DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 410, 412, 413, and 485

[HCFA–1178–IFC]

RIN 0938–AK74

Medicare Program; Provisions of the Benefits Improvement and Protection Act of 2000; Inpatient Payments and Rates and Costs of Graduate Medical Education

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Interim final rule with comment period.

SUMMARY: This interim final rule with comment period implements, or conforms the regulations to, certain statutory provisions relating to Medicare payments to hospitals for inpatient services that are contained in the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Benefits Improvement and Protection Act of 2000 (BIPA).

Many of the provisions of BIPA modify changes to the Social Security Act made by the Balanced Budget Refinement Act of 1999 or the Balanced Budget Act of 1997 or both. Some of the provisions of BIPA have effective dates that are prior to its passage on December 21, 2000.

DATES: *Effective Date:* This interim final rule with comment period is effective on June 13, 2001.

Comment Period: Comments will be considered if received at the appropriate address, as provided below, no later than 5 p.m. on July 13, 2001.

ADDRESSES: Mail written comments (an original and three copies) to the following address only: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA–1178–IFC, P.O. Box 8010, Baltimore, MD 21244–1850.

If you prefer, you may deliver by hand or courier your written comments (an original and three copies) to one of the following addresses:

Room 443–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW, Washington, DC 20201, or

Room C5–14–03, Central Building, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Comments mailed to the addresses indicated as appropriate for courier delivery may be delayed and could be considered late.

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code HCFA–1178–IFC.

Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in the Department's offices at 7500 Security Boulevard, Baltimore, MD on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: (410) 786–9994).

For comments that relate to information collection requirements, mail a copy of comments to the following addresses:

Health Care Financing Administration, Office of Information Services, Security and Standards Group, Division of HCFA Enterprise Standards, Room N2–14–26, 7500 Security Boulevard, Baltimore, Maryland 21244–1850. Attn: John Burke HCFA–1178–IFC; and

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 3001, New Executive Office Building, Washington, DC 20503, Attn: Allison Eydt Herron, HCFA–1178–IFC, HCFA Desk Officer.

FOR FURTHER INFORMATION CONTACT:

Steve Phillips, (410) 786–4548, Operating Prospective Payment, Sole Community Hospitals, Disproportionate Share Hospitals and Medicare-Dependent, Small Rural Hospitals.

Tzvi Hefter, (410) 786–4487, Excluded Hospitals, Graduate Medical Education, and Critical Access Hospital Issues.

SUPPLEMENTARY INFORMATION:

Availability of Copies and Electronic Access

Copies: To order copies of the **Federal Register** containing this document, send your request to: New Orders, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250–7954. Specify the date of the issue requested and enclose a check or money order payable to the Superintendent of Documents, or enclose your Visa or Master Card number and expiration date. Credit card orders can also be placed by calling the order desk at (202) 512–1800 or by faxing to (202) 512–2250. The cost for each copy is $9. As an alternative, you can view and photocopy the **Federal Register** document at most libraries designated as Federal Depository Libraries and at many other public and academic libraries throughout the country that receive the **Federal Register**.

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I. Background: Program Summary

Section 1886(d) of the Social Security Act (the Act) sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively set rates. Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of hospital inpatient stays under a prospective payment system. Under these prospective payment systems, Medicare payment for hospital inpatient operating and capital-related costs is made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups (DRGs). Payment for cases within each DRG is weighted to account for the average resources used to treat patients within that DRG. In addition, these payments are adjusted by a wage index (and a geographic adjustment factor derived from the wage index in the case of capital payments) to account for the varying costs of labor across areas, and by separate adjustment factors for the additional indirect operating costs associated with medical education (IME) and for treating a disproportionate share of low-income patients.

Certain specialty hospitals are excluded from the prospective payment system. Under section 1886(d)(1)(B) of the Act, the following classes of hospitals and hospital units are excluded from the prospective payment system: psychiatric hospitals and units, rehabilitation hospitals and units, children's hospitals, long-term care hospitals, and cancer hospitals. For these hospitals and units, Medicare payment for operating costs is based on reasonable costs subject to a hospital-specific annual limit.

Under sections 1820 and 1834(g) of the Act, payments are made to critical access hospitals (CAHs) (that is, rural hospitals that meet certain statutory requirements) for inpatient and outpatient services on a reasonable cost basis. Reasonable cost is determined under the provisions of section 1861(v)(1)(A) of the Act and existing regulations under 42 CFR Parts 413 and 415.

Under section 1886(a)(4) of the Act, costs of approved educational activities are excluded from the operating costs of inpatient hospital services. Hospitals with approved graduate medical education (GME) programs are paid for the direct costs of GME in accordance

with section 1886(h) of the Act; the amount of payment for direct GME costs for a cost reporting period is based on the hospital's costs per resident in a base year and the hospital's number of residents in that cost reporting period.

The regulations governing the hospital inpatient prospective payment system are located in 42 CFR Part 412. The regulations governing excluded hospitals and hospital units and the regulations governing direct GME are located in 42 CFR Part 413. The regulations governing CAHs are located in 42 CFR Parts 413 and 485.

II. Provisions of the Interim Final Rule With Comment Period

On December 21, 2000 the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Pub. L. 106–554) was enacted. Public Law 106–554 made a number of changes to the Act affecting Medicare payments to hospitals for inpatient services. Many of the provisions of Public Law 106–554 are modifications to provisions of the Act included in the Balanced Budget Act of 1997 (Pub. L. 105–33) or the Balanced Budget Refinement Act of 1999 (Pub. L. 106–113) or both. Some of the provisions of Pub. L. 106–554 have effective dates that are prior to its passage on December 21, 2000. Other provisions do not become effective until April 1, 2001 or later.

The following chart is a summary of the effective dates of the policy changes we are implementing in this interim final rule with comment period as a result of Public Law 106–554. The individual changes are summarized below.

EFFECTIVE DATE OF THE PROVISIONS OF PUBLIC LAW 106–554 INCLUDED IN THIS INTERIM FINAL RULE WITH COMMENT PERIOD

Section No.	Title	Effective date
201	Clarification of No Beneficiary Cost-Sharing for Clinical Diagnostic Laboratory Test Furnished by Critical Access Hospitals.	11/29/1999
202	Assistance with Fee Schedule Payment for Professional Services under All-Inclusive Rate	07/01/2001
211	Treatment of Rural Disproportionate Share Hospitals	04/01/2001
212	Option to Base Eligibility for Medicare-Dependent, Small Rural Hospital Program on Discharges during Two of the Three Most Recently Audited Cost Reporting Periods.	04/01/2001
213	Extension of Option to use Rebased Target Amounts to All Sole Community Hospitals	10/01/2000
301	Revision of Acute Care Hospital Payment Update for 2001	04/01/2001
302	Additional Modification in Transition for Indirect Medical Education Adjustment	04/01/2001
303	Decrease in Reductions for Disproportionate Share Hospitals	04/01/2000
306	Payment for Inpatient Services of Psychiatric Hospitals	10/01/2000
307	Payment for Inpatient Services of Long-Term Care Hospitals	10/01/2000
512	Change in Distribution Formula for Medicare+Choice-Related Nursing and Allied Health Education Costs.	01/01/2001
541	Increase in Reimbursement for Bad Debt	10/01/2000

The following is a summary of the policy changes we are implementing in this interim final rule with comment period as a result of Public Law 106–554:

A. Changes Relating to Payments for Operating Costs Under the Hospital Inpatient Prospective Payment System

• *Treatment of Rural and Small Urban Disproportionate Share Hospitals (DSH).* We are implementing the provisions of section 211 of Public Law 106–554 which lowers thresholds by which certain classes of hospitals qualify for DSH, with repsect to discharges occurring on or after April 1, 2001.

• *Decrease in Reductions for Disproportionate Share Hospital Payments.* We are implementing section 303 of Public Law 106–554 which modifies the previous reduction in the DSH payment to be 2 percent in FY 2001 and 3 percent in FY 2002.

• *Medicare-Dependent, Small Rural Hospitals (MDH).* We are implementing section 212 of Public Law 106–554 which provides an option to base eligibility for MDH status on discharges during two of the three most recently audited cost reporting periods, effective with cost reporting periods beginning on or after April 1, 2001.

• *Revision of Prospective Payment System Standardized Amounts.* We are implementing section 301 of Public Law 106–554 which revises the update factor increase for the inpatient prospective payment rates for FY 2001.

• *Indirect Medical Education Adjustment (IME).* We are implementing section 302 of Public Law 106–554 which provides that for the purposes of making the IME payment, the formula multiplier, or '*c*', for discharges occurring on or after April 1, 2001 and before October 1, 2001 will be determined as if '*c*' equaled 1.66, rather than 1.54.

• *Sole Community Hospitals (SCHs).* We are implementing section 213 of Public Law 106–554 which further extends the 1996 rebasing option, for hospital cost reporting periods beginning October 1, 2000, to all SCHs and provides that this extension is effective as if it had been included in section 405 of Public Law 106–113.

B. Payments for Nursing and Allied Health Education: Utilization of Medicare+Choice Enrollees

We are implementing section 512 of Public Law 106–554 which revised the formula for determining the additional payment amounts to hospitals for Medicare+Choice nursing and allied health education costs.

C. Changes Relating to Payments for Capital-Related Costs Under the Hospital Inpatient Prospective Payment System

As a result of implementing section 301 of Public Law 106–554, which provides increased inpatient operating payment rates, the unified outlier threshold for inpatient operating and inpatient capital-related costs was recalculated. Therefore, we are revising the capital outlier offset which also requires us to revise the capital-related rates.

D. Changes Relating to Hospitals and Hospital Units Excluded from the Prospective Payment System

• *Increase in the Incentive Payment for Excluded Psychiatric Hospitals and Units.* We are implementing section 306 of Public Law 106–554, which provides

that for cost reporting periods beginning on or after October 1, 2000, for psychiatric hospitals and units, if the allowable net inpatient operating costs do not exceed the hospital's ceiling, payment is the lower of: (1) Net inpatient operating costs plus 15 percent of the difference between inpatient operating costs and the ceiling; or, (2) net inpatient costs plus 3 percent of the ceiling.

• *Increase in the Wage Adjusted 75th Percentile Cap on the Target Amounts for Long-Term Care Hospitals.* We are implementing section 307(a) of Public Law 106–554, which provides 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.

• *Increase in the Target Amounts for Long-Term Care Hospitals.* We are implementing section 307(a) Public Law 106–554, which provides a 25 percent increase to the target amounts for long-term care hospitals for cost reporting periods beginning in FY 2001, up to the cap on target amounts.

E. Changes Relating to Critical Access Hospitals (CAHs)

• *Elimination of Coinsurance for Clinical Diagnostic Laboratory Tests Furnished by a CAH.* We are implementing section 201(a) of Public Law 106–554, which amends section 1834(g) of the Act to state that there will be no collection of coinsurance, deductible, copayments, or any other type of cost sharing from Medicare beneficiaries with respect to outpatient clinical diagnostic laboratory services furnished as outpatient CAH services furnished as an outpatient CAH service, and that those services will be paid for on a reasonable cost basis.

• *Assistance With Fee Schedule Payment for Professional Services Under All Inclusive Rate.* We are implementing section 202 of Public Law 106–554, which amends section 1834(g)(2)(B) of the Act to provide that when a CAH elects to be paid for Medicare outpatient services under the reasonable costs for facility services plus fee schedule amounts for professional services method, Medicare will pay 115 percent of the amount it otherwise pays for the professional services.

• *Condition of Participation With Hospital Requirements at the Time of Application for CAH Designation (§ 485.612).* We are implementing a conforming change to correct § 485.612 to reflect that certain entities are not required to have a provider agreement prior to CAH designation.

F. Other Inpatient Costs

• *Increase in Reimbursement for Bad Debts.* We are implementing section 541 of Public Law 106–554 which provides a 30 percent decrease of allowable hospital bad debt reimbursement for cost reporting periods, beginning during FY 2001 and all subsequent fiscal years. This section modifies section 4451 Of Public Law 105–33 that reduced the total allowable bad debt reimbursement for hospitals by 45 percent.

III. Disproportionate Share Hospitals (Sections 211 and 303 of Public Law 106–554 and 42 CFR 412.106 (c) and 412.106(d))

A. Qualifying Thresholds for DSHs

Section 1886(d)(5)(F) of the Act provides for additional payments to prospective payment hospitals that serve a disproportionate share of low-income patients. Hospitals that meet the DSH patient percentage criteria are entitled to adjustments to their payments, including outlier payments.

Under 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, a hospital qualifies for DSH if the hospital has a disproportionate 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, we are revising § 412.106(c) to reflect the change in DSH qualifying threshold percentages.

B. Calculation of the Disproportionate Share Adjustment

Section 211(b) of Public Law 106–554 further amends section 1886(d)(5)(F) to revise the calculation of the disproportionate share percentage adjustment for hospitals affected by the revised thresholds as specified in section 211(a) of the Act. These adjustments, which are effective for discharges occurring on or after April 1, 2001, are as follows:

• Urban hospitals with fewer than 100 beds and whose disproportionate patient percentage is equal to or greater than 15 percent and less than 19.3 percent receive the disproportionate share adjustment percentage determined using the following formula:

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

• Urban hospitals with fewer than 100 beds and whose disproportionate 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 (RRCs) and SCHs receive the disproportionate share adjustment percentage determined using the following:

Higher of SCH or RRC adjustment.

• Rural hospitals that are SCHs and are not RRCs and whose disproportionate patient percentage is equal to or greater than 15 percent and less than 19.3 percent receive the disproportionate share adjustment percentage determined using the following formula:

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

• Rural hospitals that are SCHs and are not RRCs and whose disproportionate 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 RRCs and whose disproportionate patient percentage is equal to or greater than 30 percent:

Receive 10 percent.

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

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

• Rural referral centers whose disproportionate 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 disproportionate patient percentage is equal to or greater than 30 percent receive the disproportionate share adjustment percentage determined using the following formula:

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

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

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

• Rural hospitals with fewer than 500 beds and whose disproportionate patient percentage is equal to or greater than 19.3 percent:

Receive a flat add on of 5.25 percent.

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

We are revising § 412.106(d) to reflect the changes in the disproportionate share adjustment.

C. Changes Relating to the DSH Reduction in Payments

Section 4403(a) of Public Law 105–33 amended section 1886(d)(5)(F) of the Act to reduce the payment a hospital would otherwise receive under the DSH formula in effect prior to Public Law 106–554 by 1 percent for FY 1998, 2 percent for FY 1999, 3 percent for FY 2000, 4 percent for FY 2001, 5 percent for FY 2002, and 0 percent for FY 2003 and each subsequent fiscal year. Subsequently, section 112 of Public Law 106–113 modified the amount of the reductions under Public Law 105–33 by changing the reduction to 3 percent for FY 2001 and 4 percent for FY 2002. Section 303 of Public Law 106–554 further modified the amount of the reductions under Public Law 106–113 by changing the reduction to 3 percent for discharges occurring on or after October 1, 2000 and before April 1, 2001, and to 1 percent for discharges occurring on or after April 1, 2001 and before October 1, 2001. Therefore, we are revising § 412.106(e) to reflect the changes made by section 303 of Public Law 106–554.

IV. Medicare-Dependent, Small Rural Hospitals (Section 212 of Public Law 106–554 and 42 CFR 412.108(a)(1)(iii))

Section 6003(f) of Public Law 101–239 added section 1886(d)(5)(G) of the Act and created the category of Medicare-dependent, small rural hospitals (MDHs) (defined in § 412.108) which are eligible for a special payment adjustment under the hospital inpatient prospective payment system. (For a more detailed discussion see the April 20, 1990 **Federal Register** (55 FR 15154)). The special payment adjustment for MDHs is effective for cost reporting periods beginning on or after April 1, 1990 and ending before October 1, 1994, or beginning on or after October 1, 1997 and ending before October 1, 2006.

Section 1886(d)(5)(G)(iii) of the Act and § 412.108(a)(1) of the regulations define an MDH as any hospital that meets all of the following criteria:

• The hospital is located in a rural area (as defined in § 412.63(b)).

• The hospital has 100 or fewer beds (as defined in § 412.105(b)) during the cost reporting period.

• The hospital is not also classified as an SCH (as defined in § 412.92).

• In the hospital's cost reporting period that began during FY 1987, at least 60 percent of the hospital's inpatient days or discharges were attributable to individuals receiving Medicare Part A benefits during the hospital's cost reporting period.

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.

Section 212 of Public Law 106–554 provides 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. The criteria for at least 60 percent Medicare utilization will be met if in at least two of the three 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 new 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 the three most recently audited cost reporting periods, 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.

We are revising § 412.108(a)(1)(iii) to reflect the additional option provided by section 212 of Public Law 106–554.

V. Changes to the Prospective Payment Rates for Inpatient Operating Costs (Section 301 of Public Law 106–554 and 42 CFR 412.63(s))

Section 301(a) of Public Law 106–554 amended section 1886(b)(3)(B)(i) of the Act by changing the percentage increase for the hospital inpatient payment rates for FYs 2001, 2002, and 2003. Previously, section 1886(b)(3)(B)(i) (as amended by section 406 of Public Law 106–113) established the update factor to the payment rates for inpatient prospective payment system hospitals (other than SCHs, who received the full market basket update effective October 1, 2000) as market basket minus 1.1 percent for FYs 2001 and 2002; the update factor for FY 2003 and subsequent fiscal years was established as the full market basket. Section 301(a) of Public Law 106–554 amended section 1886(b)(3)(B)(i) of the Act and changed the update factor for FY 2001 to the full market basket. Section 301(a) also revised the update factors applied to FYs 2002 and 2003. Prior to enactment of Public Law 106–554, the update factor for FY 2002 was the market basket minus 1.1 percentage points and the update factor for FY 2003 was the full market basket. Section 301(a) of Public Law 106–554 amended section 1886(b)(3)(B)(i) of the Act to revise the update factor for FYs 2002 and 2003 to be the market basket minus 0.55 percentage points.

Further, section 301(b) of Public Law 106–554 provided a special rule to implement the full market basket update

to inpatient hospital prospective payment rates for FY 2001. Under this special rule, for discharges occurring on or after October 1, 2000 and before April 1, 2001, the update factor for inpatient prospective payment system hospitals (other than SCHs) is equal to the market basket minus 1.1 percentage points. For discharges occurring on or after April 1, 2001 and before October 1, 2001, the update factor for the payment rates for inpatient prospective payment system hospitals (other than SCHs) is equal to the market basket plus 1.1 percentage points. Section 547 of Public Law 106–554 makes this special rule applicable solely to payments in FY 2001 and the payment increases resulting for FY 2001 are not taken into account in developing payments for future fiscal years.

As directed by the special rule in section 301(b) of Public Law 106–554, any discharges occurring on or after October 1, 2000, and before April 1, 2001, will be paid in accordance with the standardized amounts set forth in the FY 2001 hospital inpatient prospective payment system final rule published in the August 1, 2000, **Federal Register** (65 FR 47126). These rates were calculated using the market basket percentage increase of 3.4 percent minus 1.1 percentage points, for a 2.3 percent increase (see 65 FR 47112), as directed by section 1886(b)(3)(B)(i) of the Act, prior to the passage of Public Law 106–554.

To implement the special rule under section 301(b) of Public Law 106–554, we have recomputed the standardized amounts effective for discharges occurring on or after April 1, 2001. That is, we replaced the update factor of 2.3 percent applied to the standardized amounts in the August 1, 2000, final rule, with the update factor of 4.5 percent (the market basket percentage plus 1.1, or 3.4 plus 1.1 percentage points).

	Large urban areas		Other areas	
	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
National	$2,925.82	$1,189.26	$2,879.51	$1,170.43
National PR	2,900.64	1,179.02	2,900.64	1,179.02
Puerto Rico	1,402.79	564.66	1,380.58	555.72
SCHs	2,895.02	1,176.74	2,849.20	1,158.11

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National	$380.85
Puerto Rico	184.61

A. Budget Neutrality

Section 1886(d)(4)(C)(iii) of the Act specifies that, beginning in FY 1991, the annual diagnosis-related group (DRG) reclassification and recalibration of the relative weights must be made in a manner that ensures that aggregate payments to hospitals are projected to be the same as those that would have been made without such adjustments. Section 1886(d)(3)(E) of the Act requires us to update the hospital wage index on an annual basis beginning October 1, 1993. This provision also requires us to make any updates or adjustments to the wage index in a manner that ensures that aggregate payments to hospitals are projected to be the same as those that would have been made without the change in the wage index.

Finally, under section 1886(d)(8)(D) of the Act, the Secretary is required to adjust the standardized amounts so as to ensure that final aggregate payments under the prospective payment system are projected to equal the aggregate prospective payments that would have been made absent the geographic reclassification provisions of sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act.

The distributive effects on hospital payments of the IME and DSH changes also included in Public Law 106–554 required us to recalculate the budget neutrality factors that are required by section 1886(d)(8)(D) of the Act.

The budget neutrality factors that were used to establish the standardized amounts effective for discharges occurring on or after October 1, 2000 were: 0.997225 for the DRG reclassification and recalibration and updated wage index (65 FR 47112); and 0.993187 for geographic reclassification (65 FR 47113). Using the same methodology that was used to calculate the budget neutrality factors in the August 1, 2000 final rule, the corresponding budget neutrality factors for the standardized amounts effective for discharges occurring on or after April 1, 2001 and before October 1, 2001 are: 0.997122 and 0.993279. The budget neutrality factor for Puerto Rico did not change. Therefore, the budget neutrality factor for Puerto Rico as published in the August 1, 2000 **Federal Register** (65 FR 47112) is still in effect.

B. Outliers

In accordance with section 1886(d)(3)(B) of the Act, which directs the Secretary to adjust the national standardized amounts to account for the estimated proportion of total payments made to outlier cases, the fixed-loss outlier threshold was also revised as a result of the change made by Public Law 106–554 to the update factor for the operating standardized amounts. For discharges occurring on or after April 1, 2001 and before October 1, 2001, we are establishing a fixed-loss cost outlier threshold equal to: The prospective payment rate for the DRG, plus IME and DSH payments, plus $16,500 ($14,940 for hospitals that have not yet entered the prospective payment system for capital-related costs). In determining the outlier threshold, we used the same methodology employed to determine the outlier threshold for FY 2001 (65 FR 47113 through 47114). Outlier payments for discharges occurring on or after October 1, 2000 and before April 1, 2001, will be determined in accordance with the standardized amounts and outlier thresholds set forth in the FY 2001 final rule published in the August 1, 2000 **Federal Register** (65 FR 47113).

Although the market basket percentage used to update SCHs was not revised by Public Law 106–554, the standardized rates applied to these hospitals for discharges occurring on or after April 1, 2001 and before October 1, 2001 also increase slightly. This increase in SCH rates is due to the budget neutrality factors effective for this portion of the fiscal year.

For discharges occurring on or after April 1, 2001 and before October 1, 2001, the outlier adjustment factors are as follows:

	Operating standardized amounts	Capital Federal rate
National	0.948929	0.937854
Puerto Rico	0.973671	0.967355

VI. Changes to the IME Adjustment (Section 302 of Public Law 106–554 and 42 CFR 412.105(d)(3))

Section 1886(d)(5)(B) of the Act provides that prospective payment hospitals that have residents in an approved 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 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 c represents a certain percentage increase in payment for every 10 percent increase in the resident-to-bed ratio.

Public Law 106–113 revised the formula multiplier for discharges occurring during FY 2001 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 6.24 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 6.72 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.

Under amendments enacted by section 302(a) of Public Law 106–554, 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. Changes to the factor for discharges occurring in FY 2002 and thereafter are addressed in the proposed rule on FY 2002 hospital inpatient prospective payment system rates and changes (66 FR 22688). We are amending § 412.105(d)(3) to reflect the additional payment provided for discharges occurring during FY 2001 under section 302(b) of Public Law 106–554.

VII. Sole Community Hospitals (Section 213 of Public Law 106–554 and 42 CFR 412.92)

Under the hospital inpatient prospective payment system, special payment protections are provided to SCHs. Section 1886(d)(5)(D)(iii) of the Act defines an SCH as, among other things, a hospital that, by reason of factors such as isolated location, weather conditions, travel conditions, travel time, or absence of other like hospitals (as determined by the Secretary), is the sole source of inpatient hospital services reasonably available to Medicare beneficiaries. The regulations that set forth the criteria a hospital must meet to be classified as an SCH are located at § 412.92(a).

Prior to FY 2001, SCHs were paid based on whichever of the following rates yielded the greatest aggregate payment to the hospital for the cost reporting period: (1) The Federal national rate applicable to the hospital; (2) the updated hospital-specific rate based on FY 1982 costs per discharge; or (3) the updated hospital-specific rate based on FY 1987 costs per discharge.

Section 405 of Public Law 106–113, which amended section 1886(b)(3) of the Act, provides that an SCH that was paid for its cost reporting period beginning during 1999 on the basis of either its updated FY 1982 or FY 1987 cost per discharge (the hospital-specific rate as opposed to the Federal rate) may elect to receive payment under a methodology using a third hospital-specific rate, based on the hospital's FY 1996 costs per discharge. This amendment to the statute means that, for cost reporting periods beginning on or after October 1, 2000, eligible SCHs can elect to use the allowable FY 1996 operating costs for inpatient hospital services as the basis for their target amount, rather than either their FY 1982 or FY 1987 costs.

Section 213 of Public Law 106–554, extends to all SCHs the option to rebase using their FY 1996 operating costs. That is, in order to rebase using its allowable FY 1996 operating costs, it is not necessary that the SCH was paid for its cost reporting period beginning during 1999 on the basis of the either its FY 1982 or FY 1987 costs. The provision is effective as if it were included in the enactment of section 405 of Public Law 106–113. Therefore, it applies to all SCHs for cost reporting periods beginning on or after October 1, 2000.

As discussed in the August 1, 2000 final rule implementing the 1996 rebasing under section 405 of Public Law 106–113 (65 FR 47083), when calculating an eligible SCH's FY 1996 hospital-specific rate, we utilize the same basic methodology used to calculate FY 1982 and FY 1987 base period amounts. That methodology is set forth in §§ 412.71 through 412.75 of the regulations, and discussed in detail in several prospective payment system documents published in the **Federal Register** on September 1, 1983 (48 FR 39752); January 3, 1984 (49 FR 256); June 1, 1984 (49 FR 23010); and April 20, 1990 (55 FR 15150).

Our fiscal intermediaries will identify those SCHs that were not included in the FY 1996 rebasing provision prior to enactment of Public Law 106–554, and calculate the FY 1996 hospital-specific rate. If this rate exceeds the Federal rate and the higher of the FY 1982 or FY 1987 updated costs per discharge, the hospital will receive payment based on the FY 1996 hospital-specific rate (based on the blended amounts described in section 1886(b)(3)(I)(i) of the Act).

The fiscal intermediary will notify affected hospitals of their FY 1996 hospital-specific rate prior to October 1, 2001. Consistent with our policies relating to FY 1982 and FY 1987 hospital-specific rates, we will permit hospitals to appeal a fiscal intermediary's determination of the FY 1996 hospital-specific rate under the procedures set forth in 42 CFR part 405, subpart R, which concern provider payment determinations and appeals. In the event of a modification of base period costs for FY 1996 rebasing due to a final nonappealable court judgment or certain administrative actions (as defined in § 412.72(a)(3)(i)), the

adjustment would be retroactive to the time of the fiscal intermediary's initial calculation of the base period costs, consistent with the policy for rates based on FY 1982 and FY 1987 costs.

For purposes of payment to SCHs for which the FY 1996 hospital-specific rate yields the greatest aggregate payment, section 213 of Public Law 106–554 utilizes a formula similar to that set forth in section 405 of Public Law 106–113, except that the Federal rate will now be included in the blend, as set forth below:

- For discharges during FY 2001,
- 75 percent of the Federal amount or the greater of the updated FY 1982 or FY 1987 former target (identified in the statute as the subsection (d)(5)(D)(i) amount), plus 25 percent of the updated FY 1996 amount (identified in the statute as the ''rebased target amount'').
- For discharges during FY 2002,
- 50 percent of the greater of the Federal amount or the updated FY 1982 or FY 1987 former target, plus 50 percent of the updated FY 1996 amount.
- For discharges during FY 2003,
- 25 percent of the Federal amount or the greater of the updated FY 1982 or FY 1987 former target, plus 75 percent of the updated FY 1996 amount.
- For discharges during FY 2004 or any subsequent fiscal year, the hospital-specific rate would be determined based on 100 percent of the updated FY 1996 amount.

We are revising § 412.92(d) to incorporate the provisions of section 1886(b)(3)(l) of the Act as amended by section 213 of Public Law 106–554.

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

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 (CY) 1998, 40 percent in CY 1999, 60 percent in CY 2000, 80 percent in CY 2001, and 100 percent in CY 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, 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.)

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.

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).

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 are making 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. The revised methodology for calculating the additional payments is described below.

A. Calculating the Additional Payment Amount

For portions of cost reporting periods occurring on or after January 1, 2001, an eligible hospital will receive the additional payment amount calculated according to the following steps:

Step 1: Determine for each eligible hospital the—

- Total Medicare payments received for approved nursing or allied health education programs based on data from the settled cost reports for the period(s) ending in the fiscal year that is 2 years prior to the current calendar year;
- Total inpatient days for that same cost reporting period; and
- Total Medicare+Choice inpatient days for that same cost reporting period.

For example, if the current calendar year is 2001, determine the hospital's total nursing or allied health education payments made in its cost reporting period(s) ending in FY 1999. Also, determine the hospital's total inpatient days and total Medicare+Choice inpatient days for its cost reporting period ending in FY 1999. If a hospital has more than one cost reporting period ending in that fiscal year, the fiscal intermediary will add the nursing and allied health payments made to the hospital over those cost reporting periods. The inpatient days and Medicare+Choice inpatient days for the cost reporting periods would be added, as well.

Step 2: Using the data in step 1, determine the ratio of the individual hospital's total nursing or allied health payments, to its total inpatient days. Multiply this ratio by the hospital's total Medicare+Choice inpatient days.

Step 3: HCFA will determine the following:

- The total of all nursing and allied health education program payments made to all hospitals for all cost reporting periods ending in the fiscal year that is 2 years prior to the current calendar year.
- The total of all inpatient days from those same cost reporting periods.
- The total of all Medicare+Choice inpatient days for those same cost reporting periods.

Step 4: HCFA will use the data in step 3 to determine the ratio of the total of all nursing and allied health education program payments made to all hospitals for all cost reporting periods ending in the fiscal year that is 2 years prior to the current calendar year, to the total of all inpatient days from that cost reporting period. HCFA will multiply this ratio by the total of all Medicare+Choice inpatient days for that cost reporting period.

Step 5: Calculate the ratio of the product determined in step 2 to the product determined in step 4.

Step 6: Multiply the ratio determined in step 5 by the Medicare+Choice nursing and allied health payment ''pool'' (as determined below). This is the additional payment amount for the current calendar year for an eligible hospital.

Example: In its cost reporting period ending in FY 1999, Hospital A received $100,000 in total Medicare payments for approved nursing and allied health education programs. Hospital A's total inpatient days were 28,000. Total Medicare+Choice inpatient days were 2,800.

For all cost reporting periods ending in FY 1999, Medicare paid $250,000,000 in total nursing and allied health education program payments. The total number of inpatient days across all hospitals in that year was 142,000,000, and the total number of Medicare+Choice inpatient days was 14,200,000.

The CY 2001 Medicare+Choice nursing and allied health payment ''pool'' is $26,000,000. Thus, Hospital A's Medicare+Choice nursing and allied health education payment for CY 2001 will be calculated as follows:

$$\left(\frac{\frac{\$100{,}000}{28{,}000 \text{ inpatient days}} \times 2{,}800 \text{ M+C inpatient days}}{\frac{\$250{,}000{,}000}{142{,}000{,}000 \text{ inpatient days}} \times 14{,}200{,}000 \text{ M+C inpatient days}} \times 26{,}000{,}000 \right) = \$10{,}400$$

To determine these totals, we will use the best available cost reporting data for the applicable hospitals from the Hospital Cost Report Information System (HCRIS) for cost reporting periods in the fiscal year that is 2 years prior to the current calendar year. If the necessary data are not included in HCRIS because a hospital files a manual cost report, we will obtain the necessary data from the fiscal intermediaries that serve those hospitals. If a hospital has more than one cost reporting period ending in the fiscal year that is 2 years prior to the current calendar year, we will include all of the hospital's cost reports for those periods in our calculations. If a hospital does not have a cost reporting period ending in the fiscal year that is 2 years prior to the current calendar year (such as a hospital with a long cost reporting period), the hospital's data will be included in the calculations for the calendar year that is 2 years after the fiscal year in which the long cost reporting period ends.

B. HCFA Calculation of Medicare+Choice Nursing and Allied Health Payment ''Pool''

In accordance with section 1886(l) of the Act, each calendar year, HCFA estimates a total amount, not to exceed $60 million, which is the basis for determining the additional payments for nursing and allied health education associated with Medicare+Choice enrollees to hospitals that operate approved nursing or allied health education programs. The ''pool'' is calculated for each calendar year by determining the product of: (1) The ratio of total projected Medicare+Choice direct GME payments to total projected direct GME payments, and (2) the total projected nursing and allied health education payments. This methodology is explained in more detail in the August 1, 2000 interim final rule with comment period (65 FR 47038).

The projections of direct GME, Medicare+Choice direct GME, and nursing and allied health payments for a calendar year are based on the best available cost report data from HCRIS. (For example, for CY 2001, the

projections are based on the best available cost report data from HCRIS 1999). These payment amounts are then increased to the appropriate calendar year using the increases allowed by section 1886(h) of the Act for these services (using the Consumer Price Index (CPI) increases for direct GME, the percentage applicable for the current calendar year for Medicare+Choice direct GME, and assuming nursing and allied health remains a constant percentage of inpatient hospital spending).

C. Proportional Reduction to Medicare+Choice Direct GME Payments

In order for the Secretary to make the additional payments to eligible hospitals operating approved nursing or allied health education programs, section 1886(h)(3)(D) of the Act, as amended by section 541(b) of Public Law 106–113, specifies that the Secretary will carve out an estimated percentage of payments that are made to teaching hospitals for direct GME associated with services to Medicare+Choice enrollees. Specifically, the law provides that the estimated reductions in Medicare+Choice direct GME payments must equal the estimated total additional Medicare+Choice nursing and allied health education payments. The percentage reduction is estimated by calculating the ratio of the Medicare+Choice nursing and allied health payment ''pool'' for the current calendar year to the projected total Medicare+Choice direct GME payments made to all hospitals for the current calendar year. Accordingly, the regulations at § 413.86(d)(4) state that for portions of cost reporting periods occurring in a calendar year, each hospital that receives Medicare+Choice direct GME payments will have these payments reduced by a certain percentage.

D. Calculation of Amounts for CY 2001

In order for the Medicare+Choice nursing and allied health payments to be made in CY 2001 (as described in section A above), HCFA must provide the appropriate data to the fiscal intermediaries. The data that HCFA will provide include the Medicare+Choice nursing and allied health payment ''pool'' for CY 2001, the total amount of Medicare nursing and allied health education payments made to all hospitals for cost reporting periods ending in FY 1999, the total number of inpatient days from all hospitals for cost reporting periods ending in FY 1999, the total Medicare+Choice inpatient days from all hospitals for cost reporting periods ending in FY 1999, and the percent reduction to Medicare+Choice direct GME payments in CY 2001. (The fiscal intermediaries will obtain the data for each individual hospital from the hospital's cost report to complete the calculation). We are not publishing this data in this interim final rule with comment period, because the FY 1999 data in HCRIS is not complete at this time. Rather, we will provide the necessary data to the fiscal intermediaries in a Program Memorandum as soon as more complete data is available later this calendar year.

E. Regulation Changes

We are revising § 413.87 to incorporate the provisions of section 512 of Public Law 106–554.

F. Technical Amendment

It has come to our attention that the regulations at § 413.86(d)(4) and § 413.87(d) contain errors. The regulations at § 413.86(d)(4) currently 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 are revising § 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 are also making a conforming change to § 413.87(d), which currently reads, ''Subject to the provisions of paragraph (f) of this section * * *'' instead, we are revising this language to state, ''Subject to the provisions of § 413.86(d)(4) * * *.''

IX. Changes to the Capital Prospective Payment System Rates (Section 301 of Public Law 106–554)

Section 301(b) of Public Law 106–554 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 section 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 are revising the fixed-loss outlier thresholds. 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 will increase as a result of section 301 of Public Law 106–554, we decreased the fixed-loss threshold. The decrease in the outlier threshold also results in an increase in the estimated outlier payments for capital from 5.91 percent to 6.21 percent. Thus, the capital national outlier adjustment factor is revised from 0.9409 (as specified in the August 1, 2000 final rule (65 FR 47121)) to 0.9379.

The basic methodology for determining the capital Federal rate is set forth in §§ 412.308 through 412.352. Although the operating update was affected by section 301 of Public Law 106–554, the standard capital Federal rate update remains unchanged (0.9 percent). The exceptions adjustment factor is determined based on an estimate of the ratio of exception payments to total capital payments. As a result of the fixed-cost outlier threshold, which affects total capital payments, in order to maintain budget neutrality for exception payments, we are revising the exception adjustment factor from 0.9785 to 0.9787. The national GAF/DRG budget neutrality factor is revised from 0.9979 to 0.9978. The Puerto Rico GAF/DRG budget neutrality factor remains unchanged (1.0037). Accordingly as a result of the revisions to the capital outlier reduction factor and the capital exceptions adjustment factor, for discharges occurring on or after April 1, 2001 and before October 1, 2001, the national capital Federal rate is revised from $382.03 (65 FR 47127) to $380.85 and the Puerto Rico capital rate is revised from $185.06 (65 FR 47127) to $184.61 as set forth in section IX of this interim final rule with comment period.

In accordance with § 412.328(e), the hospital-specific rate is determined using the update factor and the exceptions adjustment factor. As a result of revising the exceptions adjustment factor to account for the change to the fixed-loss outlier threshold resulting from the special payment rule for FY 2001 provided for under section 301(b) of Public Law 106–554, for discharges occurring on or after April 1, 2001 and before October 1, 2001, the cumulative net adjustment to the hospital-specific rate has been revised from 1.0147 (65 FR 47124) to 1.0145. For discharges occurring on or after April 1, 2001, and before October 1, 2001, the hospital-specific rate is determined by multiplying the FY 2000 hospital-specific rate by the cumulative net adjustment of 1.0145.

X. Changes for Excluded Hospitals and Hospital Units

A. Increase in the Incentive Payment for Excluded Psychiatric Hospitals and Units (Section 306 of Public Law 106–554 and 42 CFR 413.40(d)(2))

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 has 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.

We are revising the regulations at § 413.40(d)(2) to incorporate this change.

B. Payment for Long-Term Care Hospital Costs (Section 307 of Public Law 106–554 and 42 CFR 413.40(c)(4)

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

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 amends 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, the 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, are as follows:

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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. We are revising the regulations

at § 413.40(c)(4)(iii) to incorporate this change.

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

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 amends 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 requires a revision to the determination of each long-term care hospital's FY 2001 target amount as specified § 413.40(c)(4). 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. Note 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 by section 1886(d)(1)(B) of the Act (psychiatric and rehabilitation hospitals and units, children's and cancer hospitals).

We are revising the regulations at § 413.40(c)(4)(iii) to incorporate this change.

XI. Critical Access Hospitals (CAHs)

A. Elimination of Coinsurance for Clinical Diagnostic Laboratory Tests Furnished by a CAH (§§ 410.52 and 413.70)

Under section 1834(g) of the Act, prior to the enactment of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, 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.

Section 403(e) of Public Law 106–113 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 lesser 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 Law 106–113 provided that this provision was effective with respect to services furnished on or after November 29, 1999.

Section 201(a) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA), Public Law 106–554 amends section 1834(g) of the Act to provide that there will be no collection of coinsurance, deductible, copayments, or any other type of cost sharing from Medicare beneficiaries with respect to outpatient clinical diagnostic laboratory services in a CAH.

Section 201(a) further provides that payment for these services will be made on a reasonable cost basis. Section 201(b) of the Public Law 106–554, amends section 1833(a) of the Act by eliminating any reference to CAHs receiving payment for outpatient clinical diagnostic laboratory services on a fee schedule basis. These amendments are effective for services furnished on or after November 29, 1999.

We are incorporating the provisions of section 201 of Public Law 106–554 in section 413.70 of the regulations and changing the references cited in § 410.152(k)(2). To prevent any misunderstanding of the scope of section 201(a), we are further revising § 413.70(b)(3)(iii) to clarify that payment to a CAH for clinical diagnostic laboratory tests for individuals who are not inpatients of the CAH will be made on a reasonable cost basis only if the individuals are outpatients of the CAH at the time the specimens are collected. Outpatient status will be determined under the definition in § 410.2, which provide that an ''outpatient'' is a person who has not been admitted as an inpatient but is registered as an outpatient and receives services (rather than supplies alone) from the CAH.

We recognize that CAHs may appropriately function as reference laboratories, by performing clinical diagnostic laboratory tests on specimens from persons who do not meet the ''outpatient'' definition but have the specimens drawn at other locations, such as physician offices. Payment for clinical diagnostic laboratory tests for these other individuals (that are persons who are not patients of the CAH when the specimens are collected) will be made in accordance with the provisions of sections 1833(a)(1)(D) and 1833(a)(2)(D) of the Act.

Revised program instructions and billing systems changes to implement these provisions are being developed and will be released as soon as possible.

B. Assistance With Fee Schedule Payment for Professional Services Under All Inclusive Rate

Prior to enactment of Public Law 106–113, section 1834(g) of the Act provided that the amount of payment for outpatient CAH services would be the reasonable costs of the CAH in providing such services. However, the reasonable costs of the CAH's services to outpatients included only the CAH's costs of providing facility services, and did not include any payment for professional services. Physicians and other practitioners who furnished professional services to CAH outpatients billed the Part B carrier for these services and were paid under the

physician fee schedule in accordance with the provisions of section 1848 of the Act.

Section 403(d) of Public Law 106–113 amended section 1834(g) of the Act to permit the CAH to elect to be paid for its outpatient services under an optional method. CAHs making this election would be paid amounts equal to the sum of the following costs, less the amount that the hospital may charge as described in section 1866(a)(2)(A) of the Act (that is, Part A and Part B deductibles and coinsurance amounts):

- For facility services, not including any services for which payment may be made as outpatient professional services, the reasonable costs of the CAH in providing the services; and
- For professional services otherwise included within outpatient CAH services, the amounts that would otherwise be paid under Medicare if the services were not included as outpatient CAH services.

Section 403(d) of Public Law 106–113 added section 1834(g)(3) to the Act to further specify that payment amounts under this optional method are to be determined without regard to the amount of the customary or other charge. The amendment made by section 403(d) was effective for cost reporting periods beginning on or after October 1, 2000.

Section 202 of Public Law 106–554, amends section 1834(g) of the Act to provide that when a CAH elects the option to be paid for Medicare outpatient services under the reasonable costs for facility services plus fee schedule amounts for professional services method, Medicare will pay 115 percent of the amount it would otherwise pay for the professional services. This provision is effective for items and services furnished on or after July 1, 2001.

We are revising the regulations at § 413.70(b)(3) to reflect the change in the level of payment for professional services under the alternative payment method for outpatient CAH services.

C. Conforming Change—Conditions of Participation Relating to Compliance With Hospital requirements at Time of Application for CAH Designation (§ 485.612)

Under the law in effect prior to enactment of the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 (Public Law 106–113), CAH status was available to facilities only if they were hospitals at the time of their application for designation as CAHs. This requirement was implemented through regulations, at § 485.610 (Condition of Participation: Status and limitations) and § 485.612 (Condition of Participation: Compliance with hospital requirements at time of application). Section 403(c) of the Public Law 106–113 added subparagraphs (C) and (D) to section 1820(c)(2) of the Act to specify that recently closed facilities and facilities that had downsized from hospital status to being a clinic or health center would also be eligible to apply for CAH designation.

In the August 1, 2000 final rule (65 FR 47052), we revised our regulations at § 485.610 to reflect the provisions of section 403(c) of the 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, we are revising § 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).

XII. 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.

Section 541 of Public Law 106–554 amended section 1861(v)(1)(T) 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 reduces 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. We are revising § 413.80 to implement this change.

XIII. Waiver of Notice of Proposed Rulemaking and Delay in the Effective Date

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** to provide a period for public comment before the provisions of the rule take effect. However, section 1871(b) of the Act provides that publication of a notice of proposed rulemaking is not required before a rule takes effect where ''a statute establishes a specific deadline for the implementation of the provision and the deadline is less than 150 days after the date of enactment of the statute in which the deadline is contained.'' In addition, we may waive a notice of proposed rulemaking if we find good cause that notice and comment are impracticable, unnecessary, or contrary to the public interest.

On August 1, 2000, we published a final rule addressing FY 2001 payment rates and policies for prospective payment system hospitals and excluded hospitals and hospital units (65 FR 47054). Subsequently, on December 21, 2000, Public Law 106–554 was enacted. This public law contains a number of provisions relating to issues addressed in the final rule that have effective dates of October 1, 2000, April 1, 2001, or other dates prior to the end of FY 2001.

In accordance with section 1871(b) of the Act, publication of a notice of proposed rulemaking is not required before implementing the statutory provisions of Public Law 106–554 that take effect October 1, 2000 or April 1, 2001. In addition, notice and comment would be unnecessary because the provisions of Public Law 106–554 that are addressed in this rule do not permit the exercise of discretion. Delaying publication of the rule to provide for notice and a comment period would also be impracticable and contrary to the public interest because it is important that the rule be published as soon as possible, in order for the public to know how we are implementing the statutory provisions covered by the rule, and in order to revise our current regulations to conform with the changes mandated by Public Law 106–554.

We are providing a 30-day period for public comments on all of these provisions.

This rule has been determined to be a major rule as defined in Title 5, United State Code, section 804(2), that is, one with an anticipated annual effect of $100 million or more on the economy. Ordinarily, under 5 U.S.C. 801, as added by section 251 of Public Law 104–121, a major rule shall take effect 60 days after the later of (1) the

date a report on the rule is submitted to Congress or (2) the date the rule is published in the **Federal Register**. However, section 808(2) of Title 5, United States Code, provides that, notwithstanding 5 U.S.C. 801, a major rule shall take effect at such time as the Federal agency promulgating the rule determines, if for good cause, the agency determines that notice and public procedure are impracticable, unnecessary, or contrary to the public interest. As indicated above, for good cause we find that it was unnecessary, impracticable and contrary to the public interest to complete notice and comment procedures before publication of this rule and to delay the effective date of this rule. Accordingly, pursuant to 5 U.S.C. 808, these regulations are effective April 1, 2001.

XIV. Response to Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, we are not able to acknowledge or respond to them individually. Comments on the provisions of this interim final rule with comment period will be considered if we receive them by the date specified in the **DATES** section of this preamble.

XV. Regulatory Impact Analysis

A. Introduction

We have examined the impacts of this rule as required by Executive Order 12866. Although not required to do so, due to the interim final nature of this rule, we have also examined the impacts of this rule under the criteria of the Regulatory Flexibility Act (RFA) Public Law 96–354, section 1102(b) of the Act, and the Unfunded Mandate Reform Act of 1995 (UMRA) Public Law 104–4. Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for rules that constitute significant regulatory action, including rules that have an economic effect of $100 million or more annually (major rules). We have determined that this is a major rule within the meaning of Executive Order 12866.

The RFA requires agencies to analyze options for regulatory relief of small businesses in issuing a proposed rule and a final rule that has been preceded by a proposed rule. For purposes of the RFA, small entities include small businesses, nonprofit organizations and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $25 million or less annually. For purposes of the RFA, all hospitals are considered small entities. Individuals and States are not included in the definition of a small entity.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a proposed rule or a final rule preceded by a proposed rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of an MSA and has fewer than 100 beds.

Section 202 of the UMRA also requires that agencies assess anticipated costs and benefits before issuing any proposed rule or any final rule preceded by a proposed rule that may result in expenditures in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million or more. This interim final rule with comment period does not mandate any requirements for State, local, or tribal governments.

B. Anticipated Effects

We estimated the impact of the changes described in this interim final rule with comment period resulting from the passage of Public Law 106–554 on the inpatient prospective payment systems to be $1.04 billion. The changes, discussed separately below are as follows:

The effects of the change in the DSH payment reduction factor and the DSH payment qualification criteria as set forth by sections 211 and 303 of Public Law 106–554.

- The effects of introducing the option to base eligibility for Medicare dependent hospitals (MDHs), for hospitals otherwise qualifying for MDH status, on discharges during two of the three most recently audited cost reporting periods as directed by section 212 of Public Law 106–554.
- The total change in payments for hospitals, other than SCHs, including the increase in the update factor from market basket minus 1.1 percentage points, or 2.3 percent, to market basket plus 1.1 percentage points, or 4.5 percent, based on the policies in effect for the first half of FY 2001, relative to payments based on the policies in effect for the second half of FY 2001. (As directed by section 301 of Public Law 106–554). We estimate the financial impact of this provision will be $700 million.

Table 1 displays the estimated payment impacts of the provisions of Public Law 106–554 for all hospitals under the inpatient hospital prospective payment system. Specifically, this table compares simulated payments for hospitals using the policy and payment rate updates in effect for discharges occurring on or after October 1, 2000 and before April 1, 2001, to simulated payments using the policy changes and payment rate updates published in this interim final rule with comment. The hospital categories in the table are identical to those published in the August 1, 2000 final rule. Also, the simulation methodology here is identical to the methodology described in that final rule.

The estimated overall impact of the changes in policy and the update to the standardized amounts is a 2.9 percent increase in payments across all hospitals, and the average payment per case increased $202, from $6,883 to $7,085.

- The effects of the change to the IME adjustment factor as directed by section 302 of Public Law 106–554.
- The effects of expanding the 1996 rebasing option to all SCHs as directed by Section 213 of Public Law 106–554.
- The effects of the changes made to the TEFRA payment mechanism under section 1886(b) by sections 306 and 307(a) of 106–554.

1. Decrease In Reductions for DSH Payments and Changes in Treatment of Rural and Small Urban Disproportionate Share Hospitals.

Under section 303 of Public Law 106–554, reductions in the otherwise applicable DSH payment formula amounts would be 2 percent in FY 2001 and 3 percent in FY 2002. We estimate that the financial impact of this amendment from October 1, 2000 through FY 2002 will be $40 million. To implement the FY 2001 provision, DSH payments for discharges occurring on or after October 1, 2000 and before April 1, 2001, are reduced by 3 percent (which was the reduction in effect prior to enactment of Public Law 106–554), and for discharges occurring on or after April 1, 2001 and before October 1, 2001, DSH amounts would be reduced by only 1 percent.

Additionally, Section 211 of Public Law 106–554 amended section 1886(d)(5)(F)(v) of the Act, by lowering the thresholds by which certain classes of hospitals qualify for DSH. Specifically, for discharges occurring on or after April 1, 2001, the qualifying

disproportionate payment percentage is reduced to 15 percent for SCHs, RRCs, and other small rural and urban hospitals. Also, a formula will be used to calculate DSH adjustments for these groups of hospitals that have a DSH patient percentage equal to or greater than 15 percent and less than 19.3 percent. For SCHs and RRCs with a disproportionate patient percentage equal to or greater than 19.3 percent, but less than 30 percent, a flat 5.25 percent adjustment applies, and a formula again applies to the DSH adjustment for these same hospitals with a disproportionate patient percentage equal to or greater than 30 percent. A hospital that is both an SCH and an RRC, or a small rural hospital, receives a flat 5.25 percent adjustment if its disproportionate patient percentage is equal to or greater than 19.3 percent but less than 30 percent, and if that hospital has a disproportionate patient percentage equal to or greater than 30 percent, it receives the greater of the SCH or RRC adjustment. We estimate the financial impact of this amendment from October 2000 through FY 2002 will be $60 million.

In column 1 of Table 1 we present the combined effect of the two DSH provisions, as discussed in section III of this interim final rule with comment period. We compared estimated aggregate payments for the first half of FY 2001 to estimated aggregate payments for the second half of FY 2001 keeping all payment factors constant except those affected by the DSH changes. Because the criteria for qualifying for DSH payment status was changed as discussed above, more hospitals should be receiving DSH payments for the second half of FY 2001.

Comparing Table 1 of this section to the Table 1 in the Inpatient Prospective Payment System Final Rule that appeared in the August 1, 2000 **Federal Register** (65 FR 47192), there are significant increases in the estimated number of hospitals receiving DSH payments. Specifically, whereas 3,070 hospitals were estimated not to qualify for DSH payments for the first half of FY 2001, that number is expected to decrease to 1,914, meaning that for the second half of FY 2001, 1,156 more hospitals are expected to receive DSH payments. The 1,156 new DSH hospitals in our estimate are primarily small urban or rural hospitals, which are the same groups of hospitals targeted for assistance by Section 211 of Public Law 106–554.

For example, the DSH payment category for urban hospitals with fewer than 100 beds is estimated to increase by 284, from 72 hospitals in the first half of FY 2001 to 356 hospitals in the second half of FY 2001. Rural SCHs estimated to qualify for DSH payments rose by 389, from 149 in the first half of FY 2001 to 538 hospitals in the second half of FY 2001. RRCs appear to experience an increase of 83 providers, with the number of providers estimated to qualify for DSH payments moving from 56 to 139. Other rural DSH hospitals with fewer than 100 beds appear to benefit as well, with the number of those eligible for DSH payments estimated to increase by 364 from 103 to 467.

Overall, we estimate that hospitals experience a 0.4 percent increase in payments, with rural hospitals receiving an increase of 1.7 percent and large urban and other urban hospitals both receiving a 0.2 percent increase.

Rural DSH hospitals with between 0 and 100 beds are estimated to receive the largest increase, 4.1 percent. Urban DSH hospitals with between 0 and 100 beds are estimated to receive a 3.5 percent increase in payments. We anticipate that no hospitals were negatively impacted by these changes in DSH policy.

2. Changes to Qualifications for MDHs

Section 212 of Public Law 106–554 provides an option to base eligibility for an MDH on discharges during two of the three most recently audited cost reporting periods. An otherwise qualifying hospital would be able to be classified as an MDH if at least 60 percent of its inpatient days or discharges were attributable to Medicare Part A beneficiaries during two of the three most recently audited cost reporting periods, for which the Secretary has a settled cost report, effective with discharges on or after April 1, 2001.

To estimate the effect of this change we examined cost report data from 1994 through 1999, and selected all hospitals with settled and audited cost reports for each prospective payment system year (1994 through 1999). We then took these subsets of settled and audited cost reports and selected providers who met the criteria for MDH status and who had at least 60 percent of inpatient days or discharges attributable to Medicare Part A beneficiaries, for 1 year.

We then combined the sets of qualifying providers from each prospective payment system year during the period of 1994 through 1999 and selected those providers who met the 60 percent criterion for 2 out of 3 cost reports and would therefore meet the MDH criteria as stated in Section 212 of Public Law 106–554. Although we identified 139 hospitals through this analysis, these providers were already listed as MDH providers in our records. However, it is important to note that our most complete data set for hospital cost reports is still 1998 and we are therefore unable to measure the effects of this provision on the most recent data. Therefore, while the results of one analysis appear to indicate that this provision will not have the first half of FY 2001 to the second half of FY 2001. We have estimated the financial impact of this amendment to be $10 million.

3. Indirect Medical Education (IME)

Section 302 of the Public Law 106–554 modified the transition for the IME adjustment that was first established by Public Law 105–33 and revised by Public Law 106–113. Specifically, the new transition schedule (where *c* is represented in the following formula: $c * [(1 + \textit{resident-to-bed ratio})^{.405} - 1]$) is:

- For discharges occurring on or after October 1, 2000 and before April 1, 2001, *c* equals 1.54;
- For discharges occurring on or after April 1, 2001 and before October 1, 2001, *c* equals 1.66;
- For discharges occurring during FY 2002, *c* equals 1.66;
- For discharges occurring on or after October 1, 2002, *c* equals 1.35.

We have estimated the financial impact of this provision to be $200 million. To estimate the impact of this change, we compared estimated aggregate payments for the first half of FY 2001 to estimated aggregate payments for the second half of FY 2001, keeping all payment factors except those affected by the IME changes constant.

Overall, hospitals appear to be experiencing a 0.4 percent increase in payments, with large urban hospitals receiving a 0.6 percent increase and other urban hospitals receiving an increase of 0.3 percent. Rural hospitals are estimated to receive a 0.1 percent increase. Teaching hospitals with 100 or more residents are estimated to receive a 1.2 percent increase in payments. Additionally, urban hospitals in the New England region are projected to experience an 0.8 percent increase, while rural hospitals in the New England region are projected to experience an increase of 0.4 percent.

4. Sole Community Hospitals (SCHs)

Section 405 of the Public Law 106–113 included a 1996 rebasing option for cost reporting periods beginning October 1, 2000, that was limited to SCHs that received payment based on their hospital-specific rate for reporting periods beginning in 1999. This

amendment allowed eligible SCHs to use this 1996 target amount rather than either their FY 1982 or FY 1987 costs. Section 213 of Public Law 106–554 extends this rebasing option to all SCHs and provides that this extension is effective for cost reporting periods beginning on or after October 1, 2000.

In estimating the impact of this change, we compared estimated aggregate payments for the first half of FY 2001 to estimated aggregate payments for the second half of FY 2001, keeping all payment factors except those effected by the SCH changes constant. Overall, hospitals do not appear to be experiencing any change in payments due to this provision, though some categories of hospitals, for example rural SCH and RRC hospitals, are estimated to receive a 0.1 percent increase.

5. Hospitals and Hospital Units Excluded From the PPS

We are implementing sections 306 and 307(a) of Public Law 106–554 which makes several modifications to the TEFRA payment mechanism under section 1886(b). Section 306 amends section 1886(b)(1)(A) of the Act, as it applies to a psychiatric hospital or unit, to provide that if a psychiatric hospital or unit's net inpatient operating costs are less than, or equal to, the ceiling for cost reporting periods beginning on or after October 1, 2000 and before October 1, 2001, the amount of 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.

Prior to enactment of Public Law 106–554, for cost reporting periods beginning before October 1, 1997, a hospital (or unit) that had net inpatient operating costs that were less than its ceiling was paid 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, the amount of the bonus payment would be based on the lower of 15 percent of the difference between the net inpatient operating costs and the ceiling, or 2 percent of the ceiling.

The impact on hospitals of the increase in the bonus payment from 2 percent to 3 percent depends on the hospital's or unit's total allowable net inpatient operating costs based on its current cost report. Because a hospital's or unit's cost reporting period generally covers a 12-month period of time and this provision is effective for cost reporting periods beginning on or after October 1, 2000 and before October 1, 2001, the relevant cost data needed to determine the impact of this provision will not be available until sometime after October 1, 2001. Our initial estimate of the financial impact of this provision is $20 million; however, given the lack of available data we are unable to fully estimate the financial impact this provision will have on the Medicare program.

We are also implementing section 307(a) of Public Law 106–554 which amended section 1886(b)(3) of the Act to provide for a 2 percent increase to the wage-adjusted 75th percentile cap on the target amount for LTCHs, effective for cost reporting periods beginning during FY 2001. This provision is applicable to LTCHs that were subject to the cap for existing excluded providers, as specified in § 413.40(c).

In addition to the increase to the cap on the target amounts for LTCHs, section 307(a) of Public Law 106–554 also amends section 1886(b)(3) of the Act to provide for a 25 percent increase to the target amounts determined under 1886(b)(3)(A) of the Act for all LTCHs, effective for cost reporting periods beginning during FY 2001. Thus, this provision requires a revision to the determination of each LTCH's FY 2001 target amount as specified in § 413.40(c)(4). For cost reporting periods beginning during FY 2001, the hospital-specific target amount otherwise determined for a LTCH as specified in the regulations at § 413.40(c)(4)(ii) is multiplied by 1.25 (that is, increased by 25 percent). However, the revised FY 2001 target amount for the LTCH cannot exceed its wage-adjusted national cap as required by 1886(b)(3) of the Act, as amended by section 307(a) of Public Law 106–554.

In order to estimate the impact of the 25 percent increase in the hospital-specific target amount as well as the 2 percent increase in the LTCH cap, we adjusted the historical hospital-specific target amounts for each LTCH, as specified in § 413.40(c)(4)(iii)(A), by a factor of 1.25 (that is, the 25 percent increase). We then determined the wage-adjusted cap for these LTCHs and increased the cap by 2 percent to calculate the applicable cap on the hospital's adjusted target amount. An analysis of the best available data indicates that 64.6 percent of the LTCHs will benefit only from the 25 percent increase; in other words, these hospitals' target amounts were at least 25 percent below their cap. Our analysis also indicated that 22.9 percent of the hospitals will only benefit from the 2 percent increase in the wage-adjusted cap (their target amounts prior to the BIPA provision were equal to or exceeded the cap). The analysis also showed that 13.5 percent of the hospitals will benefit from both the 25 percent increase and the 2 percent increase provisions. These hospitals will not benefit from the full 25 percent increase to their target amounts because prior to this Public Law 106–554 provision their target amounts were not less than 25 percent below their cap. Thus, these hospitals received a portion of the 25 percent increase to their target amounts plus the 2 percent increase to the payment limitations.

The impact of the increases in hospital-specific target amounts and wage-adjusted caps for LTCHs was estimated based on FY 1998 cost reporting data as this was the most complete data source available. We note that these changes will also have somewhat of an impact on incentive payments, continuous improvement bonus payments, or other payment adjustment for excluded hospitals outlined in the regulations at § 413.40(d). However, in making this comparative analysis, we did not attempt to determine the impact on those payments. Our initial estimate of the financial impact of this provision is $10 million; however, given the lack of available data we are unable to fully estimate the financial impact this provision will have on the Medicare program.

6. Critical Access Hospitals (CAH)

Section 201(a) of Public Law 106–554 amends section 1834(g) of the Act to state that there will be no collection of coinsurance, deductible, copayments, or other type of cost sharing from Medicare beneficiaries with respect to outpatient clinical diagnostic laboratory services in a CAH. This provision also provides for the payment of those services on a reasonable cost basis. Furthermore, section 201(b) of Public Law 106–554 amends section 1833(a) of the Act by eliminating any reference to a CAH receiving payment for outpatient clinical diagnostic laboratory services on a fee schedule basis. These amendments are effective for services furnished on or after November 29, 1999.

There are approximately 365 facilities that qualify as CAHs. These CAHs are paid based on reasonable costs rather than a fee schedule amount for outpatient clinical diagnostic laboratory services furnished on or after November 29, 1999. We estimate that the financial impact of this amendment from November 29, 1999 through fiscal year 2001 will be $4.5 million.

Section 202 of Public Law 106–554 amends section 1834(g) of the Act to provide that when a CAH elects to be paid for Medicare outpatient services under the reasonable costs for facility services plus fee schedule amounts for professional services method, Medicare will pay 115 percent of the amount it would otherwise pay for the professional services. This provision is effective for items and services furnished on or after July 1, 2001.

At this point, our information indicates that very few CAHs have elected this option. We note that, with the enactment of this provision, which increases payment levels, that there may be an increase in the number of CAHs that make the election. We do not have adequate data to develop a reliable estimate of the financial impact of the change. Based on current levels of interest, we believe the financial impact will be minimal.

C. Overall Impact of Inpatient Operating Changes

Overall, the changes implemented by Public Law 106–554 are estimated to increase payments to providers by 2.9 percent. Given the 0.22 percentage increase in the update factor for the inpatient hospital payment rates as discussed in section V. of this interim final rule, the increase in hospitals eligible for DSH payments, the changes to the DSH formulas and the increase in the IME adjustment factor, this is not suprising. Additionally, the lowered threshold for outlier payments enabled some classes of providers to more easily qualify for outlier status. For example, urban hospitals with neither DSH nor IME are estimated to experience a 0.1 percent increase from each of those two provisions due to the effects of the provisions on payment distribution and outliers. Therefore, it appears that all classes of hospitals in this analysis will benefit from the changes instituted by Public Law 106–554.

TABLE I.—IMPACT ANALYSIS OF CHANGES FOR THE SECOND HALF OF FY 2001 (DISCHARGES OCCURRING ON OR AFTER APRIL 1, 2001 AND BEFORE OCTOBER 1, 2001) OPERATING PROSPECTIVE PAYMENT SYSTEM

[Percent changes in payments per case]

	Number of hosps.[1] (0)	DSH changes[2] (1)	IME changes[3] (2)	SCH changes[4] (3)	All FY 2001 changes[5] (4)
By Geographic Location:					
All Hospitals	4,888	0.4	0.4	0.0	2.9
Urban Hospitals	2,756	0.2	0.5	0.0	2.9
Large Urban Areas	1,573	0.2	0.6	0.0	3.0
Other Urban Areas	1,183	0.2	0.3	0.0	2.7
Rural Hospitals	2,132	1.7	0.1	0.0	3.3
Bed Size (Urban):					
0–99 Beds	720	1.5	0.1	0.0	3.8
100–199 Beds	944	0.2	0.2	0.0	2.6
200–299 Beds	548	0.1	0.3	0.0	2.6
300–499 Beds	401	0.1	0.5	0.0	2.9
500 or More Beds	143	0.2	1.0	0.0	3.3
Bed Size (Rural):					
0–49 Beds	1,229	1.7	0.0	0.0	3.1
50–99 Beds	535	2.0	0.0	0.0	3.4
100–149 Beds	219	1.7	0.1	0.0	3.3
150–199 Beds	81	1.6	0.1	0.1	3.4
200 or More Beds	68	1.3	0.2	0.1	3.6
Urban by Census Division:					
New England	146	0.1	0.8	0.1	3.2
Middle Atlantic	422	0.1	0.6	0.0	3.0
South Atlantic	404	0.3	0.3	−0.1	2.7
East North Central	467	0.1	0.6	0.0	2.9
East South Central	161	0.2	0.3	0.0	2.7
West North Central	188	0.2	0.5	0.0	2.8
West South Central	350	0.4	0.3	0.0	2.9
Mountain	133	0.2	0.3	0.0	2.4
Pacific	440	0.4	0.4	0.0	2.9
Puerto Rico	45	0.1	0.2	0.1	2.5
Rural by Census Division:					
New England	52	0.9	0.4	0.0	2.8
Middle Atlantic	79	1.4	0.2	0.1	3.4
South Atlantic	277	2.0	0.1	0.0	3.9
East North Central	279	1.0	0.0	0.1	2.7
East South Central	266	2.4	0.0	0.0	4.5
West North Central	492	0.8	0.1	0.0	2.1
West South Central	341	2.6	0.0	0.0	4.1
Mountain	201	1.3	0.0	0.0	1.7
Pacific	140	2.2	0.1	0.0	3.4
Puerto Rico	5	0.3	0.0	0.1	2.5
By Payment Categories:					
Urban Hospitals	2,838	0.2	0.5	0.0	2.9
Large Urban	1,665	0.2	0.6	0.0	3.0
Other Urban	1,168	0.2	0.3	0.0	2.7
Rural Hospitals	2,055	1.8	0.1	0.0	3.3
Teaching Status:					
Non-Teaching	3,770	0.7	0.1	0.0	2.8
Fewer Than 100 Residents	876	0.2	0.4	0.1	2.7

TABLE I.—IMPACT ANALYSIS OF CHANGES FOR THE SECOND HALF OF FY 2001 (DISCHARGES OCCURRING ON OR AFTER APRIL 1, 2001 AND BEFORE OCTOBER 1, 2001) OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Percent changes in payments per case]

	Number of hosps.[1] (0)	DSH changes[2] (1)	IME changes[3] (2)	SCH changes[4] (3)	All FY 2001 changes[5] (4)
100 or More Residents	242	0.1	1.2	0.0	3.5
Disproportionate Share Hospitals (DSH):					
Non–DSH	1,914	0.0	0.3	−0.2	2.4
Urban DSH:					
100 Beds or More	1,390	0.2	0.6	0.0	2.9
Fewer Than 100 Beds	356	3.5	0.1	0.0	5.8
Rural DSH:					
Sole Community (SCH)	538	1.6	0.0	0.0	2.1
Referral Centers (RRC)	139	2.5	0.1	0.0	4.4
Other Rural DSH Hospitals:					
100 Beds or More	84	2.9	0.1	0.1	5.1
Fewer Than 100 Beds	467	4.1	0.0	0.1	6.4
Urban Teaching and DSH:					
Both Teaching and DSH	748	0.2	0.8	0.0	3.1
Teaching and No DSH	305	0.0	0.6	−0.1	2.8
No Teaching and DSH	998	0.5	0.1	0.0	2.8
No Teaching and No DSH	787	0.1	0.1	0.1	2.4
Rural Hospital Types:					
Nonspecial Status Hospitals	829	2.8	0.0	0.1	5.0
RRC	150	1.8	0.2	0.0	4.2
SCH	662	0.8	0.0	0.0	0.8
MDH	352	1.6	0.0	0.0	3.8
SCH and RRC	57	1.3	0.1	0.0	1.8
Type of Ownership:					
Voluntary	2,834	0.4	0.5	0.0	2.9
Proprietary	776	0.6	0.2	0.1	2.9
Government	1,278	0.8	0.5	−0.3	3.3
Unknown	0	0.0	0.0	0.0	0.0
Medicare Utilization as a Percent of Inpatient Days:					
0–25	381	0.4	0.9	0.0	3.4
25–50	1,830	0.3	0.7	0.0	3.1
50–65	1,893	0.5	0.2	0.1	2.8
Over 65	699	0.8	0.1	0.1	2.9
Unknown	85	−3.0	−2.5	−3.5	−0.1

[1] Because data necessary to classify some hospitals by category were missing, the total number of hospitals in each category may not equal the national total. Discharge data are from FY 1999, and hospital cost report data are from reporting periods beginning in FY 1997 and FY 1998.
[2] This column displays the payment impact of the change in DSH payment policy between the first and second half of FY 2001.
[3] This column displays the payment effects of the increase in the IME adjustment factor between the first and second half of FY 2001.
[4] This column displays the payment impact of allowing all SCHs to rebase using 1996 cost data between the first and second half of FY 2001.
[5] This column shows changes in payments from the first half of FY 2001 to the second half of FY 2001. It incorporates all of the changes displayed in columns 1, 2, and 3. It also displays the impact of the increase in the FY 2001 update rates, the difference in outlier offsets from FY 2000 to FY 2001, and the increase to payments from the IME adjustment and DSH changes taking effect during FY 2001. It also reflects the SCHs rebasing provision contained in Public Law 106–554.

D. Impact of Changes in the Capital Prospective Payment System

In this impact analysis, we dynamically model the impact of the capital prospective payment system for the periods from October 2000 through March 2001 and April 2001 through September 2001. We have used the actuarial model described in Appendix B of the August 1, 2001 final rule (65 FR 47204 through 47207) to estimate the changes in capital-related costs. Table III shows the effect of the capital prospective payment system on low capital costs hospitals and high capital costs hospitals by their capital prospective payment system transition period payment methodology (fully prospective or hold harmless). Assuming no behavioral changes, Table III displays the percentage change in payments per discharge for the periods between October 2000 through March 2001 and April 2001 through September 2001. Overall, there will be no significant impact on capital prospective payment system payments. We project low cost hospitals will experience a 0.04 percent decrease in payments per case, while high cost hospitals will experience a 0.16 percent increase in payments per case.

TABLE III.—IMPACT OF PROPOSED CHANGES FOR APRIL 2001–SEPTEMBER 2001 ON PAYMENTS PER DISCHARGE

	Number of hospitals	Discharges	Adjusted Federal payment	Average Federal percent	Hospital specific payment	Hold harmless payment	Exceptions payment	Total payment	Percent change over Oct-00–Mar-01
10/2000–03/2001 Payments per Discharge:									
Low Cost Hospitals	3,188	6,835,493	$637.91	99.74	.....	$2.42	$9.69	$650.02	.....
Fully Prospective ...	3,014	6,356,216	638.58	100.00	.....	.....	9.20	647.79	.....
100% Federal Rate	159	445,296	638.34	100.00	.....	.....	4.35	642.69	.....
Hold Harmless	15	33,981	506.60	60.11	.....	486.54	170.96	1,164.09	.....
High Cost Hospitals	1,594	4,146,176	653.32	98.38	.....	15.35	21.47	690.14	.....
100% Federal Rate	1,390	3,793,344	664.47	100.00	.....	.....	10.65	675.12	.....
Hold Harmless	204	352,832	533.52	80.86	.....	180.41	137.76	851.69	.....
Total Hospitals	4,782	10,981,669	643.73	99.21	.....	7.30	14.14	665.17	.....
04/2001–09/2001 Payments per Discharge:									
Low Cost Hospitals	3,188	6,835,493	637.72	99.74	.....	2.42	9.63	649.77	−0.0
Fully Prospective ...	3,014	6,356,216	638.34	100.00	.....	.....	9.15	647.49	−0.0
100% Federal Rate	159	445,296	638.64	100.00	.....	.....	4.37	643.01	0.0
Hold Harmless	15	33,981	509.14	60.15	.....	486.54	168.45	1,164.13	0.0
High Cost Hospitals	1,594	4,146,176	654.60	98.38	.....	15.35	21.28	691.23	0.1
100% Federal Rate	1,390	3,793,344	665.70	100.00	.....	.....	10.55	676.25	0.1
Hold Harmless	204	352,832	535.28	80.86	.....	180.41	136.65	852.34	0.0
Total Hospitals	4,782	10,981,669	644.09	99.21	.....	7.30	14.03	665.42	0.0

Table IV presents a cross-sectional summary of hospital groupings (geographic location, region, and payment classification) by capital prospective payment system transition period payment methodology generated by our actuarial model. The percentage of hospitals within a particular hospital grouping is not projected to change significantly from those shown in the Table IV of the impact section of the August 1, 2001 final rule (65 FR 47201 through 47202).

TABLE IV.—DISTRIBUTION BY METHOD OF PAYMENT (HOLD-HARMLESS/FULLY PROSPECTIVE) OF HOSPITALS RECEIVING CAPITAL PAYMENTS

	(1) Total number of hospitals	(2) Hold-harmless		(3) Percentage paid fully prospective rate
		Percentage paid hold-harmless (A)	Percentage paid fully federal (B)	
By Geographic Location:				
All hospitals	4,782	4.6	32.4	63.0
Large urban areas (populations over 1 million)	1,516	4.3	41.0	54.7
Other urban areas (populations of 1 million or fewer)	1,147	5.8	39.5	54.7
Rural areas	2,119	4.1	22.4	73.5
Urban hospitals	2,663	5.0	40.3	54.7
0–99 beds	652	6.3	33.6	60.1
100–199 beds	927	7.2	45.6	47.1
200–299 beds	542	3.3	41.3	55.4
300–499 beds	400	0.8	37.0	62.3
500 or more beds	142	2.1	42.3	55.6
Rural hospitals	2,119	4.1	22.4	73.5
0–49 beds	1,219	2.9	16.6	80.6
50–99 beds	532	6.8	26.9	66.4
100–149 beds	219	5.9	35.2	58.9
150–199 beds	81	2.5	25.9	71.6
200 or more beds	68	1.5	47.1	51.5
By Region:				
Urban by Region	2,663	5.0	40.3	54.7
New England	145	0.7	25.5	73.8
Middle Atlantic	407	2.9	34.6	62.4
South Atlantic	396	5.6	51.8	42.7
East North Central	454	4.2	29.7	66.1
East South Central	153	8.5	46.4	45.1
West North Central	181	6.1	37.0	56.9
West South Central	326	8.9	58.0	33.1
Mountain	124	4.8	48.4	46.8

TABLE IV.—DISTRIBUTION BY METHOD OF PAYMENT (HOLD-HARMLESS/FULLY PROSPECTIVE) OF HOSPITALS RECEIVING CAPITAL PAYMENTS—Continued

	(1) Total number of hospitals	(2) Hold-harmless		(3) Percentage paid fully prospective rate
		Percentage paid hold-harmless (A)	Percentage paid fully federal (B)	
Pacific	432	4.2	36.3	59.5
Puerto Rico	45	2.2	26.7	71.1
Rural by Region	2,119	4.1	22.4	73.5
New England	52	0.0	23.1	76.9
Middle Atlantic	78	5.1	19.2	75.6
South Atlantic	276	2.2	33.3	64.5
East North Central	279	3.9	16.5	79.6
East South Central	265	3.4	32.8	63.8
West North Central	490	3.3	14.5	82.2
West South Central	335	4.5	26.6	69.0
Mountain	200	9.5	15.0	75.5
Pacific	139	5.0	23.7	71.2
By Payment Classification:				
Large urban areas (populations over 1 million)	1,612	4.2	41.3	54.5
Other urban areas (populations of 1 million or fewer)	1,133	6.0	38.8	55.2
Rural areas	2,037	4.1	21.8	74.1
Teaching Status:				
Non-teaching	3,673	5.1	31.6	63.3
Fewer than 100 residents	871	2.9	35.9	61.2
100 or more residents	238	2.1	32.4	65.5
Disproportionate Share Hospitals (DSH):				
Non-DSH	1,841	4.5	29.2	66.3
Urban DSH:				
100 or more beds	1,377	4.6	42.6	52.8
Less than 100 beds	342	5.8	32.2	62.0
Rural DSH:				
Sole Community (SCH/EACH)	538	6.1	20.1	73.8
Referral Center (RRC/EACH)	139	6.5	36.0	57.6
Other Rural:				
100 or more beds	84	1.2	36.9	61.9
Less than 100 beds	461	2.0	27.3	70.7
Urban teaching and DSH:				
Both teaching and DSH	741	2.7	36.7	60.6
Teaching and no DSH	303	2.6	33.7	63.7
No teaching and DSH	978	6.5	43.4	50.1
No teaching and no DSH	723	6.1	42.5	51.5
Rural Hospital Types:				
Non special status hospitals	817	1.5	24.0	74.5
RRC/EACH	150	2.7	36.0	61.3
SCH/EACH	662	8.5	18.3	73.3
Medicare-dependent hospitals (MDH)	351	1.4	16.5	82.1
SCH, RRC and EACH	57	10.5	26.3	63.2
Type of Ownership:				
Voluntary	2,520	4.5	32.4	63.1
Proprietary	653	7.2	57.1	35.7
Government	1,093	4.1	19.2	76.7
Medicare Utilization as a Percent of Inpatient Days:				
0–25	367	5.4	27.5	67.0
25–50	1,820	4.3	35.1	60.7
50–65	1,882	4.7	31.2	64.1
Over 65	688	4.8	32.1	63.1

In Table V we present the results of the cross-sectional analysis using the results from our actuarial model and the aggregate impact resulting from section 301 of Public Law 106–554 that will affect capital prospective payment system payments for discharges occurring on or after April 1, 2001 and before October 1, 2001. Our comparison of payments for the periods from October 2000 through March 2001 and April 2001 through September 2001 by geographic location, region, payment classification, and type of ownership shows no significant effect (ranging from −0.2 percent to 0.2 percent) on payments for hospitals in all groupings.

TABLE V.—COMPARISON OF TOTAL PAYMENTS PER CASE

[October 2000–March 2001 Payments Compared to April 2001–September 2001 Payments]

	Number of hospitals	Average Oct 00–Mar 01 payments/case	Average Apr 01–Sept 01 payments/case	All changes	Portion attributable to Federal rate change
By Geographic Location:					
All hospitals	4,782	665	665	0.0	0.1
Large urban areas (populations over 1 million)	1,516	772	773	0.1	0.1
Other urban areas (populations of 1 million or fewer)	1,147	653	653	0.0	0.0
Rural areas	2,119	449	449	−0.1	−0.1
Urban hospitals	2,663	720	720	0.1	0.1
0–99 beds	652	518	518	0.1	0.1
100–199 beds	927	630	630	0.0	0.0
200–299 beds	542	684	685	0.0	0.1
300–499 beds	400	754	754	0.1	0.1
500 or more beds	142	923	924	0.1	0.1
Rural hospitals	2,119	449	449	−0.1	−0.1
0–49 beds	1,219	378	377	−0.2	−0.2
50–99 beds	532	429	429	−0.2	−0.2
100–149 beds	219	461	460	−0.2	−0.1
150–199 beds	81	489	489	−0.1	−0.1
200 or more beds	68	547	548	0.1	0.2
By Region:					
Urban by Region	2,663	720	720	0.1	0.1
New England	145	751	750	0.0	0.0
Middle Atlantic	407	797	798	0.1	0.1
South Atlantic	396	693	694	0.1	0.1
East North Central	454	692	692	0.0	0.0
East South Central	153	660	660	0.0	0.1
West North Central	181	715	715	0.1	0.1
West South Central	326	678	680	0.2	0.2
Mountain	124	723	723	0.0	0.0
Pacific	432	804	805	0.1	0.2
Puerto Rico	45	311	311	0.0	0.0
Rural by Region	2,119	449	449	−0.1	−0.1
New England	52	544	542	−0.3	−0.3
Middle Atlantic	78	469	468	0.0	0.3
South Atlantic	276	462	462	0.0	0.0
East North Central	279	459	458	−0.2	−0.2
East South Central	265	411	411	0.0	0.0
West North Central	490	440	438	−0.3	−0.3
West South Central	335	404	404	−0.1	−0.1
Mountain	200	478	477	−0.1	−0.1
Pacific	139	543	543	−0.1	−0.1
By Payment Classification:					
All hospitals	4,782	665	665	0.0	0.1
Large urban areas (populations over 1 million)	1,612	763	764	0.1	0.1
Other urban areas (populations of 1 million or fewer)	1,133	650	651	0.0	0.0
Rural areas	2,037	446	445	−0.1	−0.1
Teaching Status:					
Non-teaching	3,673	549	549	0.0	0.0
Fewer than 100 Residents	871	694	695	0.0	0.1
100 or more Residents	238	1,022	1,023	0.1	0.1
Urban DSH:					
100 or more beds	1,377	759	760	0.1	0.1
Less than 100 beds	342	506	506	−0.1	−0.1
Rural DSH:					
Sole Community (SCH/EACH)	538	420	419	−0.1	−0.2
Referral Center (RRC/EACH)	139	505	505	0.0	0.2
Other Rural:					
100 or more beds	84	422	421	−0.2	−0.2
Less than 100 beds	461	379	378	−0.2	−0.2
Urban teaching and DSH:					
Both teaching and DSH	741	837	837	0.1	0.1
Teaching and no DSH	303	729	729	0.0	0.0
No teaching and DSH	978	609	609	0.0	0.1
No teaching and no DSH	723	600	601	0.1	0.1
Rural Hospital Types:					
Non special status hospitals	817	394	394	−0.2	−0.2
RRC/EACH	150	515	514	−0.1	−0.1
SCH/EACH	662	448	448	−0.1	−0.1

TABLE V.—COMPARISON OF TOTAL PAYMENTS PER CASE—Continued

[October 2000–March 2001 Payments Compared to April 2001–September 2001 Payments]

	Number of hospitals	Average Oct 00–Mar 01 payments/case	Average Apr 01–Sept 01 payments/case	All changes	Portion attributable to Federal rate change
Medicare-dependent hospitals (MDH)	351	377	376	−0.2	−0.2
SCH, RRC and EACH	57	516	517	0.0	0.3
Type of Ownership:					
Voluntary	2,520	680	680	0.0	0.0
Proprietary	653	643	644	0.2	0.2
Government	1,093	602	602	0.0	0.0
Medicare Utilization as a Percent of Inpatient Days:					
0–25	367	838	839	0.1	0.1
25–50	1,820	763	764	0.1	0.1
50–65	1,882	590	590	0.0	0.0
Over 65	688	528	528	0.0	0.0

D. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications.

Although not required to do so, we have examined this interim final rule with comment period, under the criteria set forth in, Executive Order 13132 and have determined that this interim final rule with comment period will not have any negative impact on the rights, rules, and responsibilities of State, local, or tribal governments.

E. Executive Order 12866

In accordance with the provisions of Executive Order 12866, this interim final rule with comment period was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 410

Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 413

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

42 CFR Part 485

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

42 CFR Chapter IV is amended as set forth below:

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

A. Part 410 is amended as follows:

1. The authority citation for Part 410 continues to read as follows:

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

2. Section 410.152 is amended by revising paragraph (k)(2) to read as follows:

§ 410.152 Amounts of payment.

* * * * *

(k) * * *

(2) Payment for CAH outpatient services is subject to the applicable Medicare Part B deductible and coinsurance amounts, except as described in § 413.70(b)(2)(iii) of this chapter, with Part B coinsurance being calculated as 20 percent of the customary (insofar as reasonable) charges of the CAH for the services.

* * * * *

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

B. Part 412 is amended as follows:

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

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

2. Section 412.63 is amended by revising paragraph(s) to read as follows:

§ 412.63 Federal rates for inpatient operating costs for fiscal years after Federal fiscal year 1984

* * * * *

(s) *Applicable percentage change for fiscal year 2001.* The applicable percentage change for discharges occurring in fiscal year 2001 is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this subchapter) for hospitals in all areas as follows:

(1) For discharges occurring on October 1, 2000 or before April 1, 2001 the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this subchapter) for sole community hospitals and the increase in the market basket index minus 1.1 percentage points for other hospitals in all areas; and

(2) For discharges occurring on April 1, 2001 or before October 1, 2001 the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this subchapter) for sole community hospitals and the increase in the market basket index plus 1.1 percentage points for other hospitals in all areas.

* * * * *

3. Section 412.77 is amended by:

A. Revising the section heading.

B. Revising paragraph (a)(1).

C. Removing paragraph (a)(2).

D. Redesignating paragraphs (a)(3) and (a)(4) as paragraphs (a)(2) and (a)(3).

§ 412.77 Determination of the hospital-specific rate for inpatient operating costs for sole community hospitals based on a Federal fiscal year 1996 base period

(a) * * *

(1) This section applies to a hospital that has been designated as a sole community hospital, as described in

§ 412.92. If the 1996 hospital-specific rate exceeds the rate that would otherwise apply, that is, either the Federal rate under § 412.63 or the hospital-specific rates for either fiscal year 1982 under § 412.73 or fiscal year 1987 under § 412.75, this 1996 rate will be used in the payment formula set forth in § 412.92(d)(1).

* * * * *

4. Section 412.92 is amended by revising paragraphs (d)(1)(iv), (d)(2)(i), (d)(2)(ii), and (d)(2)(iii) to read as follows:

§ 412.92 Special treatment: Sole community hospitals.

* * * * *

(d) * * *

(1) * * *

(iv) For cost reporting periods beginning on or after October 1, 2000, the hospital-specific rate as determined under § 412.77 (calculated under the transition schedule set forth in paragraph (d)(2) of this section).

(2) * * *

(i) For Federal fiscal year 2001, the hospital-specific rate is the sum of 75 percent of the greater of the amounts specified in paragraph (d)(1)(i), (d)(1)(ii), or (d)(1)(iii) of this section, plus 25 percent of the hospital-specific rate as determined under § 412.77.

(ii) For Federal fiscal year 2002, the hospital-specific rate is the sum of 50 percent of the greater of the amounts specified in paragraph (d)(1)(i), (d)(1)(ii), or (d)(1)(iii) of this section, plus 50 percent of the hospital-specific rate as determined under § 412.77.

(iii) For Federal fiscal year 2003, the hospital-specific rate is the sum of 25 percent of the greater of the amounts specified in paragraph (d)(1)(i), (d)(1)(ii), or (d)(1)(iii) of this section, plus 75 percent of the hospital-specific rate as determined under § 412.77.

* * * * *

5. Section 412.105 is amended by:

A. Republishing the introductory text of paragraphs (d) and (d)(3).

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

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

* * * * *

(d) *Determination of education adjustment factor.* Each hospital's education adjustment factor is calculated as follows:

* * * * *

(3) *Step three.* The factor derived from completing steps one and two is multiplied by 'c', and where 'c' is equal to the following:

* * * * *

(v) For fiscal year 2001—

(A) For discharges occurring on or after October 1, 2000 and before April 1, 2001, 1.54.

(B) For discharges occurring on or after April 1, 2001 and before October 1, 2001, the adjustment factor is determined as if ''c'' equaled 1.66, rather than 1.54. This payment increase will not apply to discharges occurring after fiscal year 2001 and will not be taken into account in calculating the payment amounts applicable for discharges occurring after fiscal year 2001.

* * * * *

6. Section 412.106 is amended by:

A. Republishing the introductory text to paragraph (c)(1).

B. Revising paragraphs (c)(1)(i), (c)(1)(ii), (c)(1)(iii), and (c)(1)(iv).

C. Revising paragraphs (d)(2)(ii)(A), (d)(2)(ii)(B), (d)(2)(ii)(C), and (d)(2)(ii)(D).

D. Revising paragraphs (d)(2)(iii) and (d)(2)(iv).

E. Revising paragraph (e)(4).

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

* * * * *

(c) * * *

(1) The hospital's disproportionate patient percentage, as determined under paragraph (b)(5) of this section, is at least equal to one of the following:

(i) 15 percent, if the hospital is located in an urban area, and has 100 or more beds, or is located in a rural area and has 500 or more beds.

(ii) 30 percent for discharges occurring before April 1, 2001, and 15 percent for discharges occurring on or after April 1, 2001, if the hospital is located in a rural area and either has more than 100 beds and fewer than 500 beds or is classified as a sole community hospital under § 412.92.

(iii) 40 percent for discharges before April 1, 2001, and 15 percent for discharges occurring on or after April 1, 2001, if the hospital is located in an urban area and has fewer than 100 beds.

(iv) 45 percent for discharges before April 1, 2001, and 15 percent for discharges occurring on or after April 1 2001, if the hospital is located in a rural area and has 100 or fewer beds.

* * * * *

(d) * * *

(2) * * *

(ii) * * *

(A) If the hospital is classified as a rural referral center, for discharges prior to April 1, 2001, the payment adjustment factor is 4 percent plus 60 percent of the difference between the hospital's disproportionate patient percentage and 30 percent. For discharges occurring on or after April 1, 2001, the following applies:

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

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

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

(B) If the hospital is classified as a sole community hospital, for discharges prior to April 1, 2001, the payment adjustment factor is 10 percent. For discharges occurring on or after April 1, 2001, the following applies:

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

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

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

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

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

(*i*) 10 percent; or

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

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

(D) If the hospital is classified as a rural hospital and is not classified as either a sole community hospital or a rural referral center, and has 100 or more beds, for discharges prior to April 1, 2001, the payment adjustment factor is 4 percent. For discharges occurring on or after April 1, 2001, the following applies:

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

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

(iii) If the hospital meets the criteria of paragraph (c)(1)(iii) of this section, the payment adjustment factor is as follows:

(A) For discharges occurring before April 1, 2001, 5 percent.

(B) For discharges occurring on or after April 1, 2001:

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

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

(iv) If the hospital meets the criteria of paragraph (c)(1)(iv) of this section, the payment adjustment factor is as follows:

(A) For discharges occurring before April 1, 2001, 5 percent.

(B) For discharges occurring on or after April 1, 2001:

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

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

* * * * *

(e) * * *

(4) For FY 2001:

(i) For discharges occurring on or after October 1, 2000 and before April 1, 2001, 3 percent.

(ii) For discharges occurring on or after April 1, 2001 and before October 1, 2001, 1 percent.

* * * * *

7. Section 412.108 is amended by:

A. Revising paragraphs (a)(1)(iii) introductory text and (b).

B. Adding a new paragraph (a)(1)(iii)(C).

C. Adding a sentence at the end of (d)(3)(iii).

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

(a) * * *

(1) * * *

(iii) At least 60 percent of the hospital's inpatient days or discharges were attributable to individuals receiving Medicare Part A benefits during the hospital's cost reporting period or periods as follows, subject to the provisions of paragraph (a)(1)(iv) of this section:

* * * * *

(C) At least two of the last three most recent audited cost reporting periods for which the Secretary has a settled cost report.

* * * * *

(b) *Classification procedures.* The fiscal intermediary determines whether a hospital meets the criterion in paragraph (a) of this section. A hospital must notify its fiscal intermediary to be considered for MDH status based on the criterion under paragraph (a)(1)(iii)(C) of this section. Any hospital that believes it meets this criterion to qualify as an MDH, based on at least two of the three most recently audited cost reporting periods, 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 (NPR) for the cost reporting period in question. The intermediary will make its determination and notify the hospital within 180 days from the date that it receives the hospital's request and all of the required documentation. If a hospital disagrees with an intermediary's determination, it should notify its intermediary and submit documentable evidence that it meets the criteria. The intermediary determination is subject to review under subpart R of part 405 of this chapter. The time required by the intermediary to review the request is considered good cause for granting an extension of the time limit for the hospital to apply for such a review.

* * * * *

(d) * * *

(3) * * *

(iii) * * * The time required by the intermediary to review the request is considered good cause for granting an extension of the time limit for the hospital to apply for that review.

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

C. Part 413 is amended as follows:

1. The authority citation for Part 413 continues to read as follows:

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

2. Section 413.40 is amended by:

A. Republishing the introductory text of paragraph (c)(4).

B. Revising paragraphs (c)(4)(iii) introductory text and (c)(4)(iii)(A).

C. Republishing the introductory text of paragraphs (c)(4)(iii)(B) and (c)(4)(iii)(B)(*4*).

D. Revising paragraph (c)(4)(iii)(B)(*4*)(*i*).

E. Revising paragraph (d)(2).

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

* * * * *

(c) * * *

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

* * * * *

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

(A) The hospital-specific target amount.

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

(*2*) In the case of long-term care hospitals, for cost reporting periods beginning on or after October 1, 2001, the hospital-specific target amount is the net allowable costs in a base period increased by the applicable update factors multiplied by 1.25.

* * * * *

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

* * * * *

(*4*) For cost reporting periods beginning during fiscal years 2001 through 2002—

(*i*) The amounts determined under paragraph (c)(4)(iii)(B)(3)(i) of this section are: increased by the market basket percentage up through the subject period; or in the case of a long-term care hospital, for cost reporting periods beginning on or after October 1, 2001, the amounts determined under paragraph (c)(4)(iii)(B)(*3*)(*i*) of this section increased by the market basket percentage up through the subject period and further increased by 2 percent.

* * * * *

(d) * * *

(2) *Net inpatient operating costs are less than or equal to the ceiling.*

(i) For cost reporting periods beginning on or after October 1, 1997, if a hospital's allowable net inpatient operating costs do not exceed the hospital's ceiling, payment to the hospital will be determined on the basis of the lower of the—

(A) Net inpatient operating costs plus 15 percent of the difference between inpatient operating costs and the ceiling; or

(B) Net inpatient operating costs plus 2 percent of the ceiling.

(ii) For psychiatric hospitals and units, for cost reporting periods beginning on or after October 1, 2000 and before October 1, 2001, if a hospital's allowable net inpatient operating costs do not exceed the hospital's ceiling, payment to the hospital will be determined on the basis of the lower of the—

(A) Net inpatient operating costs plus 15 percent of the difference between inpatient operating costs and the ceiling; or

(B) Net inpatient costs plus 3 percent of the ceiling.

* * * * *

3. Section 413.70 is amended by revising paragraphs (b)(2)(ii), (b)(2)(iii), (b)(3)(ii)(B), and (b)(3)(iii).

§ 413.70 Payment for services of a CAH.

* * * * *

(b) * * *

(2) * * *

(ii) Payment to a CAH under paragraph (b)(2) of this section does not include any costs of physician services or other professional services to CAH outpatients and, other than for clinical diagnostic laboratory tests, is subject to the Part B deductible and coinsurance amounts as determined under §§ 410.152(k), 410.160, and 410.161 of this chapter.

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

(3) * * *

(ii) * * *

(B) For professional services otherwise payable to the physician or other practitioner, 115 percent of the amounts that otherwise would be paid for the services if the CAH had not elected payment under this method.

(iii) Payment to a CAH, other than for clinical diagnostic laboratory tests, is subject to the Part B deductible and coinsurance amounts, as determined under §§ 410.152(k), 410.160, and 410.161 of this chapter.

* * * * *

4. Section 413.80 is amended by revising paragraph (h)(3) and adding a new paragraph (h)(4).

§ 413.80 Bad debts, charity, and courtesy allowances.

* * * * *

(h) * * *

(3) For cost reporting periods beginning during fiscal year 2000, by 45 percent.

(4) For cost reporting periods beginning during a subsequent fiscal year, by 30 percent.

* * * * *

5. Section 413.86 is amended by revising paragraph (d)(4) to read as follows:

§ 413.86 Direct graduate medical education payments.

* * * * *

(d) * * *

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

* * * * *

6. Section 413.87 is amended by:

A. Redesignating the introductory text of (c) as (c)(1) introductory text.

B. Redesignating paragraphs (c)(1) and (c)(2) as paragraphs (c)(1)(i) and (c)(1)(ii) respectively.

C. Revising the newly redesignated paragraph (c)(1).

D. Adding a new paragraph (c)(2).

E. Revising the introductory text of paragraph (d).

F. Revising paragraph (d)(3)

G. Redesignating paragraph (e) as paragraph (f).

H. Adding a new paragraph (e).

I. Revising newly redesignated paragraphs (f)(1) introductory text, (f)(1)(ii), and (f)(2).

§ 413.87 Payments for Medicare+Choice nursing and allied health education programs.

* * * * *

(c) *Qualifying conditions for payment.*

(1) For portions of cost reporting periods occurring on or after January 1, 2000 and before January 1, 2001, a hospital that operates and receives payment for a nursing or allied health education program under § 413.85 may receive an additional payment amount associated with Medicare+Choice utilization. The hospital may receive the additional payment amount, which is calculated in accordance with the provisions of paragraph (d) of this section, if both of the conditions specified in paragraphs (c)(1)(i) and (c)(1)(ii) of this section are met.

(i) The hospital must have received Medicare reasonable cost payment for an approved nursing or allied health education program under § 413.85 in its cost reporting period(s) ending in the fiscal year that is 2 years prior to the current calendar year. (For example, if the current year is calendar year 2000, the fiscal year that is 2 years prior to calendar year 2000 is FY 1998.) For a hospital that first establishes a nursing or allied health education program after FY 1998 and receives reasonable cost payment for the program as specified under § 413.85 after FY 1998, the hospital is eligible to receive an additional payment amount in a calendar year that is 2 years after the respective fiscal year so long as the hospital also meets the condition under paragraph (c)(1(ii) of this section.

(ii) The hospital must be receiving reasonable cost payment for an approved nursing or allied health education program under § 413.85 in the current calendar year.

(2) For portions of cost reporting periods occurring on or after January 1, 2001, in addition to meeting the conditions specified in paragraphs (c)(1)(i) and (c)(1)(ii) of this section, the hospital must have had a Medicare+Choice utilization greater

than zero in its cost reporting period(s) ending in the fiscal year that is 2 years prior to the current calendar year.

* * * * *

(d) *Calculating the additional payment amount for portions of cost reporting periods occurring on or after January 1, 2000 and before January 1, 2001.* For portions of cost reporting periods occurring on or after January 1, 2000 and before January 1, 2001, subject to the provisions of § 413.86(d)(4) relating to calculating a proportional reduction in Medicare+Choice direct GME payments, the additional payment amount specified in paragraph (c) of this section is calculated according to the following steps:

* * * * *

(3) *Step three.* Multiply the ratio calculated in step two by the Medicare+Choice nursing and allied health payment ''pool'' determined in accordance with paragraph (f) of this section for the current calendar year. The resulting product is each respective hospital's additional payment amount.

* * * * *

(e) *Calculating the additional payment amount for portions of cost reporting periods occurring on or after January 1, 2001.* For portions of cost reporting periods occurring on or after January 1, 2001, subject to the provisions of § 413.86(d)(4) relating to calculating a proportional reduction in Medicare+Choice direct GME payments, the additional payment amount specified in paragraph (c) of this section is calculated according to the following steps:

(1) *Step one.* Each calendar year, determine for each eligible hospital the total—

(i) Medicare payments received for approved nursing or allied health education programs based on data from the settled cost reports for the period(s) ending in the fiscal year that is 2 years prior to the current calendar year; and

(ii) Inpatient days for that same cost reporting period.

(iii) Medicare+Choice inpatient days for that same cost reporting period.

(2) *Step two.* Using the data from step one, determine the ratio of the individual hospital's total nursing or allied health payments, to its total inpatient days. Multiply this ratio by the hospital's total Medicare+Choice inpatient days.

(3) *Step three.* HCFA will determine, using the best available data, for all eligible hospitals the total of all—

(i) Nursing and allied health education program payments made to all hospitals for all cost reporting periods ending in the fiscal year that is 2 years prior to the current calendar year;

(ii) Inpatient days from those same cost reporting periods; and

(iii) Medicare+Choice inpatient days for those same cost reporting periods.

(4) *Step four.* Using the data from step three, HCFA will determine the ratio of the total of all nursing and allied health education program payments made to all hospitals for all cost reporting periods ending in the fiscal year that is 2 years prior to the current calendar year, to the total of all inpatient days from those same cost reporting periods. HCFA will multiply this ratio by the total of all Medicare+Choice inpatient days for those same cost reporting periods.

(5) *Step 5.* Calculate the ratio of the product determined in step two to the product determined in step four.

(6) *Step 6.* Multiply the ratio calculated in step five by the amount determined in accordance with paragraph (f) of this section for the current calendar year. The resulting product is each respective hospital's additional payment amount.

* * * * *

(f) *Calculation of the payment ''pool.''*

(1) Subject to paragraph (f)(3) of this section, each calendar year, HCFA will calculate a Medicare+Choice nursing and allied health payment ''pool'' according to the following steps:

(i) * * *

(ii) Multiply the ratio calculated in paragraph (f)(1)(i) of this section by projected total Medicare nursing and allied health education reasonable cost payments made to all hospitals in the current calendar year.

(2) The resulting product of the steps under paragraphs (f)(1)(i) and (f)(1)(ii) of this section is the Medicare+Choice nursing and allied health payment ''pool'' for the current calendar year.

* * * * *

PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

D. Part 485 is amended as follows:

1. The authority citation for Part 485 continues to read as follows:

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

2. Section 485.612 is revised to read as follows:

§ 485.612 Condition of participation: Compliance with hospital requirements at the time of application.

Except for recently closed facilities as described in § 485.610(a)(2), or health clinics or health centers as described in § 485.610(a)(3), the facility is a hospital that has a provider agreement to participate in the Medicare program as a hospital at the time the hospital applies for designation as a CAH.

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

Dated: March 28, 2001.

Michael McMullan,

Acting Deputy Administrator, Health Care Financing Administration.

Dated: April 18, 2001.

Tommy G. Thompson,

Secretary.

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