retroactive adjustment. Our proposals, and the alternatives we considered before

arriving at them, are explained in detail in the May 4, 2001 proposed rule (66 FR 22708) and summarized below.

Although we understood that we have discretion to select other policy options, we proposed to continue our policy of requiring hospitals seeking long-term care hospital classification to demonstrate the required average length of stay based on 6 months of data, instead of permitting these hospitals to "self-certify" the required average length of stay.

We noted that the statute provides the agency with broad authority to determine the methodology by which facilities can qualify for exclusion as long-term care hospitals (section 1886(d)(1)(B)(iv)(I) of the Act specifies that "a hospital which has an average inpatient length of stay (as determined by the Secretary) of greater than 25 days" qualifies for exclusion as a long-term care hospital). As the court of appeals decided, the parenthetical phrase *as determined by the Secretary* "gives the Secretary considerable leeway to determine whether to require prospective, contemporaneous, or retrospective evaluation and payment." (*THC* at 1026.)

Having proposed to continue our policy of not allowing a hospital to self-certify the required average length of stay in order to be paid as an excluded long-term care hospital, we also considered the effective date of excluded status for a hospital that has demonstrated the required average length of stay. We considered making long-term care classification effective retroactively with the beginning of the 6-month period in which the hospital demonstrated the required average length of stay. However, we believe that such retroactive application of excluded status is inappropriate.

Therefore, we proposed to continue our policy that a hospital's payment as a long-term care hospital would be effective with the beginning of the hospital's cost reporting period that follows the determination to classify the hospital as a long-term care hospital.

*Comment:* One commenter expressed general approval of the policies set forth in the May 4 proposed rule, stating that hospitals seeking long-term care status should be required to demonstrate the required length of stay based on 6 months of data.

*Response:* We appreciate the support of the commenter for our proposed policy.

*Comment:* Another commenter disagreed with our proposed policy and requested that we reconsider it. This commenter stated that our proposals were inconsistent with the purpose of

the prospective payment system exclusion, resulted in disparate treatment of similarly situated providers, and produced inappropriate reimbursement shortfalls. The commenter also argued that our reliance on the general prospective nature of the prospective payment system was misplaced and inconsistent with our regulations.

*Response:* We have examined the commenter's contentions in detail but have concluded that they do not warrant adoption of a policy different from the one we have proposed. First, we disagree that our proposal is inconsistent with the purpose of the long-term care hospital exclusion. We agree with the commenter that the purpose of the exclusion is to ensure adequate reimbursement to hospitals that treat long-stay patients. However, the question addressed by our proposed policy is how to determine which providers meet the criteria for being considered hospitals that treat such patients. We believe that our proposed policy is the most appropriate methodology for making this determination. We believe that our proposed policy furthers the purpose of the exclusion by ensuring that only hospitals that can demonstrate compliance with the statutorily required length of stay receive long-term care hospital status. It also ensures that decisions granting such status are implemented in accordance with the general goals of the prospective payment system and our longstanding policies regarding the effective dates of changes in the various components of providers' prospective payment system payment rates.

Second, we do not agree with the commenter's contention that our proposed policy results in disparate treatment of similarly situated providers because we allow rehabilitation hospitals to self-certify that they will meet certain aspects of the criteria for exclusion but do not allow long-term care hospitals to do so. We dealt with this issue at length in the May 4 proposed rule and explained there that the differences in the nature of the two types of facilities, and the differences in their statutory and regulatory definitions, justified their varying treatment for these purposes. The commenter's assertion that the self-certification option that is permitted as to rehabilitation facilities and the same type of option that is not permitted as to long-term care hospitals both relate to the types of patient to be admitted—even if true in some general sense—is not sufficient in our view to overcome the clear differences in the two types of

facilities that informs our different treatment of them.

Similarly, the fact that long-term care hospitals must meet a series of regulatory conditions of participation does not make them sufficiently similar to rehabilitation hospitals so as to make the use of self-certification by long-term care hospitals appropriate, as the commenter suggested. All hospitals must meet conditions of participation to participate in the Medicare program. However, that does not change the fact that, as pointed out in the May 4 proposed rule, the statute itself requires that a hospital meet the length of stay criterion to qualify as a long-term care hospital, while the statute grants the Secretary broad authority to promulgate various criteria for a hospital to qualify as a rehabilitation hospital. It is the additional certainty supplied by the additional criteria for status as a rehabilitation hospital under this authority that has led us to allow rehabilitation hospitals to self-certify that they will comply with the remaining criterion. Such certainty is lacking in the case of long-term care hospitals, since the length-of-stay criterion is extremely difficult to predict into the future at any particular point in time.

Conditions of participation exist as a matter of Medicare survey and certification activities to ensure that the provider meets the requirements of participation in the program, not as definitional criteria that establish a hospital's status for payment purposes. As a result, they do not provide the type of additional certainty that derives from the nature and number of rehabilitation hospital criteria and that might warrant allowing long-term care facilities to self-certify that they will meet the required average length of stay. The commenter also pointed out that there are various criteria in § 412.22(e) that a facility must meet to qualify as a hospital within a hospital. However, the existence of these criteria does not alter the fact that a hospital must meet the statutory length-of-stay criterion in order to qualify as a long-term care hospital, making self-certification by such a hospital inappropriate.

The commenter suggested that, if we reject its suggestion to allow self-certification by long-term care hospitals, we should then adopt a policy whereby we would pay a long-term care hospital provisionally under the prospective payment system during its initial cost reporting period; evaluate compliance with the length-of-stay requirement at the end of that period; and, if the requirement had been met, retroactively adjust its reimbursement to provide for

payment on a reasonable cost basis. We do not agree with the commenter that such a scheme would result in no significant administrative burden because the retroactive adjustments could be made as part of the cost report review process. Whether performed as part of this process or not, the scheme the commenter suggested would result in just the type of burden that has generally led to our making changes in components of the prospective payment system rates prospective only, as noted in the May 4 proposed rule. As also noted in the proposed rule, such prospective only changes are consistent with our approach, validated by the courts in cases like *THC*, *Methodist Hospital of Sacramento*, and *County of Los Angeles*, of balancing absolute accuracy and finality and favoring the latter in the context of the prospective payment system. We find nothing in the commenter's suggestions on this point that persuades us to depart from our intention to adopt our proposed policy.

Third, we disagree with the commenter's statement that our proposed policy produces inappropriate reimbursement shortfalls. To the contrary, as noted above, our policy is designed to identify those hospitals that qualify for appropriate payment as long-term care facilities, in accordance with principles of prospectivity that have been approved by the courts. Although the commenter stated that Congress did not intend for us to require that new long-term care hospitals wait at least 6 months before being excluded from the hospital inpatient prospective payment system, the court of appeals in *THC* specifically found that the Medicare statute did not preclude just such a policy. We also note that, while the policy described in the May 4 proposed rule is one of longstanding, Congress has never seen fit to amend the statute to require us to implement long-term care exclusions immediately upon a new hospital's participation in the program.

Finally, we do not agree with the commenter that our reliance on the prospective nature of the prospective payment system in arriving at our proposed policy is misplaced or that the policy conflicts with our regulations. As to the former point, as noted above, we believe that the court decisions in *THC*, *Methodist Hospital of Sacramento*, and *County of Los Angeles* directly support the adoption of our proposed policy. We do not find the commenter's analyses of these cases persuasive. They cannot be distinguished on the basis that they apply to hospitals paid under the hospital inpatient prospective payment system but not to hospitals excluded

from the prospective payment system, as the commenter suggested. Making the determination whether a hospital is excluded from or subject to the hospital inpatient prospective payment is an important part of implementing the prospective payment system payment methodology, and, like other aspects of that implementation, should be guided by the general principles underlying the prospective payment system. That is especially so since the "default" payment mode for acute care hospitals is payment subject to the hospital inpatient prospective payment system, and reasonable cost payment does not result until it is determined (again, as part of administering the prospective payment system) that the hospital's status should change to excluded status.

Moreover, while the court of appeals in *Methodist Hospital* may have stated that retroactive corrections are not necessarily inconsistent with the hospital inpatient prospective payment system, all three cases stand for the proposition that neither is the agency's prospective only policy inconsistent with the statute. Indeed, that is largely the point of the court of appeals' decision in *THC*—that the agency has broad statutory authority to adopt retroactive, contemporaneous, or prospective application of decisions granting long-term care status. For the reasons set out in the May 4 proposed rule and in this final rule, we have elected the latter policy. The policy at issue here is thus quite different from the one at issue in *Georgetown University Hospital v. Bowen*, 862 F.2d 323 (D.C. Cir.1988), which the commenter also cited, because the court of appeals held that that policy was contrary to express Congressional intent.

Nor is our proposed policy contrary to our regulations. The only regulations that the commenter cited in support of this point are those that implement the statutory requirement that a hospital cost report be subject to retroactive adjustment upon review by the intermediary after the close of the applicable cost reporting period. However, those regulations, and the statutory provisions they implement, merely establish a year end "book-balancing" process to reconcile the amount of estimated payments made to the provider during the year with the actual amount of reimbursement the provider is due for that year, determined in accordance with the methods prescribed by the agency. Among those methods is prospective only application of the prospective payment system status decisions. These regulations then

are in no way inconsistent with our proposed policy.

#### 4. Payment for Long-Term Care Hospital Costs: Provisions of the June 13, 2001 Interim Final Rule with Comment Period (Section 307 of Public Law 106–554 and 42 CFR 413.40(c)(4))

##### a. Increase in the Limitation on the Target Amounts for Long-Term Care Hospitals

As stated in the June 13 interim final rule with comment period (66 FR 32181), in the August 29, 1997 final rule with comment period (62 FR 46018), in accordance with section 4414 of Public Law 105–33, we implemented section 1886(b)(3)(H) of the Act, which provides for caps on the target amounts for existing and new excluded hospitals and units for cost reporting periods beginning on or after October 1, 1997, through September 30, 2002. The caps on the target amounts apply to three classes of excluded hospitals: psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals. In establishing the caps on the payment amounts within each class of hospital for *new* hospitals, section 1886(b)(7)(C) of the Act, as amended by section 4416 of Public Law 105–33, instructed the Secretary to provide an appropriate adjustment to take into account area differences in average wage-related costs. However, because the statutory language under section 4414 of Public Law 105–33 did not provide for the Secretary to adjust for area differences in wage-related costs in establishing the caps on the target amounts within each class of hospital for *existing* hospitals, we did not adjust for wage-related differences for existing facilities. In the August 1, 2000 interim final rule with comment period (65 FR 47039), we implemented section 121 of Public Law 106–113, which further amended section 1886(b)(3)(H) of the Act by directing the Secretary to provide for an appropriate wage adjustment to the caps on the target amounts for *all* psychiatric hospitals and units, rehabilitation hospitals and units and long-term care hospitals, effective for cost reporting periods beginning on or after October 1, 1999, through September 30, 2002. For purposes of calculating the caps, section 1886(b)(3)(H)(ii) of the Act requires the Secretary to first "estimate the 75th percentile of the target amounts for such hospitals within such class for cost reporting periods ending during fiscal year 1996." Section 1886(b)(3)(H)(iii) of the Act, as added by section 121 of Public Law 106–113, requires the Secretary to provide for "an appropriate

adjustment to the labor-related portion of the amount determined under such subparagraph to take into account differences between average wage-related costs in the area of the hospital and the national average of such costs within the same class of hospital."

The August 1, 2000 final rule (65 FR 47096) listed the FY 2001 labor-related share and nonlabor-related share of the national 75th percentile wage-neutralized cap for long-term care hospitals as follows:

- Labor-related Share: \$29,284
- Nonlabor-related Share: \$11,642

The final rule also discussed that within each class a hospital's wage-adjusted cap on its target amount is determined by adding the hospital's nonlabor-related portion of the national wage-neutralized cap to its wage-adjusted labor-related portion of the national wage-neutralized cap. A hospital's wage-adjusted labor-related portion is calculated by multiplying the labor-related portion of the national wage-neutralized 75th percentile cap for the hospital's class by the hospital's applicable wage index. For FY 2001, a hospital's applicable wage index is the wage index under the hospital inpatient prospective payment system as shown in Tables 4A and 4B of the August 1, 2000 final rule (65 FR 47149 through 47156) corresponding to the area in which the hospital is physically located (MSA or rural area).

Section 307(a) of Public Law 106–554 further amended section 1886(b)(3) of the Act and provides for a 2-percent increase to the wage-adjusted 75th percentile cap on the target amount for long-term care hospitals effective for cost reporting periods beginning during FY 2001. This provision is only applicable to long-term care hospitals that were subject to the cap for existing excluded providers as specified in § 413.40(c).

In accordance with section 1886(b)(3) of the Act as amended, for cost reporting periods beginning during FY 2001, in the June 13 interim final rule with comment period, we specified the following revised labor-related and nonlabor-related shares of the cap on the target amount for long-term care hospitals, which reflect the 2-percent increase:

#### REVISED FY 2001 NATIONAL CAP FOR LONG-TERM CARE HOSPITALS

FY 2001 labor-related share	FY 2001 nonlabor-related share
\$29,870	\$11,875

Note that the national 75th percentile wage-neutralized caps on the target amount for the other excluded hospitals and units subject to the caps under section 1886(b)(3)(H) of the Act (psychiatric and rehabilitation) are not affected by section 307 of Public Law 106-554. In the June 13 interim final rule with comment period, we revised the regulations at § 413.40(c)(4)(iii) to incorporate this change.

We did not receive any public comments on our proposed revision of § 413.40(c)(4)(iii) to incorporate this provision of the statute and, therefore, are adopting it as final.

#### b. Increase in the Target Amounts for Long-Term Care Hospitals

As stated in the June 13, 2001 interim final rule with comment period (66 FR 32181), in the August 29, 1997 final rule with comment period (62 FR 46016) we implemented the amendment to section 1886(b)(3)(B) of the Act, as made by section 4411 of Public Law 105-33, which set forth the applicable rate-of-increase percentage for cost reporting periods beginning during FY 1999 through FY 2002. The rate-of-increase is equal to the market basket increase percentage minus an amount based on the percentage by which the hospital's operating costs exceed the hospital's ceiling for the most recent available cost reporting period. The applicable rate-of-increase percentages (update factors) for FY 2001 are described in the August 1, 2000 final rule (65 FR 47125). For FY 2001, the market basket increase percentage was forecast at 3.4 percent, which results in an update for long-term care hospitals for FY 2001 of between 0.9 percent and 3.4 percent, or 0 percent, depending on the hospital's costs in relation to its rate-of-increase limit.

In addition to the increase to the cap on the target amounts for long-term care hospitals, section 307(a) of Public Law 106-554 also amended section 1886(b)(3) of the Act to provide for a 25-percent increase to the target amounts determined under section 1886(b)(3)(A) of the Act for long-term care hospitals, for cost reporting periods beginning in FY 2001, subject to the applicable cap on the target amounts. Thus, this provision required a revision to the determination of each long-term care hospital's FY 2001 target amount as specified in § 413.40(c)(4). As stated in the June 13 interim final rule with comment period, for cost reporting periods beginning during FY 2001, the hospital-specific target amount otherwise determined for a long-term care hospital as specified in the regulations at § 413.40(c)(4)(ii) is

multiplied by 1.25 (that is, increased by 25 percent), subject to the limitation that the revised FY 2001 target amounts for a long-term care hospital cannot exceed its wage-adjusted national cap as required by section 1886(b)(3) of the Act, as amended by section 307(a) of Public Law 106-554. We noted that the 25-percent increase to the target amount under section 307(a) of Public Law 106-554 is applicable only to long-term care hospitals, and not to other excluded hospitals as defined in section 1886(d)(1)(B) of the Act (psychiatric and rehabilitation hospitals and units, children's and cancer hospitals).

In the June 13, 2001 interim final rule with comment period, we revised the regulations at § 413.40(c)(4)(iii) to incorporate this change.

We did not receive any public comments on this revision of § 413.40(c)(4)(iii) to incorporate this provision of the statute and, therefore, are adopting it as final.

#### 5. Development of Prospective Payment System for Inpatient Rehabilitation Hospitals and Units

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

Shortly, we will be issuing a final rule on the establishment of the prospective payment system for inpatient rehabilitation facilities, to be effective January 1, 2002.

#### 6. Increase in the Incentive Payment for Excluded Psychiatric Hospitals and Units: Provision of the June 13, 2001 Interim Final Rule with Comment Period (Section 306 of Public Law 106-554 and 42 CFR 413.40(d)(2))

As we stated in the June 13 interim final rule with comment period (66 FR 32181), for cost reporting periods

beginning before October 1, 1997, a hospital that had inpatient operating costs less than, or equal to, its ceiling was paid its costs plus the lower of 50 percent of the difference between inpatient operating costs and the ceiling or 5 percent of the ceiling. Section 4415 of Public Law 105-33 amended section 1886(b)(1)(A) of the Act to provide that for cost reporting periods beginning on or after October 1, 1997, if a hospital's net inpatient operating costs are less than or equal to, the ceiling, the amount of the bonus payment would be the lower of 15 percent of the difference between the inpatient operating costs and the ceiling or 2 percent of the ceiling. Section 306 of the Public Law 106-554 further amended section 1886(b)(1)(A) of the Act, as it applied to a psychiatric hospital or unit, to provide that effective for cost reporting periods beginning on or after October 1, 2000, and before October 1, 2001, if a psychiatric hospital or unit's net inpatient operating costs are less than, or equal to, the ceiling, the amount of the bonus payment is the lower of 15 percent of the difference between the inpatient operating costs and the ceiling, or 3 percent of the ceiling.

In the June 13 interim final rule with comment period, we revised the regulations at § 413.40(d)(2) to incorporate this change.

We did not receive any public comments on our revision to § 413.40(d)(2) in the interim final rule with comment period to incorporate this provision of the statute and, therefore, are adopting it as final.

#### 7. Changes in the Types of Patients Served or Inpatient Care Services That Distort the Comparability of a Cost Reporting Period to the Base Year are Grounds for Requesting an Adjustment Payment in Accordance with Section 1886(b)(4) of the Act

Section 4419(b) of Public Law 104-33 requires the Secretary to publish annually in the **Federal Register** a report describing the total amount of adjustment (exception) payments made to excluded hospitals and units, by reason of section 1886(b)(4) of the Act, during the previous fiscal year. However, the data on adjustment payments made during the previous fiscal year are not available in time to publish a report describing the total amount of adjustment payments made to all excluded hospitals and units in the subsequent year's final rule published in the **Federal Register**.

The process of requesting, adjudicating, and awarding an adjustment payment for a given cost reporting period occurs over a 2-year

period or longer. An excluded hospital or unit must first file its cost report for the previous fiscal year with its intermediary within 5 months after the close of the previous fiscal year. The fiscal intermediary then reviews the cost report and issues a Notice of Program Reimbursement (NPR) in approximately 2 months. If the hospital's operating costs are in excess of the ceiling, the hospital may file a request for an adjustment payment within 6 months from the date of the NPR. The intermediary, or CMS, depending on the type of adjustment requested, then reviews the request and determines if an

adjustment payment is warranted. This determination is often not made until more than 6 months after the date the request is filed. Therefore, it is not possible to provide data in a final rule on adjustments granted for cost reports ending in the previous Federal fiscal year, since those adjustments have not even been requested by that time. However, in an attempt to provide interested parties at least some relevant data on adjustments, we are publishing data on requests for adjustments that were processed by the fiscal intermediaries or CMS during the previous Federal fiscal year.

The table below includes the most recent data available from the intermediaries and CMS on adjustment payments that were adjudicated during FY 2000. By definition, these were for cost reporting periods ending in years prior to FY 1999. The total adjustment payments awarded to excluded hospitals and units during FY 2000 are \$12,344,419. The table depicts for each class of hospital, in aggregate, the number of adjustment requests adjudicated, the excess operating cost over the ceiling, and the amount of the adjustment payment.

Class of hospital	Number	Excess cost over ceiling	Adjustment payment
Psychiatric .....	40	\$19,172,613	\$9,114,944
Rehabilitation .....	8	6,128,515	2,254,393
Long-Term Care .....	3	827,821	814,971
Children's .....	1	160,111	160,111

### B. Critical Access Hospitals (CAHs)

Section 4201 of Public Law 105–33 amended section 1820 of the Act to create a nationwide Medicare Rural Hospital Flexibility (MRHF) Program to replace the 7-State Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) program. Under section 1820(c)(2) of the Act, as amended, a State could designate certain rural hospitals as CAHs if they were located a specified distance from other hospitals, made 24-hour emergency care available, and kept inpatients for a limited period of time. Additionally, CAH staffing requirements differed from those of other hospitals under Medicare and CAHs received payment for inpatient and outpatient services on the basis of reasonable cost. A comprehensive discussion of CAHs within the context of the MRHF Program may be found in the August 29, 1997 **Federal Register** (62 FR 45970 and 46008–46010).

#### 1. Permitting Certain Facilities to be Designated as CAHs (Section 401(b) of Public Law 106–113 and 42 CFR 485.610)

As discussed in the August 1, 2000 interim final rule with comment period, one of the threshold criteria for designation as a CAH under section 1820(c)(2)(B)(i) of the Act is that the hospital must be rural as defined in section 1886(d)(2)(D)(ii) of the Act. Section IV.A. of the interim final rule with comment period discussed the option of urban to rural classification for a “subsection (d)” hospital authorized by section 401(a) of Public Law 106–113 under an amendment to section

1886(d)(8) of the Act. Section 401(b)(2) of Public Law 106–113 amended section 1820(c)(2)(B) of the Act to authorize a State to designate a hospital in an urban area as a CAH if, under one of the criteria set forth in section 1886(d)(8)(E) of the Act, it would be treated as being located in the rural area of the State in which the hospital is located. Section 401(b)(2) only provides authority for a hospital to meet the rural requirement. We note that the hospital would have to otherwise meet the statutory and regulatory requirements governing CAH designation.

The first criteria in section 401(a) specified that a hospital will be treated as located in a rural area if the hospital is located in a rural census tract of an MSA, as determined under the most recent Goldsmith Modification, originally published in the **Federal Register** on February 27, 1992. In Appendix B of the August 1, 2000 interim final rule with comment period, we published a listing of existing hospitals that may qualify as CAHs because they are located in Goldsmith areas.

In the August 1, 2000 interim final rule, we specified that the application procedures and effective dates for an urban hospital seeking to reclassify as rural in order to apply for CAH status under section 1820(c)(2)(B)(i) of the Act were set forth in new § 412.103 that implements section 401(a), and discussed in section IV.C. of that interim final rule with comment period (65 FR 47041). In the August 1 interim final rule with comment period, we revised the regulations on location for

CAHs at § 485.610(b) to reflect this amendment.

We did not receive any comments on the revised section of the regulations in the interim final rule with comment period and have not made any further changes to it.

#### 2. Exclusion of CAHs From Payment Window Requirements

Section 1886 of the Act specifies the requirements governing payment to full-service hospitals for the operating costs of inpatient hospital services under both the inpatient hospital prospective payment system and the limits on the target amounts for hospitals excluded from the prospective payment system. “Operating costs of inpatient hospital services” are defined in section 1886(a)(3) of the Act, which provides in part that costs of certain services provided to a beneficiary during the 3 days (or in the case of an excluded hospital or unit, during the 1 day) immediately preceding the patient's admission are to be included in the payments for costs under the inpatient hospital prospective payment system, or costs subject to the target amount for excluded hospitals and units. This part of the definition is sometimes referred to as the “payment window” requirement. Regulations implementing the payment window requirement are found at § 412.2(c)(5) for hospitals subject to the prospective payment system, and § 413.40(c)(2) for hospitals excluded from the prospective payment system.

As we stated in the May 4, 2001 proposed rule, payment to CAHs for inpatient services is not made under the

inpatient hospital prospective payment system mandated by section 1886 of the Act, nor are CAHs considered to be hospitals excluded from the inpatient hospital prospective payment system. Instead, payment is made on a reasonable cost basis, as mandated by section 1814(l) of the Act. Neither section 1814(l) nor section 1861(v) of the Act (which defines "reasonable cost") requires application of the payment window to services furnished on an outpatient basis immediately before admission to a CAH. Therefore, we stated in the May 4 proposed rule that we have determined that the payment window provision does not apply to CAHs. To clarify this point and avoid possible misapplication of the payment window, we proposed to amend § 413.70(a)(1) to provide that the requirements of §§ 412.2(c)(5) and 413.40(c)(2) do not apply to CAHs.

*Comment:* Several commenters expressed support for the proposal to explicitly exclude CAHs from the payment window requirements. None of the commenters opposed the proposal or suggested changes to it.

*Response:* We appreciate the commenters' support and are adopting the proposed regulation amendments as final.

### 3. Availability of CRNA Pass-Through for CAHs

Generally, anesthesia services furnished to a hospital patient by a certified registered nurse anesthetist (CRNA) must be billed to the Part B carrier and payment is made under the applicable fee schedule provisions of § 414.60. However, certain rural hospitals that furnish no more than 500 surgical procedures requiring anesthesia per year and meet other specified requirements are exempted from the fee schedule. These hospitals are paid on a reasonable cost basis for their costs of anesthesia services furnished by qualified nonphysician anesthetists. The exemption is provided in accordance with section 9320(k) of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) (as added by section 608(c)(2) of the Family Support Act of 1988 (Public Law 100-185), as amended by section 6132 of the Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239)). We have codified this exemption at § 412.113(c).

We pointed out in the May 4 proposed rule that, although § 412.113(c) does not specifically extend eligibility for the pass-through payment for CRNAs to CAHs, some CAHs have pointed out that they are similar to the rural hospitals that are eligible for this payment, in that they also furnish low

volumes of surgical procedures requiring anesthesia and could face the same problem of potentially inadequate payment for CRNA services if they are not allowed to qualify for the pass-through payment. We share this concern.

We recognize that the legislation cited above, which provides the legal basis for the pass-through payments, refers only to "hospitals," not to CAHs. Moreover, section 1861(e) of the Act states that "the term "hospital" does not include, unless the context otherwise requires, a critical access hospital \* \* \*." It is clear from section 1861(e) of the Act that CAHs are not to be considered hospitals under the Medicare law for most purposes. However, the reference to "context" in the provision indicates that CAHs may be classified as hospitals where, in specific contexts, it would be consistent with the purpose of the legislation to do so.

We stated that we believe this is the case with the statutory provisions authorizing pass-through payments for CRNA costs. The purpose of the pass-through legislation is to provide small rural hospitals with low surgical volumes with relief from the difficulties they might otherwise have in furnishing CRNA services for their patients. CAHs are by definition limited-service facilities located in rural areas and, as such, they serve a population much like those served by hospitals eligible for the pass-through payments. In some cases, an institution that now participates as a CAH may even have been eligible for the pass-through payments when it participated as a hospital. Such an institution would clearly be disadvantaged if it were to lose this status. Thus, in accordance with section 1861(e) of the Act and in light of the context of the pass-through legislation cited above, we consider CAHs to be "hospitals" for purposes of extending eligibility for the CRNA pass-through payments to them.

Therefore, in the May 4 proposed rule, we proposed to add a new § 413.70(a)(3) and revise §§ 413.70(a)(2), (b)(1), and (b)(6) to permit CAHs that meet the criteria for the pass-through payments in § 412.113(c) to qualify for pass-through payments for the costs of anesthesia services for both inpatient and outpatient surgeries, on the same basis as full service rural hospitals. As an unrelated technical correction, we proposed to revise § 413.70(b)(2)(i)(C) to delete the incorrect reference to § 413.130(j)(2) and replace it with a reference to reduction in capital costs under § 413.130(j). We also proposed to revise § 412.113(c) by changing the term "hospital" to "hospital or CAH".

*Comment:* Several commenters favored extension of the CRNA pass-through to CAHs. However, some commenters suggested that the pass-through be made available to all CAHs, even if they furnish 500 or more surgical procedures requiring anesthesia service in the prior year.

*Response:* Section 412.113(c), which is based on the provisions of the Medicare law, is specific with respect to the volume of surgeries that may be performed by facilities qualifying for the CRNA pass-through. The volume of surgeries is a criterion for a hospital to qualify for CRNA pass-through. As we are treating CAHs as hospitals for purposes of the CRNA pass-through, a CAH would have to meet the same qualifying criteria as would a hospital. Accordingly, we are not adopting the commenters' suggestion that the 500 procedure criterion be revised for CAHs.

*Comment:* One commenter stated that anesthesia services in many rural facilities are furnished by anesthesiologists rather than CRNAs, and suggested that pass-through also be made available for the costs of anesthesia services provided by anesthesiologists.

*Response:* The Medicare law is specific to CRNAs and does not offer similar treatment for costs of services of anesthesiologists. Therefore, we are not adopting this suggestion.

### 4. Payment to CAHs for Emergency Room On-Call Physicians (§ 413.70(b)(4))

Under section 1834(g) of the Act, Medicare payment to a CAH for facility services to Medicare outpatients is the reasonable costs of the CAH in providing such services. The term "reasonable cost" is defined in section 1861(v) of the Act and in regulations at 42 CFR Part 413, including, with specific reference to CAHs, § 413.70. Consistent with the general policies stated in section 2109 of the Medicare Provider Reimbursement Manual (PRM), Part I (HCFA Publication 15-1), the reasonable cost of CAH services to outpatients may include reasonable costs of compensating physicians who are on standby status in the emergency room (that is, physicians who are present and ready to treat patients if necessary). However, under existing policy, the reasonable cost of CAH services to outpatients may not include any costs of compensating physicians who are not present in the facility but are on call.

Section 204 of Public Law 106-554 further amended section 1834(g) of the Act (as amended by section 201 of Public Law 106-554) by adding a new

paragraph (5). New section 1834(g)(5) of the Act provides that, in determining the reasonable costs of outpatient CAH services under sections 1834(g)(1) and 1834(g)(2)(A) of the Act, the Secretary shall recognize as allowable costs amounts (as defined by the Secretary) for reasonable compensation and related costs for emergency room physicians who are on call (as defined by the Secretary) but who are not present on the premises of the CAH involved, are not otherwise furnishing physicians' services, and are not on call at any other provider or facility. The provisions of section 204 of Public Law 106-554 are effective for cost reporting periods beginning on or after October 1, 2001.

As we provided in the May 4 proposed rule, to implement the provisions of section 1834(g)(5) of the Act, we proposed to add a new paragraph (4) to § 413.70(b). The proposed § 413.70(b)(4) would permit the reasonable costs of CAH outpatient services to include the reasonable compensation and related costs of emergency room on-call physicians under the terms and conditions specified in the statute. As directed in the statute, under § 413.70(b)(4)(ii)(A) of the proposed rule, we defined "amounts for reasonable compensation and related costs" as those allowable costs of compensating emergency room physicians for being on call, to the extent these costs are found to be reasonable under the rules in § 413.70(b)(2).

In addition, as specified under § 413.70(b)(4)(ii)(A) of the proposed rule, we defined an "emergency room physician who is on call" as a doctor of medicine or osteopathy with training or experience in emergency care who is immediately available by telephone or radio contact, and who is available on site within the timeframes specified in our existing regulations under § 485.618(d). Existing § 485.618(d) specifies that the physician must be available on site (1) Within 30 minutes, on a 24-hour a day basis, if the CAH is located in an area other than an area described in item (2); or (2) within 60 minutes, on a 24-hour a day basis, if all of the following requirements are met:

- The CAH is located in an area designated as a frontier area (that is, an area with fewer than six residents per square mile based on the latest population data published by the Bureau of the Census) or in an area that meets criteria for a remote location adopted by the State in its rural health care plan, and approved by HCFA, under section 1820(b) of the Act.

- The State has determined under criteria in its rural health care plan that

allowing an emergency response time longer than 30 minutes is the only feasible method of providing emergency care to residents of the area served by the CAH.

- The State maintains documentation showing that the response time of up to 60 minutes at a particular CAH it designates is justified because other available alternatives would increase the time needed to stabilize a patient in an emergency.

We also believe that it is essential that physicians who are paid to be in on-call status in fact come to the facility when summoned. Therefore, we proposed to specify that costs of on-call emergency room physicians are allowable only if the costs are incurred under written contracts that require them to come to the CAH when their presence is medically required.

*Comment:* One commenter noted that existing regulations at § 413.70(a)(2) prohibit application, in making reasonable cost determinations for CAHs, of the reasonable compensation equivalent (RCE) limits on physician services to providers. The commenter expressed concern that more explicit reasonableness guidelines may be needed to ensure that costs recognized for on-call services are reasonable.

*Response:* We understand the commenter's concern, but note that existing reasonable cost rules at § 413.9(c)(2) authorize intermediaries to disallow costs of services that are "substantially out of line" with costs of other, similar providers in the same area. We will continue to monitor these costs and will consider proposing further or more specific reasonableness standards if necessary.

*Comment:* One commenter stated that contracts for emergency services are typically executed between a CAH and a physician group, and, for legal purposes, the individual physician is not distinguishable from the group. The commenter further stated that if the regulations prohibit the "physician" from otherwise furnishing services or being on call at another facility, the proposed language of the regulation may inadvertently prohibit any member of the physicians group from otherwise furnishing services or being on call.

*Response:* We have reconsidered the proposed language of § 413.70(b)(4) in the light of this comment, but find no basis for interpreting the proposed revised language in the way the commenter has suggested may occur. The proposed revised language makes it clear that it is the individual physician who is on call for the CAH that may not be otherwise engaged in furnishing

physician's services, or on call at another provider or facility.

We are adopting proposed § 413.70(b)(4) as final.

#### 5. Treatment of Ambulance Services Furnished by Certain CAHs (§ 413.70(b)(5))

Under section 1861(s)(7) of the Act, Medicare Part B covers and pays for ambulance services, to the extent prescribed in regulations, when the use of other methods of transportation would be contraindicated. Various Congressional reports indicate that Congress intended that (1) the ambulance benefit cover transportation services only if other means of transportation are contraindicated by the beneficiary's medical condition; and (2) only ambulance services to local facilities be covered unless necessary services are not available locally, in which case, transportation to the nearest facility furnishing those services is covered. (H.R. Rept. No. 89-213, 89th Cong., 1st Sess. at 37 (1995) and S. Rept. No. 89-404, 89th Cong., 1st Sess., Pt. I, at 43 (1995).)

The Medicare program currently pays for ambulance services on a reasonable cost basis when furnished by a provider and on a reasonable charge basis when furnished by a supplier. (The term "provider" includes all Medicare-participating institutional providers that submit claims for Medicare ambulance services (hospitals, CAHs, SNFs, and home health agencies).) The term "supplier" means an entity that is independent of any provider. The reasonable charge methodology that is the basis of payment for ambulance services is determined by the lowest of the customary, prevailing, actual, or inflation indexed charge.

Section 4531(a)(1) of Public Law 105-33 amended section 1861(v)(1) of the Act and imposed an additional per trip limitation on reasonable cost payment to hospitals and CAHs for ambulance service. As amended, the statute provides that, in determining the reasonable cost of ambulance services furnished by a provider of services, the Secretary shall not recognize the cost per trip in excess of the prior year's reasonable cost per trip updated by an inflation factor. This trip limit provision was first effective for services furnished during Federal fiscal year 1998 (October 1, 1997 through September 30, 1998).

Section 205 of Public Law 106-554 amended section 1834(l) of the Act by adding a new paragraph (8) to that section. New section 1834(l)(8) provides that the Secretary is to pay the reasonable costs incurred in furnishing ambulance services if such services are

furnished by a CAH (as defined in section 1861(mm)(1) of the Act), or by an entity owned and operated by the CAH. This provision in effect eliminates any trip limit that CAHs had been subject to as a result of section 1861(v)(1) of the Act, as amended by Public Law 105-33. However, section 205 further states that in order to receive reasonable cost reimbursement for the furnishing of ambulance services, the CAH or entity must be the only provider or supplier of ambulance services located within a 35-mile drive of the CAH. Section 205 is effective for services furnished on or after December 21, 2000, the date of enactment of Public Law 106-554.

As stated in the May 4 proposed rule, to implement the provisions of section 1834(l)(8) of the Act, we proposed to add a new paragraph (5) to § 413.70(b) to permit a CAH, or an entity owned or operated by a CAH, to be paid for furnishing ambulance services on a reasonable cost basis if the CAH or entity is the only provider or supplier of ambulance services within a 35-mile drive of the CAH. In determining whether there is any other provider or supplier of ambulance services within a 35-mile drive of a CAH or entity, we first identify the site where the nearest other ambulance provider or supplier garages its vehicles, and then determine whether that site is within 35 miles, calculated as the shortest distance in miles measured over improved roads. An improved road for this purpose is defined as any road that is maintained by a local, State, or Federal government entity, and is available for use by the general public. Consistent with the change, in the May 4 proposed rule concerning § 412.92(c)(1) relating to SCH determinations (as explained in section IV.A. of this preamble), we proposed to consider improved roads to include the paved surface up to the front entrance of the hospital and, for purposes of § 413.70(b)(5), the front entrance of the garage.

*Comment:* Several commenters recommended that we support a legislative change that would eliminate the 35-mile requirement and allow all designated CAHs owning ambulance services to be reimbursed at cost. Another commenter requested that we support a legislative change to address situations where the distance requirement involves mountainous terrain or only secondary roads and that in such cases the mileage requirement be 15 miles.

*Response:* As the commenters pointed out, the statute as currently worded is clear as to applicability of the 35-mile rule in connection with the

requirements for cost reimbursement of ambulance services furnished by CAHs. Therefore, we are not making any changes in the final regulation based on these comments.

*Comment:* One commenter described a situation where both the CAH and ambulance services are wholly owned by a city but the CAH provides operating services to the ambulance company. The commenter asked whether in such a case the ambulance services could be considered to be furnished by an entity that is wholly owned and operated by the CAH.

*Response:* As stated in section 205 of the Public Law 106-554, payment on a reasonable cost basis may be made for ambulance services furnished by a CAH, or an entity owned and operated by the CAH. The legislation does not allow us to extend similar treatment to ambulance services that may be operated but not owned by a CAH. Accordingly, we are not making any changes in this final rule based on this comment.

We are adopting proposed § 413.70(b)(5) as final without change.

#### 6. Qualified Practitioners for Preanesthesia and Postanesthesia Evaluation in CAHs

Section 1820 of the Act sets forth the conditions for designating certain hospitals as CAHs. Implementing regulations for section 1820 of the Act are located in 42 CFR part 485, Subpart F. Included in the conditions of participation regulations for CAHs in subpart F is the condition for surgical services (§ 485.639). Existing § 485.639 specifies that preanesthesia and postanesthesia services in a CAH can only be performed by a doctor of medicine or osteopathy, including an osteopathic practitioner recognized under section 1101(a)(7) of the Act; a doctor of dental surgery or dental medicine; or a doctor of podiatric medicine. This Medicare condition of participation requirement regarding preanesthesia and postanesthesia evaluations for CAHs differs from, and is more restrictive than, the current requirement for acute care hospitals in general. In an acute care hospital, the CRNA is listed among the practitioners who may perform the preanesthesia and postanesthesia evaluations.

Our principal consideration in regulating providers is to ensure patient safety and high quality patient outcomes. As circumstances and health care environments change, we reassess regulations and propose changes accordingly.

In the May 4 proposed rule, we stated that when the regulations for the initial

Rural Primary Care Hospital (RPCH) program (which later became the CAH program) were adopted, RPCHs were limited to patient stays of no more than 72 hours and to bed counts of no more than 6 acute care beds. We initially viewed RPCHs as very limited-service facilities that would be unlikely to perform any surgery beyond what might be done in a physician's office; therefore, we did not have a condition of participation for surgery. Section 102(a)(1) of the Social Security Amendments of 1994, Public Law 103-432, specifically authorized surgical care in RPCHs. In June 1995, we proposed a surgical condition of participation that incorporated the ambulatory surgery center (ASC) standards. We expected that the types of procedures done in a RPCH would most likely be those that could be done in ASCs. At the time, we received no comments in response to the proposed standards and therefore adopted them in the final RPCH conditions of participation that were published on September 1, 1995 (60 FR 45851).

In 1997, the RPCH (now CAH) program was expanded through a statutory change to include all States and to allow for an increase in bed size and length of stay (August 29, 1997 final rule, 62 FR 46035). Since that time, the program's original conditions of participation have been revised (and more recently have been proposed to be revised) to remove possible barriers to access to care. One example of our latest effort is our proposed rule to eliminate the Federal requirement for physician supervision of CRNAs in CAHs as well as in acute care hospitals and ASCs that was published in the **Federal Register** on January 18, 2001 (66 FR 96570).

Recently, provider and medical groups have suggested that CAHs may be at risk of losing the ability to provide access to appropriate surgical services without the full support of available CRNAs. They indicated that the existing regulations place the responsibility of the preanesthesia and postanesthesia evaluations on the operating practitioner, thereby creating a higher standard for CAHs than for other hospitals.

In an effort to eliminate or minimize potential access issues in rural areas and to recognize the CAH's program expansion, in the May 4, 2001 proposed rule, we proposed to revise § 485.639(b) to allow CRNAs to perform preanesthesia and postanesthesia evaluations in a CAH. As with any licensed independent health care provider, the proposed change would not permit CRNAs to practice beyond his or her licensed scope of practice or

the approved policies and procedures of the CAH.

We received 26 comments on our proposal.

*Comment:* Almost all of the 26 commenters supported our proposed change to the existing CAH conditions of participation to remove the requirement that only physicians can perform the preanesthesia and postanesthesia evaluations. The proposed regulation includes CRNAs among the practitioners that may perform these services. The commenters stated that the existing anesthesia evaluation requirements for CAHs are more restrictive than the requirements for hospitals and they impose an unnecessary burden on operating surgeons and the facilities.

*Response:* We appreciate the commenters' support.

*Comment:* One commenter stated that the proposed amendment to the condition of participation for surgical services under § 485.639(b) is ill-advised and should not be adopted, or, at the very least, should be postponed until the regulation regarding physician supervision of CRNAs in hospitals is finalized.

*Response:* The commenter correctly notes that we have not finalized the regulation to amend the physician supervision requirement for CRNAs (66 FR 96570, January 18, 2001). Our proposal that CRNAs perform preanesthesia and postanesthesia evaluations in CAHs in our May 4, 2001 proposed rule does not conflict with the January 18, 2001 proposed physician supervision regulation because our proposal does not affect current requirements for CRNAs, such as physician supervision. We mentioned the proposed physician supervision regulation in the preamble to the May 4 proposed rule as an example of our continual effort to review and evaluate our policies and regulations to better facilitate patient access and improve patient outcomes.

*Comment:* One commenter stated that there is no basis for us to assume that the safety-oriented anesthesia standards for CAHs should be any less stringent than those applicable to ambulatory surgical centers (ASCs).

*Response:* We acknowledge the commenter's concern regarding the anesthesia risk and evaluation standard for ASCs. Our existing conditions for coverage for ASCs require examination of patients by a physician immediately before surgery to evaluate the risk of anesthesia and of the procedure to be performed. The ASC conditions for coverage also require evaluation of patients by a physician for proper

anesthesia recovery prior to discharge from the ASC. We expect to review and modify the ASC condition of coverage, including the current anesthesia risk and evaluation standard, through a notice of proposed rulemaking in 2002. At that time, we will consider the commenter's concern.

*Comment:* One commenter stated that according to a recent national survey of one-third of rural hospital chief executives, almost 80 percent of the respondents reported that their institutions perform high-complexity surgery, such as gall bladder and stomach surgery. The commenter further stated that the hospital conditions of participation require that the preoperative evaluation be conducted by an individual qualified to administer anesthesia, but in the cases of a nurse anesthetist, the anesthesia provider must work under the supervision of the operating practitioner or an anesthesiologist. As such, the commenter summarized that the hospital requirements are not less stringent than the CAH requirements.

*Response:* The commenter has misunderstood the proposal to mean that physician supervision for CRNAs is eliminated. The proposed regulation, as noted in response to a previous comment, will not remove physician supervision of CRNAs.

Unlike in acute care hospitals, CRNAs are currently listed among the qualified practitioners who can administer anesthesia under physician supervision in CAHs but they cannot perform the preanesthesia and postanesthesia evaluations. In response to the provider industry's concerns with access to care, our proposal was that CRNAs be allowed to perform preanesthesia and postanesthesia evaluations.

We are adopting the proposed § 485.639(b) as final without change.

#### 7. Clarification of Location Requirements for CAHs (§§ 485.610(b) and (c))

Under section 1820(c)(2)(B)(i) of the Act, a facility seeking designation by the State as a CAH must meet two distinct types of location requirements. First, the facility must either be actually located in a county or equivalent unit of local government in a rural area, as defined in section 1886(d)(2)(D) of the Act, or it must be located in an urban area as defined in section 1886(d)(2)(D) of the Act, but be treated as being located in a rural area under section 1886(d)(8)(E) of the Act. Second, the facility must also be 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 similar facility described in section 1820(c) of the Act, or it must be certified by the State as being a necessary provider of health care services to residents in the area. Implementing regulations for these provisions were published in an interim final rule with comment period in the **Federal Register** on August 1, 2000 (65 FR 47026) and are set forth at § 485.610(b).

As we indicated in the May 4 proposed rule, recently, concern has been expressed that § 485.610(b) does not accurately reflect the fact that a facility may satisfy the "rural location" requirement either by actually being located in a rural area or by being located in an urban area but qualifying for treatment as rural under section 1886(d)(8)(E) of the Act. In addition, we have received questions as to whether a potential CAH must meet both the rural location requirement and the requirement for location relative to other facilities (or certification by the State as a "necessary provider").

To avoid any further confusion, and ensure that our regulations reflect the provisions of the law accurately, we proposed to revise § 485.610(b) to clarify that a potential CAH must either be actually located in a rural area, or be treated as being rural under section 1886(d)(8)(E) of the Act. In addition, we proposed to place the provisions of the existing § 485.610(b)(5) in a newly created paragraph (c) entitled, "Location relative to other facilities or necessary provider certification". We proposed to relocate this provision in order to clarify that these criteria are separate from the rural location criteria. These changes do not reflect any change in policy; they are merely an attempt to improve the clarity of the regulations.

We did not receive any comments on these proposed changes and, therefore, are adopting them as final.

#### 8. Other Legislative Changes Affecting CAHs

a. 96-hour Average Length of Stay Standard (Section 403(a) of Public Law 106-113 and 42 CFR 485.620(b))

As stated in the August 1, 2000 interim final rule with comment period, prior to the enactment of Public Law 106-113, section 1820(c)(2)(B)(iii) of the Act limited CAH designation only to facilities that provided inpatient care to each patient for a period of time not to exceed 96 hours, unless a longer period was required because of inclement weather or other emergency conditions, or a peer review organization (PRO) or equivalent entity, on request, waived the 96-hour restriction. Section 403(a) of

Public Law 106–113 amended section 1820(c)(2)(B)(iii) of the Act to require that the 96-hour limit on stays be applied on an annual average basis, and to delete the provisions regarding waiver of longer stays. Therefore, CAHs will be permitted to keep some individual patients more than 96 hours without a waiver request, so long as the facility's average length of acute stays in any 12-month cost reporting period is not more than 96 hours.

The effective date of this provision is November 29, 1999.

In the August 1, 2000 interim final rule with comment period, we revised the regulations on conditions of participation for length of stay for CAHs at § 485.620(b) to reflect this change.

*Comment:* One commenter noted that 96-hour length of stay limitation for CAHs clearly contemplates that the facility-wide average length of stay be computed as an hourly average, while Medicare cost report instructions require inpatient utilization to be reported by days of care rather than hours. The commenter expressed concern that if cost report data on days of care are converted to an hourly equivalent, this might overstate the length of stay for some facilities, since patients in the facility for only a few hours might be counted as having been inpatients for a full 24 hours. The commenter requested that we provide further directions to the fiscal intermediaries on the exact data to be used and the precise method to capture the length of stay average.

*Response:* We understand the commenter's concern and will ensure that any directions to intermediaries and State agencies on determining facility-wide average length of stay provide for calculating that average accurately. However, no change is needed to the proposed regulation and we are adopting it as final.

**b. For-Profit Facilities (Section 403(b) of Public Law 106–113 and 42 CFR 485.610(a))**

As stated in the August 1, 2000 interim final rule with comment period, prior to enactment of Public Law 106–113, section 1820(c)(2)(B) of the Act allowed only nonprofit or public hospitals to be designated as CAHs. Section 403(b) of Public Law 106–113 revises section 1820(c)(2)(B) of the Act to remove the words “nonprofit or public” before “hospitals”, thus enabling for-profit hospitals to qualify for CAH status.

In that interim final rule with comment period, we revised the regulations on the conditions of participation related to the status and

location for CAHs at § 485.610(a) to reflect this change.

We did not receive any comments on this provision and are adopting the revision to § 485.610(a) as final.

**c. Closed and Downsized Hospitals (Section 403(c) of Public Law 106–113 and 42 CFR 485.610(a)(1))**

Under section 1820(c)(2) of the Act, CAH designation was available only to facilities currently operating as hospitals. As stated in the August 1, 2000 interim final rule with comment period, section 403(c) of Public Law 106–113 amended the statute to permit a State to designate as a CAH a facility that previously was a hospital but ceased operations on or after November 29, 1989 (10 years prior to the enactment of Public Law 106–113), if that facility fulfills the criteria under section 1820(c)(2)(B) of the Act for CAH designation as of the effective date of its designation. The amendment also allows CAH designation for facilities that previously had been hospitals, but are currently State-licensed health clinics or health centers if they meet the revised criteria for designation under section 1820(c)(2) of the Act as of the effective date of designation. In the August 1 interim final rule with comment period, we revised the CAH criteria for State certification under regulations at § 485.610(a)(1) to reflect this change.

Although we received no public comment on the revision to § 485.610(a)(1), we have determined that one technical revision to § 486.610 is needed. We are making a technical correction to paragraph (a)(2) of § 485.610. Currently, that paragraph states that a closed facility may qualify for designation as a CAH only if it meets applicable criteria for designation under Subpart F of Part 485 “as of November 29, 1999.” However, under section 1820(c)(2)(C)(ii) of the Act, as added by section 403(c)(2) of Public Law 106–113, the facility must meet all other applicable requirements for CAH designation by the State as of the effective date of its designation as a CAH. Therefore, we are revising § 485.610(a)(2) to state that a closed facility may qualify for designation as a CAH only if it meets applicable criteria for designation under Subpart F of Part 485 as of the effective date of that designation.

In the August 1, 2000 final rule (65 FR 47052), we revised § 485.610 to reflect the provisions of section 403(c) of Public Law 106–113. However, we inadvertently did not make a conforming change to § 485.612, which continues to state that the applicant

facility must be a hospital with a provider agreement to participate in the Medicare program at the time it applies for designation as a CAH. To correct this oversight and reflect the provisions of section 403(c) in the regulations at § 485.612, in the June 13, 2001 interim final rule with comment period (66 FR 32183), we revised § 485.612 to state that the requirement to have a provider agreement as a hospital at the time of application does not apply to recently closed facilities as described in § 485.610(a)(2) or to health clinics or health centers as described in § 485.610(a)(3).

We did not receive any comments on this provision and are adopting the provisions as final without change.

**d. Elimination of Coinsurance for Clinical Diagnostic Laboratory Tests Furnished by a CAH (§§ 410.152 and 413.70))**

As we indicated in both the August 1, 2000 and June 13, 2001 interim final rules with comment period, under the law in effect before the enactment of Public Law 106–113, clinical diagnostic laboratory services furnished by a CAH to its outpatients were, like other outpatient CAH services, paid for on a reasonable cost basis, subject to the Part B deductible and coinsurance provisions. With respect to coinsurance, this meant that the beneficiary was responsible for payment of 20 percent of the CAH's customary charges for the services and the CAH received payment from the Medicare program equal to 80 percent of its reasonable costs of furnishing the services.

In the August 1, 2000 interim final rule with comment period (65 FR 47042), we implemented section 403(e) of Public Law 106–113, which amended section 1833(a) of the Act and eliminated the Part B coinsurance and deductible for laboratory tests furnished by a CAH on an outpatient basis. Thus, CAHs were not permitted to impose a deductible or coinsurance charge on the beneficiary for these services. Also, in accordance with section 1833(a)(1)(D) and (a)(2)(D), as also amended by section 403(e) of Public Law 106–113, Medicare Part B was to pay 100 percent of the least of the amount determined under the local laboratory fee schedule, the national limitation amount for that test, or the amount of the charges billed for the tests.

The effect of this change was that clinical diagnostic laboratory tests furnished by a CAH to its outpatients, were paid for on the same basis as clinical diagnostic laboratory tests furnished by full-service hospitals to outpatients. Section 403(e)(2) of Public