DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

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Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 1998 Rates

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

ACTION: Final rule.

SUMMARY: This final rule responds to public comments received on those portions of a final rule with comment period published in the **Federal Register** on August 29, 1997, that revised the Medicare hospital inpatient prospective payment systems for operating costs and capital-related costs to implement necessary changes resulting from the Balanced Budget Act (BBA) of 1997, Public Law 105–33. This rule also addresses public comments on other BBA changes relating to cost limits for hospitals and hospital units excluded from the prospective payment systems as well as direct graduate medical education payments that were included in the August 29, 1997 document. Generally, these BBA changes were applicable to hospital discharges occurring on or after October 1, 1997.

EFFECTIVE DATE: This final rule is effective on June 11, 1998.

FOR FURTHER INFORMATION CONTACT:

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SUPPLEMENTARY INFORMATION:

I. Background

A. Summary

Under section 1886(d) of the Social Security Act (the Act), payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) is based on prospectively-set rates. Under this system, which was established effective with hospital cost reporting periods beginning on or after October 1, 1983, Medicare payment for hospital inpatient operating costs is made at a predetermined, specific rate for each hospital discharge. All discharges are classified according to a list of diagnosis-related groups (DRGs). The regulations governing the hospital inpatient prospective payment system are located in 42 CFR Part 412.

As required by section 1886(g) of the Act, effective with cost reporting periods beginning on or after October 1, 1991, we also use a prospective payment methodology for hospital inpatient capital-related costs. Under the capital-related cost methodology, a predetermined payment amount per discharge is made for Medicare inpatient capital-related costs.

The prospectively set rates and methodologies are updated annually as required by law or as new legislation is enacted.

B. Summary of the Provisions of the August 29, 1997 Final Rule with Comment Period Resulting from the Balanced Budget Act of 1997

On August 29, 1997, we published a final rule with comment period in the **Federal Register** (62 FR 45966) setting forth statutorily required changes to the Medicare hospital inpatient prospective payment systems for both operating costs and capital-related costs, which were effective for discharges occurring on or after October 1, 1997. This final rule with comment period followed a proposed rule published in the **Federal Register** on June 2, 1997 (62 FR 29902) that set forth proposed updates and changes. Following issuance of the June 2, 1997 proposed rule, the Balanced Budget Act (BBA) of 1997, Public Law 105–33, was enacted on August 5, 1997. This new law made major changes to the hospital prospective payment systems, effective October 1, 1997. Therefore, a major part of the August 29, 1997 final rule with comment period incorporated changes made by the BBA. Because the BBA was enacted after we had issued the June 2 proposed rule and because most of the BBA changes were effective October 1, 1997, we issued the August 29, 1997 document as a final rule with comment period.

The BBA made major changes that affected Medicare payments for inpatient hospital services under the prospective payment systems, and the cost limits applicable to excluded hospitals and hospital units as well as payment for the direct costs of graduate medical education. The provisions of the BBA that we implemented in the August 29, 1997 final rule with comment period related to the following:

- The hospital operating payment update factor. (Sections 4401(a) and (b))
- The hospital capital rate reduction. (Section 4402)
- Reductions in payments to disproportionate share hospitals. (Section 4403)
- Elimination of payment of indirect medical education (IME) and disproportionate share adjustment on outlier payments. (Section 4405)
- Base payment rate to Puerto Rico hospitals. (Section 4406)
- Special reclassification of Stanly County, North Carolina for purposes of the prospective payment system. (Section 4408)
- New guidelines for geographic reclassification of certain hospitals for Federal fiscal year 1998 and subsequent fiscal years. (Sections 4409 and 4410(c))
- Floor on area wage index. (Sections 4410(a) and (b))
- Revision of the IME formula, limitations on full-time equivalent residents, and payment to teaching hospitals for IME costs associated with Medicare managed care discharges. (Sections 4621(a), 4621(b), and 4622)
- Classification of rural referral centers (RRC) for FY 1998 and

subsequent fiscal years. (Section 4202(b))

- Special treatment of Medicare-dependent, small rural hospitals (MDHs). (Section 4204)
- Reinstatement of the add-on payment for blood clotting factor for inpatient beneficiaries with hemophilia. (Section 4452)
- Counting residents for direct graduate medical education. (Section 4623)
- Payments to managed care plans for graduate medical education. (Section 4624)
- Payment to nonhospital providers for the direct costs of medical education incurred in the operation of an approved medical residency training program. (Section 4625)
- Payment for combined medical residency training programs. (Section 4627)
- Payment update for excluded hospitals and hospital units. (Section 4411)
- Reductions in capital payment amounts for certain excluded hospitals and hospital units. (Section 4412)
- Rebasing target amounts for excluded hospitals. (Section 4413)
- Cap on target amounts for excluded hospitals and hospital units (psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals) for FYs 1998 through 2002. (Section 4414)
- Bonus and relief payments to excluded hospitals and hospital units. (Section 4415)
- Change in payment and target amount for new providers. (Sections 4416 and 4419)
- Treatment of certain long-term care hospitals. (Sections 4417(a) and 4417(b))
- Exclusion of certain cancer hospitals from the prospective payment system. (Section 4418)
- Establishment of a new ''Medicare Rural Hospital Flexibility Program'' to replace the existing Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) program that operates in seven States. (Section 4201)
- Beginning with the FY 1999 update, a change in the publication dates for the DRG prospective payment rate methodology and the recommended hospital prospective payment updates as a proposed rule by April 1 and as a final rule by August 1 of each year. (Section 4644(a)(1) and (b)(1))

As a conforming change, the deadline for applications for geographic reclassification for years beginning with FY 2000 was moved from October 1 to September 1. Because the FY 1999 applications were due on October 1, 1997, we shortened the deadlines for decisionmaking by the Medicare Geographic Classification Review Board (MGCRB), so that a final decision for all applications is made by June 15, 1998. (Section 4644(c))

II. Summary of the BBA Provisions and Discussion of Public Comments

A. General

We received a total of 180 pieces of correspondence containing public comments on the BBA changes addressed in the August 29, 1997 final rule with comment period. Below we discuss the BBA provisions, the changes we made to implement these provisions, the public comments received on each provision, and our response to the public comments.

B. Hospital Operating Payment Update Factor

1. General Provision

The BBA made several revisions to the applicable percentage change (the update factor) to the Federal rates for prospective payment hospitals. Section 4401(a)(1) of the BBA amended section 1886(b)(3)(B)(i) of the Act to revise the update factors for the Federal rates for inpatient operating costs for FYs 1998 through 2002. The update factor for FY 1998 was set at 0 percent for hospitals in all areas. For FY 1999, the update for hospitals in all areas is the market basket rate of increase minus 1.9 percentage points. For FY 2000, the update for all areas is the market basket rate of increase minus 1.8 percentage points. For FY 2001 and FY 2002, the update for all areas is the market basket rate of increase minus 1.1 percentage points. For FY 2003 and subsequent years, the update for all areas is the market basket rate of increase.

In the August 29 final rule with comment period, we made necessary changes to § 412.63 of our regulations.

Comment: One commenter asserted that while the 0 percent update of the prospective payment rates for FY 1998 is consistent with the requirements of section 4401(a)(2) of the BBA, it is inappropriate given circumstances in the real world.

Response: As the commenter noted, HCFA is required by statute to implement the 0 percent update to the prospective payment rates for FY 1998. We believe that the 0 percent update is appropriate for the reasons discussed in both our update recommendation in the June 2 proposed rule (62 FR 30035) and our responses to comments on that recommendation in the August 29 final rule with comment period (62 FR 46139).

2. Special Update for Certain Nonteaching, Nondisproportionate Share Hospitals that do not Qualify as MDHs

Section 4401(b) of the BBA provided a temporary special payment for FYs 1998 and 1999 for certain hospitals that do not receive any additional payment through the IME or DSH adjustment and do not meet the criteria to be classified as an MDH. As set forth in section 4401(b)(2), in order to qualify for the special payment, a hospital must be located in a State in which the aggregate operating prospective payment for hospitals that meet the special payment criteria (that is, non-IME, non-DSH, non-MDH hospitals) is less than the aggregate allowable operating costs of inpatient hospital services (referred to hereafter as a negative operating prospective payment margin) for those hospitals for their cost reporting periods that began during FY 1995. In addition, a hospital must have a negative operating prospective payment margin during the cost reporting period at issue (beginning in FY 1998 or 1999).

Under the provisions of section 4401(b)(1), for these hospitals, the percentage increase otherwise applicable to the standardized amount for FY 1998 was increased by 0.5 percentage points and, for FY 1999, the applicable percentage increase will be increased by 0.3 percentage points. Based on current statutory provisions, this means that these hospitals will receive an update of 0.5 percent for FY 1998 (the update for all other hospitals is 0) and, for FY 1999, an update of the market basket increase minus 1.6 percentage points (1.9 for all other hospitals). Under section 4401(b)(1), in applying these updates, the increase provided in FY 1998 will not apply in computing the update for FY 1999 and neither update will affect the updates provided for discharges in fiscal years after FY 1999.

In accordance with section 4401(b)(2) of the BBA, in determining whether a hospital qualifies for the special payment for a given cost reporting period, we looked first at statewide aggregate data for non-IME, non-DSH, non-MDH hospitals for cost reporting periods beginning during FY 1995, and second at hospital-specific characteristics for the cost reporting period at issue to determine whether the hospital has a negative operating prospective payment margin for that period, and whether the hospital received IME or DSH payments or qualified as an MDH for that period. Using the latest cost reporting data, we identified 17 States that met the criteria

set forth in section 4401(b)(2): Alaska, Connecticut, Delaware, Hawaii, Illinois, Indiana, Iowa, Louisiana, Maine, Missouri, New Hampshire, New Jersey, Ohio, Puerto Rica, Rhode Island, Vermont, and Wisconsin. The fiscal intermediaries will make interim payment to hospitals in these 17 designated States, beginning with discharges occurring on or after October 1, 1997, based on the higher standardized amount during the fiscal year. However, as noted above, the final decision as to a hospital's qualification for the additional payment is determined based on whether the hospital has a negative operating prospective payment margin during its FY 1998 or FY 1999 cost reporting period. Therefore, the final determination will be made at cost report settlement.

In the August 29 final rule with comment period, we added a new § 412.107 to the regulations and revised § 412.90 to implement this provision.

Comment: Two hospital associations commented that any hospital identified by its fiscal intermediary as likely to qualify for an update of 0.5 percentage points under the temporary special payment provision of section 4401(b) of the BBA should be given the option of declining the higher interim payments. The commenters were concerned that some hospitals that receive the additional money on an interim basis might have difficulty paying back the funds should the intermediary determine at cost report settlement that the hospital does not qualify for the update.

Response: If a hospital that has been identified as eligible for the higher interim payment believes that ultimately it may not qualify for the higher update and wishes to decline the higher interim payments, it should notify its intermediary.

C. Hospital Capital Rate Reduction

Section 4402 of the BBA amended section 1886(g)(1)(A) of the Act to require that, for discharges occurring on or after October 1, 1997, the Secretary must apply the budget neutrality adjustment factor used to determine the Federal capital payment rate in effect on September 30, 1995 (as described in § 412.352) to the unadjusted standard Federal capital payment rate (as described in § 412.308(c)) effective September 30, 1997, and the unadjusted hospital-specific rate (as described in § 412.328(e)(1)) effective September 30, 1997. For discharges occurring on or after October 1, 1997, and before September 30, 2002, the Secretary must reduce the same rates an additional 2.1 percent.

The budget neutrality adjustment factor effective September 30, 1995 was 0.8432 (59 FR 45416), which is equivalent to a 15.68 percent ((1.0–0.8432) * 100) reduction in the unadjusted standard Federal capital payment rate and the unadjusted hospital-specific rate in effect on September 30, 1997. The additional 2.1 percent reduction to the rates reduces the rates in effect on September 30, 1997 by a total of 17.78 percent. The unadjusted standard Federal rate must be distinguished from the annual Federal rate actually used in making payment under the capital PPS system. The unadjusted standard Federal rate is the underlying or base rate used to determine the Federal rate for each Federal fiscal year by applying the formula described in § 412.308(c). The annual Federal rate is the result of that determination process in § 412.308(c). In accordance with the broad authority conferred in section 1886(g) of the Act, to implement a capital prospective payment system, we extended the reduction to the capital rates to the Puerto Rico capital rates and incorporated it in § 412.374(a).

Under the statute, the additional 2.1 percent reduction applies to discharges occurring ''*before* September 30, 2002''. This provision would have required us to calculate special rates that would be in effect for only one day. Because we believed that the Congress intended to apply the reduction to discharges occurring *through* September 30, 2002, we indicated in the August 29 final rule with comment period that we plan to seek a technical correction to change the date that the 2.1 percent reduction expires from September 29, 2002, to September 30, 2002. Since we assumed this technical error would be corrected, we used the September 30, 2002 expiration date in our regulations.

When we restore the 2.1 percent reduction to the Federal rate after September 30, 2002, we plan to restore the rate to the level that it would have been without the reduction. We determined the adjustment factor for FY 1998 by deducting both cuts (0.1568 and 0.021) from 1 (1 − 0.1568 − 0.021 =0.8222). We then applied 0.8222 to the unadjusted standard Federal rate. The adjustment factor to restore the 2.1 percent cut would be the adjustment without the 2.1 percent cut (0.8432) divided by the adjustment with the 2.1 percent cut (0.8222). (0.8432/0.8222=1.02554). To restore the 2.1 percent reduction, we will apply 1.02554 to the unadjusted standard Federal capital payment rate in setting rates for discharges after September 30, 2002.

Section 412.328(e) of the regulations provides that the hospital-specific rate for each fiscal year is determined by adjusting the previous fiscal year's hospital specific rate by the hospital specific rate update factor and the exceptions payment adjustment factor. After these two adjustments are applied, a net adjustment to the rate is determined. The previous year's hospital specific rate is analogous to the standard Federal rate, which is updated each year to become the annual Federal rate.

When the 2.1 percent reduction is restored, most hospitals will have completed the transition to a fully prospective payment system for capital related costs. However, new hospitals might be eligible for hold harmless payments beyond the transition, so we may need to continue to compute a hospital specific rate. If we need to restore the 2.1 percent reduction to the hospital specific rates, we will do so in a manner similar to that described above with respect to the unadjusted standard Federal capital payment rate.

In the August 29 final rule with comment period, we revised two sections of the capital prospective payment system regulations to implement these statutory requirements. Specifically, we revised §§ 412.308(c) and 412.328(e) to provide for the required 15.68 and 2.1 percent reduction to the rates. The 2.1 percent reduction will be restored after September 30, 2002.

Comment: One commenter noted that as a result of the high capital rate paid in FY 1997, many hold-harmless hospitals switched from being paid based on a blend of their old and new capital to being paid based on 100 percent of the Federal rate, because the Federal rate was higher than their old and new capital payment would have been. The commenter also stated that when Congress reduced the capital rate as part of the provisions of the BBA, many hospitals' payments would have been higher had they been allowed to return to their previous old capital and new capital payment methodology. The commenter suggested deleting the requirement at § 412.344(b) that once a hospital is paid based on 100 percent of the Federal rate, it cannot return to payments based on a blend of its old and new capital costs. The commenter also noted that when the Federal capital rate was reduced under the provisions of OBRA 1993, fiscal intermediaries were given specific authority to redetermine each hospital's payment methodology.

Response: In section 13501(a)(3) of the Omnibus Budget Reconciliation Act of 1993 (Public Law 103–66), Congress reduced the Federal capital rate and not the hospital-specific rate. Hospital payment methodology redeterminations were expressly provided for in that section of the statute. However, in 1997, when Congress reduced both the hospital-specific rate and the Federal capital rate as part of the BBA, hospital payment methodology redeterminations were not provided for by the legislation and we do not believe that it would be appropriate to provide for redeterminations by regulation. In addition, we do not believe it would be appropriate to allow hospitals to return to payment based on their ratio of old and new capital once they have been paid based on 100 percent of the Federal rate. We are in the seventh year of the 10 year transition to a fully prospective capital payment system. By October 1, 2002, all hospitals will be paid based on 100 percent of the Federal rate. It would not be appropriate to allow hospitals to return to cost-based payment this point in the transition.

D. Disproportionate Share Hospital (DSH) Payments

Section 4403(a) of the BBA reduced the payment for hospitals that treat a disproportionately large number of low-income patients. The payment a hospital would otherwise receive under the disproportionate share formula is reduced 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. In the August 29 final rule with comment period, we added a new paragraph (e) to § 412.106 to implement this provision.

Comment: One commenter asked that we clarify the applicability of the provisions of section 4403(a) of the BBA, which relate to disproportionate share operating payments, to the prospective payment system for capital related costs. Specifically, the commenter requested that we verify that the phased-in 5 percent reduction of operating DSH payments does not apply to capital DSH payments. The commenter also asked us to codify our decision as to the applicability of this provision in the appropriate section of the capital regulations governing DSH.

Response: The commenter is correct. Section 4403 amended section 1886(d)(5)(F) of the Act to reduce the amount otherwise payable for operating DSH. The capital DSH adjustment set forth at § 412.320 references the operating DSH definition of low income patients at § 412.106(b) and uses the definition of the disproportionate patient percentage at § 412.106(c)(2), but section 4403 does not affect capital DSH payments. In response to the commenter's request that we codify in the regulations the applicability of the BBA operating provisions to capital payments, we do not believe that it is necessary to do so. The capital regulations that are affected will be automatically included by their reference to the appropriate section of the operating regulations. The capital regulations that are not affected (regarding the reduction to DSH payments need not be revised.

E. Outlier Payments

Section 4405 of the BBA amended sections 1886(d)(5)(B)(i)(I) and (d)(5)(F)(ii)(I) of the Act to provide that, in determining the payment for hospitals that receive indirect medical education or disproportionate share payments, the IME and DSH adjustment factors are applied only to the base DRG payment, not the sum of the base DRG payment and any cost outlier payments, effective with discharges occurring on or after October 1, 1997. The same section of the BBA also amended section 1886(d)(5)(A)(ii) of the Act to require that the fixed loss cost outlier threshold is based on the sum of DRG payments and IME and DSH payments for purposes of comparing costs to payments. Therefore, in the August 29 final rule with comment period, we revised our regulations at § 412.84(g) to remove the provision that costs be reduced by the IME and DSH adjustment factors for purposes of comparing costs to payments to determine if costs exceed the fixed loss cost outlier threshold, as well as to delete § 412.80(c). Conforming changes were made to § 412.105(a) (IME adjustment) and § 412.106(a)(2) (DSH adjustment). We also made a corresponding change to the capital cost outlier methodology. We received two comments on this provision, both of which concurred with HCFA's interpretation of section 4405 of the BBA.

F. Payment Rate for Puerto Rico Hospitals

1. Operating Payment Rate

Section 4406 of the BBA amended section 1886(d)(9)(A) of the Act to revise the Puerto Rico and national shares of the Puerto Rico payment rate. Beginning with discharges occurring on or after October 1, 1997, the Puerto Rico payment rate will be a blend of 50 percent of the Puerto Rico standardized amount and 50 percent of a national standardized amount (compared to a blend of 75 and 25 percent, respectively, prior to enactment of the BBA). In the August 29 final rule with comment period, we revised § 412.204 of the regulations to conform with this amendment.

2. Capital Payment Rate

Under the broad authority of section 1886(g) of the Act, in the August 29 final rule with comment period, we revised the calculation of capital payments to Puerto Rico to parallel the change that was made in the calculation of operating payments to Puerto Rico. Effective October 1, 1997, we will base capital payments to hospitals in Puerto Rico on a blend of 50 percent of the national rate and 50 percent of the Puerto Rico-specific rate. This change will increase payments to Puerto Rico hospitals since the national rate is higher than the Puerto Rico rate.

We did not receive any public comments on either of these provisions.

G. Special County Designation

In the August 29 final rule with comment period, the Secretary exercised the authority granted to her by section 4408 of the BBA to include Stanly County in the Charlotte-Gastonia-Rock Hill, North Carolina-South Carolina MSA for purposes of the prospective payment system. This change was reflected in the final wage index included in that document.

We did not receive any public comments on this provision.

H. Changes to the Medicare Geographic Classification Review Board (MGCRB) Guidelines and Timeframes

Various provisions of the BBA addressed the guidelines the MGCRB uses to reclassify hospitals to other geographic areas as well as the timetable under which hospitals must submit applications for reclassification and when the MGCRB and the Secretary must make decisions on those applications.

1. Revised Application and MGCRB Timeframes

Prior to the enactment of the BBA, a hospital had to submit an application to the MGCRB for geographic reclassification for a fiscal year by the first day of the preceding fiscal year (that is, October 1, 1997 for reclassification effective in FY 1999). The MGCRB had 180 days to make a decision on that application (no later than March 31 of the fiscal year), the hospital has 15 days to request a review of that decision by the Administrator of HCFA (by April 15), and the

Administrator had up to 90 days to issue a final decision (July 15). The July 15 deadline allowed the final geographic reclassification decisions to be incorporated in the wage index and payment rates that were published in the final rule (on or about September 1).

Sections 4644(a)(1) and (b)(1) of the BBA amended section 1886(d)(6) and (e) of the Act to provide that the prospective payment system final rule setting the payment rates for years beginning with FY 1999 must be published by August 1. Because this change in publication date would conflict with the timetable for geographic reclassification decisions, section 4644(c) of the BBA amended section 1886(d)(10)(C)(ii) of the Act to require a hospital, beginning with applications filed for reclassification for FY 2000, to submit its application for reclassification no later than the first day of the month preceding the beginning of the Federal fiscal year (that is, by September 1). Under this timetable, the amount of time the MGCRB and the Administrator have to make decisions will not change from the existing schedule.

In addition, because applications filed for reclassification effective in FY 1999 were not due until October 1, 1997, section 4644(c)(2) required us to shorten the deadlines under section 1886(d)(10)(C) of the Act so that all final decisions on MGCRB applications will be completed by June 15, 1998.

In the August 29 final rule with comment period, we revised §§ 412.256 and 412.274 to implement the change in the application deadline.

2. Alternative Wage Index Reclassification Guidelines for Individual Hospitals

Effective for FY 1998 reclassification, sections 4409 and 4410 of the BBA required the Secretary to establish alternative wage index guidelines for geographic reclassification for certain disproportionately large hospitals. In the case of a hospital that is owned by a municipality and that was reclassified as an urban hospital for FY 1996, in calculating the hospital's average hourly wage for the purposes of geographic reclassification for FY 1998 only, section 4410(c) of the BBA required the exclusion of general service wages and hours of personnel associated with a skilled nursing facility that is owned by the hospital of the same municipality and that is physically separated from the hospital to the extent that such wages and hours of such personnel are not shared with the hospital and are separately documented. Because the application and decisionmaking processes for FY 1998 reclassification were already completed, we had to provide special guidelines for hospitals to apply for reclassification under these provisions for FY 1998.

A hospital seeking reclassification for FY 1998 under either section 4409 or 4410(c) had to submit its application to the MGCRB (7 copies) by September 15, 1997. If the MGCRB rendered a favorable decision on a hospital's application, the hospital was reclassified for purposes of the wage index for FY 1998 as if that decision had been made under the usual guidelines and timetable.

We also extended the existing appeal rights for decisions on requests for reclassification to decisions made under sections 4409 and 4410. Therefore, for such appeals, in the August 29 final rule with comment period, we incorporated the existing appeals and review process (including the timetables for a hospital to request review and for the Administrator to complete review) even though that process was not finalized until after the beginning of the fiscal year. We revised the regulations at § 412.230(e) to implement section 4409. However, because the provision of section 4410(c) applied for only one year, we did not revise the codified regulations text to reflect that provision.

3. Reclassification for Rural Referral Centers and the Disproportionate Share Adjustment

Currently, under section 1886(d)(10)(D) of the Act, rural referral centers (RRCs) are allowed to apply to the MGCRB to be reclassified for purposes of the wage index adjustment. To be reclassified, RRCs must meet the following criteria:

- The hospital's average hourly wage must be at least 108 percent of the Statewide rural hourly wage.
- The hospital's average hourly wage must be at least 84 percent of the average hourly wage of the target urban area to which the RRC is applying.

Section 4202 of the BBA prohibits the MGCRB from rejecting a hospital's request for reclassification on the basis of any comparison between the hospital's own average hourly wage and the average hourly wage of hospitals in the area in which the hospital is located if the hospital was ever classified as an RRC. However, RRCs will continue to be required to have an average hourly wage that is at least 84 percent of the average hourly wage of the target urban area to which the RRC is applying. In addition, while RRCs do not have to meet the proximity requirements for reclassification, they continue to be required to seek reclassification to the nearest urban area. In the August 29 final rule with comment period, we revised § 412.230(a)(3) to implement this provision.

Section 4203 of the BBA provided that, for a limited time, a rural hospital may apply and qualify for reclassification to another area for purposes of disproportionate share adjustment payments whether or not the standardized amount is the same for both areas. For 30 months after the date of enactment of the BBA, the MGCRB will consider the application under section 1886(d)(10)(C)(i) of the Act from a hospital requesting a change in the hospital's geographic classification for purposes of determining, for a fiscal year, eligibility for and additional payment amounts under section 1886(d)(5)(F) of the Act. The MGCRB will apply the guidelines for standardized amount reclassification (§ 412.230(d)) until the Secretary establishes separate guidelines. Therefore, hospitals seeking such reclassification for FY 1999 must have submitted a reclassification application to the MGCRB by October 1, 1997. Decisions based on these applications will be effective for FY 1999 (beginning on October 1, 1998). Section 4203 of the BBA is effective for the 30-month period beginning on the date of enactment. Accordingly, hospitals may seek reclassification for purposes of DSH for FY 1999, FY 2000, and FY 2001. In the August 29 final rule with comment period, we revised § 412.230(a)(5)(ii) of the regulations to implement this provision.

Comment: One commenter questioned the effective date of sections 4202 and 4203 of the BBA, which exempt RRCs from the 108 percent criterion in applying for wage index reclassification and allow a hospital to reclassify to another area for purposes of the disproportionate share adjustment even if the standardized amount of both areas is the same, respectively. The commenter asserted that the conference report accompanying the statute clearly states that the effective date of these provisions is ''enactment'' of the BBA, that is, August 5, 1997. Therefore, the commenter believes that hospitals should have been allowed to apply to the MGCRB and reclassify under these provisions for FY 1998 reclassifications, which were effective beginning October 1, 1997. The August 29 final rule with comment period limited the effect of these provisions to reclassifications beginning in FY 1999.

Response: We agree that the provisions of sections 4202 and 4203 of the BBA are effective August 5, 1997. However, the statutory language contains no

directive to apply these provisions to hospital reclassifications effective for FY 1998 (compare sections 4409 and 4410(c) of the BBA, both of which specifically stated that their provisions were effective for FY 1998 reclassifications). Section 4202 amends section 1886(d)(10)(D) of the Act to provide that the MGCRB ''may not reject the application'' of a hospital on the basis of a comparison specified in the statute. Accordingly, if the MGCRB considers an application on or after August 5, 1997, it will not reject the application on the basis specified in the statute. Section 4202 does not require the MGCRB to re-evaluate applications that the MGCRB rejected before August 5, 1997.

Similarly, section 4203 provides that, for the 30-month period beginning on August 5, 1997, the MGCRB ''shall consider'' a hospital's application for reclassification for purposes of DSH payments. Accordingly, if a hospital submits an application to be reclassified for purposes of DSH on or after August 5, 1997, the MGCRB will consider the application. Generally, the deadline for FY 1998 reclassifications was October 1, 1996. Section 4203, unlike other provisions of the BBA, does not require the MGCRB to grant reclassifications for FY 1998 notwithstanding this deadline.

Thus, hospitals may apply for reclassification under the provisions of sections 4202 and 4203 after August 5, 1997. The first such applications would be those for FY 1999 reclassification beginning on October 1, 1998, which were due by October 1, 1997. We note that, although the provisions of section 4202 are permanent, section 4203 is effective for 30 months and applies only to those reclassifications effective for FY 1999, 2000, and 2001.

I. Floor on Area Wage Index

As provided by section 4410(a) of the BBA, for discharges on or after October 1, 1997, the area wage index applicable to any hospital that is not located in a rural area may not be less than the area wage index applicable to hospitals located in rural areas in the State in which the hospital is located. For FY 1998, this change affected 128 hospitals in 32 MSAs. Furthermore, this wage index floor is to be implemented in such a manner as to assure that aggregate prospective payment system payments are not greater or less than those which would have been made in the year if this section did not apply.

We did not receive any public comments on this provision.

J. Indirect Medical Education (IME) Adjustment

1. Operating IME Adjustment

In the August 29 final rule with comment period, we revised our regulations to incorporate the provisions of section 4621 of the BBA, which amended section 1886(d)(5)(B) of the Act in several ways. First, it gradually reduces the current level of the IME adjustment (approximately a 7.7 percent increase for every 10 percent increase in the resident-to-bed ratio) over the next several years according to the following schedule: 7.0 percent for discharges during FY 1998; 6.5 percent during FY 1999; 6.0 percent during FY 2000; and 5.5 percent during FY 2001 and thereafter.

Second, section 4621 established certain limits both on the full-time equivalent (FTE) number of residents counted by each hospital and on the resident-to-bed ratio. Effective for discharges on or after October 1, 1997, section 4621(b)(1) added a new section 1886(d)(5)(B)(v) to the Act to require that a hospital's total number of resident FTEs in the fields of allopathic and osteopathic medicine may not exceed the total number of such resident FTEs counted by the hospital during its most recent cost reporting period ending on or before December 31, 1996. Furthermore, section 1886(d)(5)(B)(vi)(I) provides that the ratio of residents-to-beds may not exceed the ratio calculated during the prior cost reporting period (after accounting for the cap on the number of resident FTEs).

Third, for cost reporting periods beginning on or after October 1, 1997, and subject to the new limit on counting residents described above (as well as the expansion of allowable settings to off-site services, as described below), section 1886(d)(5)(B)(vi)(II) provides that ''the total number of full-time equivalent residents for payment purposes shall equal the average of the actual full-time equivalent resident count for the cost reporting period and the preceding two cost reporting periods.'' For the first cost reporting period beginning on or after October 1, 1997, this provision ''shall be applied using the average for such period and the preceding cost reporting period.'' For purposes of this provision, section 1886(d)(5)(B)(vii) requires the Secretary to make appropriate modifications in the event of a cost reporting period other than 12 months.

With respect to medical residency training programs established on or after January 1, 1995, section 1886(d)(5)(B)(viii) provides that the Secretary must develop rules to apply these limits to such new programs, giving special consideration to ''facilities that meet the needs of underserved areas,'' and to facilitate the application of aggregate limits in the case of affiliated groups (as defined by the Secretary). Finally, ''(t)he Secretary may require any entity that operates a medical residency training program . . . to submit to the Secretary such additional information as the Secretary considers necessary to carry out such (limits).'' We revised the regulations at § 413.86(g)(6) to comply with these directions for both the indirect and direct GME FTE counts.

Finally, section 4621(b)(2) amended section 1886(d)(5)(B)(iv) of the Act to allow all the time spent by a resident in patient care activities under an approved medical residency training program at an entity in a nonhospital setting to be counted towards the determination of full-time equivalency if the hospital incurs all, or substantially all, of the costs for the training program in the setting. Therefore, in the August 29 final rule with comment period, we revised § 412.105(g)(1)(ii)(C), which allowed hospitals to include the time residents spent in patient care activities in nonhospital settings, for purposes of IME. The eligibility criteria for this provision is similar to a provision regarding direct graduate medical education payments at section 1886(h)(4)(E) of the Act, and implemented at § 413.86(f)(iii). For IME purposes, we intend to rely upon the same criteria as are applied for the direct GME to identify eligible situations under this new provision.

In the August 29 final rule with comment period, we revised § 412.105 to reflect these changes, and issued instructions to fiscal intermediaries to implement these changes prior to October 1, 1997. In response to our discussion of the changes enacted by the BBA, we received numerous comments seeking clarification on many of these issues.

Comment: Several commenters noted a discrepancy in the preamble of the August 29 document concerning the effective date of the cap on allopathic and osteopathic FTEs: In the preamble summary of the BBA changes at 62 FR 45968, the effective date of the provision is stated as ''cost reporting periods beginning on or after October 1, 1997.'' In the full discussion of the provision in the preamble at 62 FR 46003, the provision is made effective for ''discharges on or after October 1, 1997.''

Response: The effective date for applying the cap on allopathic and osteopathic FTEs, as set forth in section

1886(d)(5)(B)(v) of the Act, is for ''discharges on or after October 1, 1997.'' This effective date citation in the preamble summary at 62 FR 45968 was a typographic error.

Comment: Commenters noted that the requirements set forth in section 1886(h)(4)(H) of the Act concerning special rules for applying the FTE limits for direct graduate medical education for new programs and affiliated groups also apply to IME payments. The commenters requested that they be added to the regulations at § 412.105.

Response: The commenters are correct. Under section 1886(d)(5)(B)(viii) of the Act, as added by section 4621(b)(1) of the BBA, rules similar to the rules set forth at section 1886(h)(4)(H) of the Act apply for purposes of implementing: the cap on resident FTEs; the cap on the resident-to-bed ratio; and the 3-year rolling average resident count. We are revising § 412.105(f)(1)(vi) and (vii) accordingly.

The count of residents in accordance with the rules for special circumstances (new programs and affiliated groups) under section 1886(d)(5)(B)(viii) of the Act is described in sections II.N.3 and 4 of this final rule. We note that this section of the Act applies only to the limits set forth in sections 1886(d)(5)(B)(v) and (vi) of the Act.

Comment: Several commenters objected to our interpretation of the language of section 1886(d)(5)(B)(vi) of the Act, which describes the cap on the resident-to-bed ratio. In the August 29 final rule with comment period, we stated that this is a cap on the total resident FTE count including dental and podiatry residents. The commenters believe the Congress intended that dental and podiatry residents should be exempt from this cap in addition to their exemption from the cap established for resident FTEs. In support of their interpretation, the commenters noted the reference to the FTE cap in establishing the cap on the ratio (section 1886(d)(5)(B)(vi) of the Act). One commenter stated that including dental and podiatry residents in the FTE calculation before applying the ratio cap leads to a nonsensical result since the Congress established a cap on allopathic and osteopathic residents but explicitly did not include dental and podiatry residents under this cap.

Another commenter supported applying the cap to total FTEs, including dentists and podiatrists. This commenter noted that the ratio could increase after a one-year lag to reflect additional dental or podiatry residents.

Response: Section 1886(d)(5)(B)(vi) of the Act, as amended by the BBA, establishes a cap on the value of ''r,'' which is defined in section 1886(d)(5)(B)(ii) of the Act as ''the ratio of the hospital's full-time equivalent interns and residents to beds.'' The IME formula defined in this section of the Act explicitly includes the value 'r' in the IME calculation. Therefore, 'r' has a very precise and significant value.

Section 1886(d)(5)(B)(v) of the Act (as amended) states that ''the total number of full-time equivalent interns and residents in the fields of allopathic and osteopathic medicine'' may not exceed the number of such residents in either a hospital or nonhospital setting with respect to the hospital's most recent cost reporting period ending on or before December 31, 1996. This section sets a cap on a subset (allopathic and osteopathic medical residents) of the total number of residents. The numerator of the ratio is the total number of residents including the effect of the cap; the Congress did not provide that 'r' would be computed using only a subset of residents. In fact, one could argue that under such an interpretation, there would be no explicit methodology in the Act for including dental and podiatry residents in the IME calculation. The reference in section 1886(d)(5)(B)(vi)(I) of the Act to ''the limit under clause (v)'' means that the numerator includes the effect of the cap on allopathic and osteopathic residents, not that the numerator is limited to those residents. Thus, the statutory language requires that we apply the cap on the ratio after including all residents, dental and podiatry as well as allopathic and osteopathic, in the calculation of the numerator.

Comment: Other commenters believe that it is inappropriate not to allow exceptions to the ratio cap when hospitals are voluntarily closing inpatient beds. In addition, commenters requested that the cap be adjusted to include the residents' time spent in nonprovider settings.

Response: Section 4621 of the BBA addresses the application of the cap, specific situations where special rules are appropriate, and the allowance of residents' time spent in nonprovider settings. In addition, we note that the ratio could increase after a one-year delay for legitimate changes in either the numerator or the denominator. That is, the ratio is capped based on its value during the prior cost reporting period. An increase in the ratio thereby establishes a higher cap for the following cost reporting period.

Comment: One commenter requested clarification of the term ''the prior cost reporting period'' as used in the preamble of the final rule with comment period when describing the application of the cap on the ratio of residents-to-beds (62 FR 46003).

Response: The phrase ''prior cost reporting period'' refers to the immediately preceding period. A hospital's cost reporting period beginning July 1, 1998 would have its ratio capped at the value of its ratio for its cost reporting period ending June 30, 1998. In determining a hospital's resident-to-bed ratio for a cost reporting period that begins before October 1, 1997 (the effective date of the cap on allopathic and osteopathic FTEs) and ends after that date, the ratio for that period will reflect a prorated resident FTE count. That is, the numerator is determined through averaging the uncapped and capped FTE amounts based on the number of months in the cost reporting period before and after October 1, 1997. This FTE count will also be used to determine the rolling average amount for subsequent years.

Comment: Commenters requested an explanation of how the ratio cap would be determined under the special rules implemented pursuant to section 1886(d)(5)(B)(viii) of the Act (that is, the new program and affiliated group provisions).

Response: The ratio is first determined by calculating the resident FTE count taking into account all of the relevant limitations and applicable rolling averages, and the denominator in the ratio is the hospital's available bed count during the current cost reporting period. If this results in a ratio in excess of the previous cost reporting period's ratio, the hospital's IME adjustment is based on the ratio from the previous cost reporting period.

Special rules apply for the special circumstances at section 1886(d)(5)(B)(viii) of the Act. In the event that the application of section 1886(d)(5)(B)(viii) results in a higher resident-to-bed ratio for a hospital compared to its most recently completed cost reporting period, the special rule will be applicable only for the portion of the higher ratio due to the increase in residents. In such instances, the ratio during the prior cost reporting period is similarly applicable, but it is adjusted for the additional residents allowed by the special circumstances rule. In practice, this is accomplished by adding the additional residents to the resident FTE count used in the prior cost reporting period's resident-to-bed ratio. It should be noted that this adjustment is the result of a special rule for applying the cap on 'r' for new programs and affiliated groups as set forth in section 1886(d)(5)(B)(viii) of the Act. Therefore, no adjustment to the ratio is made for an increase in dental

or podiatry residents during the cost reporting period in which an increase occurs.

In the case of recognized affiliation arrangements, each hospital will be paid on the basis of its individual resident-to-bed ratio. Under such an arrangement, the ratio is the number of residents counted by the hospital in accordance with the special FTE counting rules for these arrangements, over the hospital's bed count during the current cost reporting period. As described above, the ratio may increase during a particular cost reporting period due to an increase in the number of residents allowed under the special affiliation arrangement. Any such exemption from the ratio cap will be limited to the increase in residents and will not reflect changes in hospital bed size.

Comment: Commenters were concerned about the language establishing the resident FTE cap (section 1886(d)(5)(B)(v) of the Act) that the number of allopathic and osteopathic residents may not exceed ''the number of such full-time equivalent interns and residents in the hospital'' during the most recent cost reporting period ending on or before December 31, 1996. The commenters believed that this disadvantages the programs that have already been training residents in nonprovider settings. Commenters suggested that we support the effort to delete the phrase ''in the hospital'' from this section.

Response: As is indicated by the comments, residents in nonhospital settings during the most recent cost reporting period ending on or before December 31, 1996, are excluded by the Act from the determination of the allopathic and osteopathic cap. Furthermore, although we recognize that many of these arrangements that were in existence during 1996 reflected the demand for more primary care physicians, we would note that the purpose of allowing hospitals to count this time in the future is to create an incentive for even more primary care training. In that regard, hospitals that had previously established residency training in nonhospital settings did so in response to the existing incentives at that time.

Comment: Several commenters suggested that the reduction in the IME adjustment factor (from approximately a 7.7 percent increase for every 10 percent increase in the ratio of residents to beds to 7.0 percent for discharges during FY 1998, and gradually reducing further for 3 years beyond that) places a disproportionate share of the cost-cutting burden on teaching hospitals, especially academic medical centers.

Response: The reduction to the IME adjustment factor is set forth in the statute. However, given the gradual reduction in the factor and the recent very high Medicare operating margins for teaching hospitals (especially major teaching hospitals), we disagree that the reductions to the IME adjustment unfairly burden these hospitals. We note that HCFA and the Prospective Payment Assessment Commission (ProPAC) have both supported a reduction in the IME adjustment for several years based on our analysis of the indirect effect of graduate medical education programs on total hospital costs.

2. Capital IME Adjustment

Comment: One commenter asked us to clarify whether the following conclusions are correct in applying the IME provisions of the BBA to the capital prospective payment system:

(1) The cap on the number of residents training in the fields of allopathic and osteopathic medicine for purposes of computing the operating IME adjustment *does* pertain to the capital IME adjustment;

(2) The rolling average resident count for purposes of computing the operating IME adjustment *does* pertain to the capital IME adjustment; and

(3) The cap on the ratio of interns and residents to beds for purposes of computing the operating IME adjustment *does not* pertain to the ratio of interns and residents to the average daily census for purposes of computing the capital IME adjustment.

As with the DSH provisions, the commenter also asked us to codify our policy on the applicability of these operating provisions in the appropriate sections of the capital regulations governing the IME adjustment.

Response: Cap on Number of Residents in Allopathic and Osteopathic Medicine—The regulations at § 412.322 describe the capital IME adjustment. Section 412.322(a)(1) provides that the hospital's number of full-time equivalent (FTE) residents is determined in accordance with § 412.105(f) of the operating regulation. Since the BBA provisions affected § 412.105(f)(iv) by capping the number of allopathic and osteopathic interns and residents at the number of interns and residents reported on a hospital's cost report for the period ending December 31, 1996, the capital IME intern and resident count for allopathic and osteopathic residents is also capped automatically.

Rolling Average Resident Count—The BBA provision implementing a rolling average resident count (section 4623) is also included in § 412.105(f) of the operating IME regulations. Since the capital IME regulations reference the operating IME regulation at § 412.105(f), the capital IME FTE count is affected by the rolling average resident count as well.

Cap on Ratio of Interns to Beds—The cap on the number of interns and residents to beds (section 4621) does not have an impact on the capital IME payments because we use the ratio of hospital FTEs to average daily census to determine the capital IME adjustment factor.

In response to the commenter's request that we codify in the regulations the applicability of these BBA operating IME provisions to capital payments, we do not believe that it is necessary to do so. The capital regulations that are affected (regarding the cap on the number of residents in allopathic and osteopathic medicine, and the rolling average resident count) will be automatically included by their reference to the appropriate section of the operating regulations. The capital regulations that are not affected (regarding the cap on the ratio of interns to beds) need not be revised.

It has come to our attention that there has also been some question raised about the applicability of sections 4001 and 4622 of the BBA—Payment to Hospitals of Indirect Medical Education Costs for Medicare+Choice Enrollees to capital IME payments. Section 4001 of the BBA instructs the Secretary to exclude from the Medicare+Choice capitation rate payment adjustments for the indirect costs of medical education under section 1886(d)(5)(B) of the Act. Section 4622 of the BBA provides for payments to teaching hospitals for discharges associated with Medicare managed care beneficiaries for portions of cost reporting periods beginning on or after January 1, 1998.

Section 4001 of the BBA refers only to the indirect costs of medical education as defined in section 1886(d)(5)(B) of the Act. This section refers to operating IME payments and not capital IME payments, which were established by regulation. Thus, section 4001 affects only operating IME payments.

K. Rural Referral Centers

Based on section 1886(d)(5)(C)(i) of the Act and the Conference Committee Report accompanying Public Law 98–21 (the original legislation implementing the prospective payment system), we established qualifying criteria for referral center status to identify those rural hospitals that, because of bed size,

a large number of complicated cases, a high number of discharges, or a large number of referrals from other hospitals or from physicians outside the hospital's service area, were likely to have operating costs more similar to urban hospitals than to the average smaller community hospitals. The regulations implementing the referral center provision are codified at § 412.96.

In 1984, after a year's experience with the referral center criteria, we determined that once approved for the referral center adjustment, a hospital would retain its status for a 3-year period. At the end of the 3-year period, we would review the hospital's performance to determine whether it should be requalified for an additional 3-year period. The requirement for triennial review was added to the regulations in 1984 (§ 412.96(f)) to be effective for cost reporting periods beginning on or after October 1, 1987 (the end of the first 3 years of the referral center adjustment). However, since then, three statutory moratoria on the performance of the triennial reviews were enacted by Congress. When the third of these moratoria expired at the end of cost reporting periods that began during FY 1994, we implemented the triennial review requirements and some hospitals lost their referral center status. (See the September 1, 1993 final rule (58 FR 46310) for a detailed explanation of the moratoria and the implementation of the triennial reviews.)

Hospitals could lose rural referral center status in other ways. With the creation of the MGCRB and a hospital's ability, beginning in FY 1992, to request that it be reclassified from one geographic location to another, we stated that if a referral center was reclassified to an urban area for purposes of the standardized amount, it would, in most instances, be voluntarily terminating its referral center status. (See the June 4, 1991 final rule with comment period (56 FR 25482).) This was true because, in most instances, a hospital's ability to qualify as a ''rural referral center'' was contingent upon (among other criteria) its status as a rural hospital.

In addition, rural referral centers located in areas that were redesignated as urban by the Office of Management and Budget (OMB) lost their referral center status. These hospitals had qualified for referral center status under criteria applicable only to hospitals located in rural areas. OMB's designation of the areas to urban status meant that such hospitals were urban for *all* purposes and thus could no longer qualify as *rural* referral centers.

Section 4202(b)(1) of the BBA states that, ''Any hospital classified as a rural referral center by the Secretary . . . for fiscal year 1991 shall be classified as such a rural referral center for fiscal year 1998 and each subsequent fiscal year.'' Thus, many of the hospitals that lost their referral center status for the reasons listed above must be reinstated. For the purpose of implementing this provision, we consider that a hospital that was classified as a referral center for any day during FY 1991 (October 1, 1990 through September 30, 1991) meets the reinstatement criterion.

In the August 29 final rule with comment period, we reinstated rural referral center status for all hospitals that lost the status due to triennial review or MGCRB reclassification regardless of whether it was classified as an RRC during FY 1991. We did not reinstate rural referral center status to hospitals in areas redesignated as urban by OMB because they are no longer *rural* hospitals. We also did not reinstate the status of the six hospitals that voluntarily requested termination of their RRC status. However, we would allow any of these six hospitals to requalify if they so desire.

In addition, we terminated the requirement for triennial reviews of referral center status. Thus, §§ 412.96(f) and (g) (1) and (2) were deleted in the August 29 final rule with comment period. If we later discover some hospital or class of hospitals that we believe should not be allowed to retain referral center status because they fail to meet some basic requirement we believe is essential to receiving this special designation, we will consider reinstating some type of annual or periodic qualifying criteria.

Finally, we eliminated our policy that terminated RRC status for any hospital that is reclassified as urban by the MGCRB.

Comment: One commenter expressed agreement with our decision to reinstate hospitals that lost their RRC status as a result of failure to meet triennial review requirements or due to MGCRB reclassification to an urban area for purposes of the standardized amount. The commenter further commended HCFA for terminating triennial reviews and eliminating the policy that a hospital loses its RRC status if it is reclassified as urban by the MGCRB. However, the commenter disagreed with our decision to not restore the RRC status of hospitals that are in areas redesignated as urban by OMB. The commenter believes that this policy unfairly disadvantages those hospitals when applying for reclassification for the wage index. That is, they will be unable to reclassify under the special provisions of section 1886(d)(10)(D)(iii) of the Act as amended by section 4202(a) of the BBA if they meet all requirements except the 108 percent rule.

Response: The language of section 4202(b)(1) states that any hospital classified as a rural referral center for FY 1991, '' * * * shall be classified as such a *rural* referral center for fiscal year 1998 and each subsequent year.'' (Emphasis added.) Hospitals located in areas redesignated as urban by OMB are no longer physically located in a rural area. Designation by OMB of an area to urban status means that any hospital located in that area becomes urban for all purposes and thus could no longer qualify as rural referral centers. In reinstating referral center status, section 4202(b) of the BBA did not revise the qualifying criteria for these hospitals. Thus, we believe that our decision to not reinstate hospitals located in urban areas as rural referral centers is appropriate.

We note, however, that these hospitals are not precluded from taking advantage of the provisions of section 1886(d)(10)(D)(iii) of the Act, which state that the MGCRB is prohibited from rejecting a hospital's application for reclassification on the basis of any comparison between its hourly wage and the average hourly wage of the hospitals in the area in which the hospital is located if the hospital ''has *ever* been classified by the Secretary as a rural referral center.'' (Emphasis added.) This means that the hospital need not currently be classified as an RRC in order to take advantage of this provision.

L. Medicare-Dependent Small, Rural Hospitals

Section 4204 of the BBA amended section 1886(d)(5)(G) of the Act to reinstate the classification of Medicare-dependent, small rural hospitals (MDHs) for cost reporting periods beginning on or after October 1, 1997 and before October 1, 2001. This category of hospitals was originally created by section 6003(f) of the Omnibus Budget Reconciliation Act of 1989 (Public Law 101–239), enacted on December 19, 1989, which added a new section 1886(d)(5)(G) of the Act. The statute provides that the special payment for MDHs was to be available for cost reporting periods beginning on or after April 1, 1990 and ending on or before March 31, 1993. Hospitals classified as MDHs were paid using the same methodology applicable to sole community hospitals.

Section 13501(e)(1) of the Omnibus Budget Reconciliation Act of 1993 (Public Law 103–66), enacted on August 10, 1993, extended the MDH provision through discharges occurring before October 1, 1994. Under this revised provision, after the hospital's first three 12-month cost reporting periods beginning on or after April 1, 1990, the additional payment to an MDH whose applicable hospital-specific rate exceeded the Federal rate was limited to 50 percent of the amount by which that hospital-specific rate exceeded the Federal rate.

In reinstating the MDH special payment for discharges occurring on or after October 1, 1997 and before October 1, 2001, section 4204 of the BBA did not revise either the qualifying criteria for these hospitals nor the most recent payment methodology. Therefore, the criteria a hospital must meet in order to be classified as an MDH are the same as before. Since classification as an MDH is not optional, we reinstated all qualifying hospitals as of October 1, 1997.

In the August 29 final rule with comment period, we revised §§ 412.90 and 412.108 to reflect the reinstatement of the MDH special payment.

Section 4204(a)(3) of the BBA permits those hospitals that qualify as an MDH and that applied and were approved for reclassification to a large urban area for purposes of receiving the large urban rates through the MGCRB to decline that reclassification for FY 1998. Normally, hospitals approved for reclassification have only 45 days from the date of the proposed rule to withdraw their request for reclassification. However, the statute provides that, in this situation, hospitals may withdraw their request for FY 1998 reclassification to a large urban area for purposes of the standardized amount. Any hospital that does not requalify for MDH reinstatement for FY 1998 because of a reclassification to an urban area by the MGCRB for FY 1998 will be notified and given the opportunity to decline that reclassification.

Comment: Three commenters support the reinstatement of the special payment for MDHs. However, the commenters recommended that HCFA establish a process for identifying those hospitals that did not qualify previously but now meet the criteria for classification as an MDH.

Response: Since section 4204 of the BBA did not revise the criteria for classification as an MDH, it is unlikely that there will be new hospitals that qualify except for those hospitals that met all of the original criteria except bed size.

We have instructed our fiscal intermediaries to review their records to determine if there are any hospitals that did not meet the criteria in 1994 and that do now; for example, a hospital that had more than 100 beds in 1994 and now has 100 or fewer beds. In addition, as discussed in the August 29, 1997 final rule (62 FR 46000), at the time of a hospital's year-end cost report settlement, the fiscal intermediary will determine if the hospital met the criteria to qualify as an MDH.

Although the fiscal intermediaries are making every effort to identify and notify all affected hospitals, any hospital that believes it meets the criteria for MDH status but has not received notification should contact its fiscal intermediary.

M. Reinstatement of the Add-On Payment for Blood Clotting Factor for Hemophilia Inpatients

Section 4452 of the BBA amended section 6011(d) of Public Law 101–239 to reinstate the add-on payment for the costs of administering blood clotting factor to Medicare beneficiaries who have hemophilia (which was previously in effect from June 19, 1990 through September 30, 1994) and who are hospital inpatients for discharges occurring on or after October 1, 1997. The payment is based on a predetermined price per unit of clotting factor multiplied by the number of units provided.

In our August 29, 1997 final rule with comment period, we stated that we would calculate the add-on payment for FY 1998 using the same methodology we have used in the past (62 FR 46002). Thus, we established a price per unit of clotting factor based on the current price listing available from the 1997 Drug Topics Red Book, the publication of pharmaceutical average wholesale prices (AWP). We set separate add-on amounts for the following clotting factors, as described by HCFA's Common Procedure Coding System (HCPCS). The add-on payment amount for each HCPCS code is based on the median AWP of the several products available in that category of factor, discounted by 15 percent.

Based on this methodology, we established the following prices per unit of factor for discharges occurring on or after October 1, 1997:

J7190 Factor VIII (antihemophilic factor-human)	$0.76
J7192 Factor VIII (antihemophilic factor-recombinant)	1.00
J7194 Factor IX (complex)	0.32
J7196 Other hemophilia clotting factors (e.g., anti-inhibitors)	1.10

In the August 29 final rule with comment period, we solicited comments on the appropriateness of the add-on payment amount and suggestions for the best methodology to calculate this amount.

Comment: We received five comments on this issue. The commenters indicated that the payment add-ons for blood clotting factors were appropriate with the exception of the payment amount under HCPCS code J7194, Factor IX (complex). The commenters asserted that ''purified'' Factor IX products (that is, products that contained Factor IX only) constituted a distinctly different and much more costly group of products than Factor IX (complex); thus, it was inappropriate to group all ''Factor IX'' products together under one HCPCS code. They recommended that HCFA either allow the purified Factor IX products to be billed under HCPCS code J7196 (Other hemophilia clotting factors) or establish a separate HCPCS code (or codes) for the purified Factor IX products.

Response: We agree that there is a need for further distinctions among the Factor IX products. Therefore, as suggested by the commenters, we are establishing the following two new HCPCS billing codes for purified Factor IX products:

Q0160 Factor IX (antihemophilic factor, purified, nonrecombinant)	$0.93
Q0161 Factor IX (antihemophilic factor, purified, recombinant)	1.00

(Note that ''Q-codes'' are national temporary HCPCS codes that HCFA establishes unilaterally. We will request approval for permanent HCPCS codes at the next session of the national HCPCS panel.)

We will issue instructions to Medicare hospitals and fiscal intermediaries stating that payment should be made under these codes for all applicable discharges occurring on or after the effective date of this rule (that is, June 11, 1998). As discussed in the August 29 document, payment will be made for blood clotting factor only if there is an ICD–9–CM diagnosis code for hemophilia included on the bill.

N. Counting Residents for Direct Graduate Medical Education

1. Limit on the Count of Residents

Section 4623 of the BBA added section 1886(h)(4)(F) of the Act to establish a limit on the number of allopathic and osteopathic residents that a hospital can include in its full time equivalent (FTE) count for direct GME payment. Residents in dentistry and podiatry are exempt from the cap. For cost reporting periods beginning on or after October 1, 1997, a hospital's

unweighted direct medical education FTE count may not exceed the hospital's unweighted FTE count for its most recent cost reporting period ending on or before December 31, 1996.

Section 1886(h)(4)(H)(iii) of the Act gives the Secretary authority to collect whatever data are necessary to implement this provision. Hospitals have been required to report resident-specific information to their fiscal intermediaries under longstanding requirements of § 413.86, and we believe it is possible to implement section 1886(h)(4)(F) without mandating significant additional reporting. We expect to amend the Medicare cost report in light of all of the provisions of the BBA addressing indirect and direct GME payments. We believe that the data, for the most recent cost reporting periods ending on or before December 31, 1996, necessary to implement the indirect and direct GME provisions is already available to fiscal intermediaries through the intern and resident information system.

We believe the hospital's unweighted FTE limit for its most recent cost reporting period ending on or before December 31, 1996 should be based on a 12 month cost reporting period. If the hospital's most recent cost reporting period ending on or before December 31, 1996 is a short period report, the fiscal intermediaries shall make adjustments so that the hospital's unweighted FTE limit corresponds to the equivalent of a 12-month cost reporting period. In the August 29 final rule with comment period, we revised § 413.86(g)(4) accordingly.

Comment: We received comments that many hospitals received approval from the Accreditation Council on Graduate Medical Education (ACGME) to expand existing medical residency training programs prior to enactment of the BBA. The additional residents associated with these program expansions may not have been included in the hospital's most recent cost reporting period ending on or before December 31, 1996. Some commenters felt that it was not the intent of the Congress to ''unduly burden residency programs and hospitals by putting into effect regulations which retroactively punish programs attempting to expand.'' These commenters stated that even if it was Congressional intent to halt program expansion, programs serving rural and rural underserved areas should be exempt. Some commenters urged that the cap be adjusted to allow for situations where documented expansion plans were approved by national credentialing bodies or state regulatory agencies prior to August 5, 1997, or where hospitals made commitments to residents for the 1997/1998 academic year. Other commenters stated that HCFA should allow all residents training before August 5, 1997, to be included in hospital FTE caps. One commenter suggested that HCFA consider the number of approved slots rather than the actual number of residents on December 31, 1996, for purposes of calculating the FTE cap. This commenter did not believe that Congress intended to punish well-established programs that happened to have an open slot on a particular date, nor to force programs with significant activity in the training of rural physicians to reduce their number of residency slots. Some commenters recognized that the statute requires the Secretary to establish hospital specific FTE caps from the hospitals' most recent cost reporting period ending on or before December 31, 1996, even in situations where hospitals made commitments to training additional residents after their cost reporting period ending during 1996 and before the enactment of the BBA. The commenters urged HCFA to recommend a statutory change to the 1996 cost report year provision to ameliorate the retrospective nature of this provision.

Response: Under sections 1886(d)(5)(B)(v) and 1886(h)(4)(F), as amended by the BBA, the number of a hospital's residents in allopathic medicine and osteopathic medicine may not exceed the number of such residents for the hospital's most recent cost reporting period ending on or before December 31, 1996. The limit applies to discharges occurring on or after October 1, 1997, for indirect medical education and to cost reporting periods beginning on or after October 1, 1997, for direct GME. Thus, for an individual hospital, the amount of Medicare payment for direct and indirect GME is limited by the number of residents in a base year specified by the statute.

Many of the comments we received indicated that hospitals made commitments to expand existing residency programs between their most recent cost reporting periods ending on or before December 31, 1996, and their first cost reporting period in which the caps apply. As a result, the hospital may have more residents in its current cost reporting period than its FTE cap. If we adjusted the caps for these hospitals we would effectively give them a base year contrary to the one specified by the statute.

Similarly, establishing FTE caps based on the number of residents training on August 5, 1997 or in the 1997–1998 program year would be inconsistent with the statutory base year. In response to the comment that we establish FTE caps based on approved slots rather than the actual number of residents in training, the statute specifically establishes that the cap equals the number of allopathic and osteopathic FTE residents (before the application of the initial residency period weighting factors) in the hospital's most recent cost reporting period ending on or before December 31, 1996. The Conference Report for the BBA states that ''the conference agreement provides for a 'cap' or limit on the number of residents that may be reimbursed by the Secretary, on a national and a facility level.''

Section 1886(h)(5)(H) states that the Secretary shall give special consideration to facilities that meet the needs of underserved areas but only in the context of prescribing rules for medical residency training programs created on or after January 1, 1995. Thus, we disagree with these commenters that hospitals that meet the needs of rural underserved areas should be exempt from the FTE caps.

Comment: We received several comments on the need for flexibility in the FTE caps. These comments stated that an institution-specific cap does not allow training to move from one hospital to another even if those sites become undesirable. One commenter suggested that a hospital's FTE resident count should be allowed to increase if the residents are moved from another teaching hospital because that hospital no longer provides a desirable training site. Another commenter stated that program sponsors are responsible for ensuring that residency program sites meet accreditation requirements, and that a program sponsor is required to move residency slots if an affiliated hospital cannot or does not want to continue to support residency program changes. These commenters noted that if the sponsor of a residency program moves residents from one hospital to another, the receiving hospital will not be paid for those residents above its cap even though there is no net growth in the number of residents. These commenters requested that the regulations be modified to allow a hospital's FTE cap to increase if the residents are moved from one teaching hospital to another by the program sponsor if there is no net growth in residency slots. One comment proposed setting the cap at the number of residents included in an institution's sponsored programs as an alternative to the unweighted cap based on the time a resident works at a facility. Rotating residents would be counted outside the

cap since the increase in FTEs at one institution due to rotations is balanced by a decrease in the FTEs at the originating institution. One commenter stated that since hospitals now ''own'' residency slots, program sponsors are put at a disadvantage in negotiating with affiliated hospitals for reimbursement of resident salaries and faculty supervision costs, and an affiliated hospital may choose to ''sell its residency slots to the highest bidder.''

Response: The statute does not prohibit program sponsors from restructuring a residency training program or resident rotation schedules. Sections 1886(d)(5)(B)(v) and 1886(h)(4)(F) only provide for hospital-specific FTE caps for purposes of determining Medicare payment for indirect and direct GME. We believe the concerns of these commenters may be addressed by our rules for affiliated groups, which permit hospitals to elect to apply the caps on an aggregate basis. As discussed later, if two or more hospitals are members of the same affiliated group, they can, by mutual agreement, adjust each respective hospital's FTE cap under an aggregate FTE cap. Absent this mutual agreement, we do not believe it is appropriate for the Secretary to establish rules that allow adjustments to hospital-specific FTE caps based on unilateral decisions by the residency training program director.

With regard to the comment that the hospital's FTE caps should be based on the hospital's sponsored programs, sections 1886(d)(5)(B)(v) and 1886(h)(4)(F) specifically limit the hospital's FTEs for determining Medicare payment to the number included in the hospital's most recent cost reporting period ending on or before December 31, 1996. We would further note that medical residency training programs may also be sponsored by medical schools. If we were to adopt this commenter's suggestion that the FTE cap be equal to the number of residents in a hospital's sponsored programs, residents in programs sponsored by medical schools would not be included in any hospital's FTE cap.

We recognize the concern of the commenter who stated that the FTE caps may result in changes in financial relationships between program sponsors and affiliated training sites to the disadvantage of program sponsors. If, indeed, program sponsors are at a disadvantage in negotiating financial arrangements, it is a result of the BBA statutory requirement that Medicare payment for direct and indirect GME be limited by hospital specific FTE caps and not a result of any regulations promulgated by the Secretary.

Comment: One commenter stated that because of osteopathic medicine's commitment to primary care and work in underserved communities, HCFA should create an exemption to the residency cap for osteopathic residency programs. Other commenters stated concerns about the adequacy of postgraduate medical education training positions for osteopathic medicine residents. One commenter stated that the osteopathic medical profession is currently 3,000–3,500 positions in deficit, based on the postdoctoral needs of all students who are currently and will register in colleges of osteopathic medicine over the next 3 years. The commenter argues that, since the allopathic positions total approximately 143 percent of U.S. allopathic medical graduates, a similar restriction on U.S. osteopathic positions does not seem warranted. This commenter stated that a mechanism should be permitted to allow the osteopathic profession the flexibility to enhance osteopathic training positions by approximately 3,000–4,000 positions. Another commenter noted that osteopathic physicians serve disproportionately in rural areas and appear to fulfill physician workforce objectives, which represents an additional justification for maintaining osteopathic residency slots. One commenter noted that it is important that a GME FTE cap not adversely affect training osteopathic surgical subspecialty physicians. According to this commenter, osteopathic medical graduates do not have access to allopathic surgical subspecialty programs.

Response: Section 1886(h)(4)(F) provides for a cap on the total number of FTE residents in a hospital's ''approved medical residency training programs in the fields of allopathic and osteopathic medicine.'' The statutory limit on the number of residents paid for by Medicare specifically encompasses residents in osteopathic medicine.

Comment: Several commenters asked about application of the cap for hospitals that merged after December 31, 1996 but before the BBA, where only one hospital maintains its provider number and participation agreement. Another commenter stated that the law and regulations do not address application of the resident cap for hospital mergers and acquisitions. These commenters do not believe that it was the intent of the BBA to eliminate funding for residents when hospitals merge. Another commenter stated that applying the limits based on cost reports ending on or before December 31, 1996, does not allow for the long-term plans of providers attempting to reduce medical education costs and consolidate programs. The commenters recommended that HCFA interpret the BBA provisions to allow hospitals that merged after the base year to include the count of both hospitals. Some commenters suggested that another approach would be to redefine an affiliated group to include hospitals that merged after the December 31, 1996, cost reporting period. Another commenter stated that where there is a merger involving two hospitals, the merged cap should reflect a 12-month cost reporting period. This commenter suggested we amend the regulations specifically to ensure that the FTE cap is based on the equivalent of a 12-month cost report in the context of a merger.

Response: We agree with the commenters that when there is a merger, the cap for the hospital should reflect the base year FTE counts for the hospitals that merged. This is consistent with the principle of limiting payments based on the base year specified in the statute. Also, in implementing the COBRA 1985 provision establishing a hospital-specific per resident amount in the situation of a merger, we have calculated the revised per resident amount for the merged hospital using an FTE weighted average of each of the respective hospital's per resident amount which is part of the merger. We believe that it would be appropriate to address the FTE caps using the same principle. For purposes of this final rule, where two or more or more hospitals merge after each hospital's cost reporting period ending during FY 1996, the merged hospital's FTE cap will be an aggregation of the FTE cap for each hospital participating in the merger. We are modifying § 413.86(g)(6) to reflect this change.

With regard to the comment that we modify the regulations to ensure that the FTE caps are applied on the basis of a 12-month cost reporting period specifically in the context of mergers and acquisitions, the existing regulations state that the fiscal intermediary may make appropriate modifications to apply the FTE cap based on the equivalent of a 12-month cost reporting period. We do not believe that additional regulatory revisions are warranted.

Comment: Several commenters argued that we should adjust the caps when a hospital began training additional residents after its cost reporting period ending during 1996 because another hospital closed or discontinued its

teaching programs during the July 1996-June 1997 residency year. One commenter stated that there should be a mechanism for allowing FTE positions from merged or closed osteopathic residency programs to be used by other programs. One commenter suggested that we allow an adjustment to the FTE cap if the hospital met the following criteria: (1) During the July 1996-June 1997 residency year the hospital assumed additional medical residents from a hospital that was closing or discontinuing its training programs; (2) The hospital added the residents with the intent of allowing them to complete their education program; and (3) The hospital that closed does not seek reimbursement for the residents. If a hospital meets these three criteria, this commenter stated that it should have an unweighted FTE count which equals its unweighted FTE count for its most recent cost reporting period ending on or before December 31, 1996, adjusted for the additional residents added from residency programs at the closed hospital.

Response: Similar to the situation of a merger, we agree that, when a hospital takes on residents because another hospital closes or discontinues its program, a temporary adjustment to the cap is appropriate and consistent with the base year system. In these situations, residents may have partially completed a medical residency training program and would be unable to complete their training without a residency position at another hospital. We believe that it is appropriate to allow temporary adjustments to the FTE caps for a hospital that provides residency positions to medical residents who have partially completed a residency training program at a hospital which closed.

For purposes of this final rule, we will allow for temporary adjustments to a hospital's FTE cap to reflect residents affected by a hospital closure. That is, we will allow an adjustment to a hospital's FTE cap if the hospital meets the following criteria: (1) During the July 1996-June 1997 residency year the hospital assumed additional medical residents from a hospital that was closing; (2) The hospital added the residents with the intent of allowing them to complete their education program; and (3) The hospital that closed does not seek reimbursement for the residents. As stated above, this adjustment will be temporary to allow Medicare payment for those residents from the closed hospital. After this period, the hospital's cap will be based solely on the statutory base year. Hospitals seeking an adjustment for this situation must document to their intermediary that an adjustment is warranted for this purpose and the length of time that the adjustment is needed.

Comment: One commenter stated that an appeals process must be established for providers to present cases when they believe their particular medical education programs have been unfairly penalized.

Response: Since the direct and indirect medical education FTE counts are used in determining hospital payments on the basis of a cost reporting period and the hospital has appeal rights on the settlement of the cost report under 42 CFR Part 405, we do not believe that a new appeals process needs to be established.

2. Counting Residents Based on a 3-Year Average

Section 1886(h)(4)(G)(iii) of the Act, as added by section 4623 of the BBA, provides that for the hospital's first cost reporting period beginning on or after October 1, 1997, the hospital's weighted FTE count for payment purposes equals the average of the weighted FTE count for that cost reporting period and the preceding cost reporting period. For cost reporting periods beginning on or after October 1, 1998, section 1886(h)(4)(G) of the Act requires that hospitals' direct medical education weighted FTE count for payment purposes equal the average of the actual weighted FTE count for the payment year cost reporting period and the preceding 2 cost reporting periods. This provision provides incentives for hospitals to reduce the number of residents in training by phasing in the associated reduction in payment over a 3-year period. In the August 29 final rule with comment period, we revised § 413.86(g)(5) accordingly.

For cost reporting periods beginning on or after October 1, 1997, we indicated in the August 29 final rule with comment period how we would determine direct GME payments.

To address situations in which a hospital increases the number of FTE residents over the cap, notwithstanding the limit established under section 1886(h)(4)(F), in the August 29 final rule with comment period we established the following policy for determining the hospital's weighted direct GME FTE count for cost reporting periods beginning on or after October 1, 1997.

- Determine the ratio of the hospital's weighted FTE count for residents in allopathic and osteopathic medicine to the hospital's unweighted number of FTE residents without application of the cap for the cost reporting period at issue.
- Multiply the ratio determined above by the hospital's FTE cap. Add the weighted count of residents in dentistry and podiatry to determine the weighted FTEs for the cost reporting period. This methodology should be used for purposes of determining payment for cost reporting periods beginning on or after October 1, 1997. The hospital's unweighted count of interns and residents for a cost reporting period beginning before October 1, 1997 will not be subject to the FTE limit.

If a hospital's unweighted count of residents in specialties other than dentistry and podiatry does not exceed the limit, the weighted FTE count equals the actual weighted FTE count for the cost reporting period. The weighted FTE count in either instance will be used to determine a hospital's payment under the 3-year rolling average payment rules. We believe this proportional reduction in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision.

Section 1886(h)(4)(G)(ii) of the Act provides that the Secretary makes appropriate modifications to ensure that the average FTE resident counts are based on the equivalent of full 12 month cost reporting periods. In the August 29 final rule with comment period, we revised § 413.86(g)(5) to allow the fiscal intermediaries to make the appropriate adjustments to ensure that 3-year and 2-year average FTE counts are based on the equivalent of 12-month periods.

Comment: Some commenters stated that application of the 3-year rolling average rule penalizes hospitals that participate in an affiliated group and increase residents under an aggregate FTE cap. We received comments stating that the 3-year rolling average may penalize hospitals that legitimately qualify for an increase in their FTE count because they established a medical residency training program on or after January 1, 1995. The commenters argue that, in these cases, hospitals should be able to choose to have IME or direct GME payments based on the current year count of FTE residents or the 3-year rolling average. One commenter stated that the rolling average methodology arbitrarily penalizes areas of the country undergoing substantial growth.

Response: Section 1886(h)(4)(H)(i) states that ''the Secretary shall, consistent with the principles of subparagraphs (F) and (G), prescribe rules for the application'' of the FTE caps and the 3-year rolling average in the case of medical residency programs established after January 1, 1995. We agree with these commenters that FTE

residents participating in new medical residency training programs should be included in the direct and indirect GME FTE counts after application of the 3-year averaging methodology. Accordingly, we are revising § 413.86(g)(5) to determine a hospital's 3-year average FTE count prior to adding residents participating in new medical residency training programs consistent with section 1886(h)(4)(H)(i). However, section 1886(h)(4)(H)(ii) states that ''the Secretary may prescribe rules which allow institutions which are members of the same affiliated group (as defined by the Secretary) to elect to apply the limitation of subparagraph (F) on an aggregate basis.'' Since the statute provides that the Secretary's rules regarding affiliated groups should only apply to the FTE cap, we believe the 3-year rolling average should be applied for affiliated groups. That is, we will apply the 3-year rolling average for hospitals that are part of an affiliated group, subject to application of the aggregate cap.

Comment: We received some comments asking HCFA to clarify that dental and podiatric residents are not included in the rolling average resident count. Several other commenters suggested that we modify the regulations so that dental and podiatric residents are not included in the 3-year averaging of FTE counts. The commenters asserted that the intent of the provision was that the count of dental and podiatric positions be made separately.

Response: Although the FTE caps established under sections 1886(d)(5)(B)(v) and (h)(4)(F) are limited to residents in allopathic and osteopathic medicine, there is no similar limitation in section 1886(d)(5)(B)(vi) and (h)(4)(G) when determining indirect and direct GME payments based on a 3-year average. These provisions state that the Secretary shall determine payment based on an ''average of the actual full-time equivalent resident count for the cost reporting period and the preceding two cost reporting periods.'' There is no statutory distinction between dental, podiatric and other residents in determining payment based on the 3-year averaging rules.

Comment: One commenter stated that capping FTEs for individual cost reporting periods in calculating the 3-year average is not the intention of the statute. This commenter stated that capping the FTEs in the individual years depreciates the FTE count for that year, misrepresenting the total number of FTEs during that year. This commenter recommended that in calculating the 3-year rolling average, the gross number of FTEs should be used in the calculation.

Response: Section 1886(h)(4)(G), as added by the BBA, provides that the computation of the rolling average is ''subject to the limit described in subparagraph (F)''. The 3-year rolling average must reflect application of the FTE cap.

3. Special Rules for Applying the Direct GME FTE Limit and Rolling Average

Under section 1886(h)(4)(H)(i) of the Act, as added by the BBA, the Secretary is required, consistent with the principles of establishing a limitation on the number of residents paid for by Medicare and the 3-year rolling average, to establish rules with respect to the counting of residents in medical residency training programs established on or after January 1, 1995. Such rules must give special consideration to facilities that meet the needs of underserved rural areas. Language in the Conference Report for the BBA indicates concern that there be proper flexibility to respond to changing needs given the sizeable number of hospitals that elect to initiate new (or terminate existing) training programs.

Pursuant to the statute, in the August 29 final rule with comment period, we established the following rules for applying the FTE limit and determining the FTE count for hospitals that established new medical residency training programs on or after January 1, 1995. For purposes of this provision, a ''program'' would be considered newly established if it is accredited for the first time, including provisional accreditation, on or after January 1, 1995, by the appropriate accrediting body. The Secretary has broad authority to prescribe rules for counting residents in new programs, but the Conference Report for the BBA indicates concern that the aggregate number of FTE residents should not increase over current levels. Accordingly, we indicated that we would continue to monitor growth in the aggregate number of residency positions and may consider changes to the policies described below if there continues to be growth in the number of residency positions.

Comment: One commenter believed that the Congress intended to create exceptions for circumstances where commitments to begin new training programs had been made prior to enactment of the cap, including situations where programs had begun prior to enactment but were not filled in 1996 and situations where a new facility opens after enactment, and had no residents in the base year.

Response: The regulations published on August 29, 1997 provide for adjustments to hospital FTE caps for hospitals that previously did not participate in GME training and hospitals that established new medical residency training programs on or after January 1, 1995 and on or before the August 5, 1997 enactment of the BBA.

Comment: Some commenters questioned the definition of ''new medical residency training program'' established for purposes of section 1886(h)(4)(H) of the Act. The regulation defines a new program as one that receives initial accreditation on or after July 1, 1995. Several commenters stated that the definition of new program should recognize programs that have not yet received accreditation but are approved GME programs eligible for payment. The commenter suggested that the current definition of ''new medical residency training program'' would not recognize programs leading to an American Board of Medical Specialties certification since they are not accredited by an accreditation body, even though such programs qualify as approved GME programs and are eligible for payment. Some commenters suggested that the new program definition be based on the date the residents begin training rather than the date of an accreditation letter. These commenters noted that the majority of programs starting July 1, 1995, received their accreditation letters prior to January 1, 1995, and would not qualify as new programs. Other commenters believed that a new medical residency program should be determined based on the date a program received approval from the accrediting body. One commenter stated that programs which receive ''provisional accreditation'' should be included in the regulatory definition of a new program. One commenter stated that the new program definition should include programs for which hospitals submitted a formal application before August 5, 1997. The commenter noted that it takes from 8–12 months before accreditation action is taken. Another comment requested clarification that the documentation required under this section (42 CFR 413.86(g)(6)(iv)) related solely to justifying the existence of a new program.

Response: We inadvertently used the date ''July 1, 1995'' when we added § 413.86(g)(7) in the final rule with comment published August 29, 1997. We are correcting the date to January 1, 1995 in this final rule.

As the comments reflect, establishing a newly accredited medical residency training program can be a costly and

time consuming process. We recognize that hospitals that either received accreditation for a new medical residency training program or began training residents in the new program may have expended substantial resources during the accreditation process. We also recognize that hospitals usually do not begin training residents immediately upon receiving an accreditation letter. For these reasons, we believe it is appropriate to consider a medical residency training program to be newly established if the program received initial accreditation or began training residents on or after January 1, 1995. We are modifying the regulation accordingly.

A hospital seeking to qualify as a new program must provide documentation to the intermediary indicating the date a program received accreditation and/or the date the residents begin training for the hospital to receive an adjustment to its FTE cap. We are not allowing programs to be considered newly established based on the date the sponsor began seeking accreditation since the date of an accreditation application is not indicative of a substantial commitment of resources that warrant an adjustment to FTE caps.

Comment: Some commenters requested that the example in the August 29 final rule with comment period at 62 FR 46006, on programs that received direct GME before January 1, 1995, clearly state that dentistry and podiatry positions are not subject to the cap and that hospitals may add new programs in dentistry and podiatry without being subject to the Secretary's rules for establishment of new programs. The commenter would also like the statement on page 46006 that HCFA ''will continue to monitor growth in the aggregate number of residency positions and may consider changes to the policies described below if there continues to be growth in the number of residency positions' modified to indicate that it applies only to allopathic and osteopathic residency positions.

Response: The regulations and preamble published on August 29, 1997, clearly stated that hospitals may include dental and podiatric residents in their FTE counts for purposes of direct and indirect medical education payment without limit, regardless of whether it is an expansion of an existing program or the establishment of a new program. We do not believe modification of the regulation is necessary.

Comment: Several commenters requested clarification about adjustments to the FTE cap for new osteopathic rotating internships. Another commenter suggested that the osteopathic rotating internship should be exempt from the cap as are residents in dentistry and podiatry. One commenter noted that the rules call for counting the number of first year residents in the third year of the residency program. The commenter proposed that a consistent rule for internships would adjust the FTE cap for a new internship program based on the number of internship positions filled in the third year. One commenter expressed concern that our rules should recognize that specialty training in osteopathic medical specialties occurs subsequent to the osteopathic rotating internship in the second postgraduate year and that we should separately make adjustments to the FTE caps for new osteopathic internships and new osteopathic specialty training programs.

Response: The osteopathic rotating internship is the first postgraduate year of training for osteopathic medical graduates and precedes all subsequent specialty training. Since osteopathic rotation internship programs are individually accredited, we are applying the same rules for new osteopathic rotating internships that we apply for all other new medical residency training programs. That is, if a hospital qualifies for an adjustment to its FTE cap for a new osteopathic rotating internship, the adjustment will be equal to the product of the minimum accredited length for the osteopathic rotating internship (that is, one year) and the number of FTEs participating in the internship in its third year of existence. Since osteopathic rotating internships are one year in length, the minimum accredited length is equal to one year.

We will allow adjustments to FTE caps for new osteopathic specialty programs based on the product of the minimum length for the accredited program and the highest number of residents in any program year subsequent to the osteopathic rotating internship (that is, program year 2, program year 3 or program year 4) in the third year of the program's existence. We are applying the same rule for new allopathic training programs (that is, the adjustment for the new medical residency program is based on the highest number of residents in any program year in the third year of the program's existence). The adjustment to the hospital's FTE cap may not exceed the number of accredited resident slots for the new medical residency training program. In response to the comment that the osteopathic rotating internship be exempt from FTE caps, as stated earlier, the FTE caps under sections 1886(d)(5)(B)(v) and (h)(4)(F) specifically encompass residents participating in allopathic and osteopathic training programs.

a. Hospitals with no residents prior to January 1, 1995. Section 1886(h)(4)(H) of the Act allows the Secretary to prescribe special rules for the application of the FTE caps and 3-year averaging for medical residency training programs established on or after January 1, 1995. In the August 29, 1997 final rule with comment period (62 FR 46005), we provided a special rule for application of the FTE resident cap for hospitals which did not participate in GME training prior to January 1, 1995. Under this special rule, we allowed hospitals to establish their FTE cap based on the product of the number of first year residents participating in accredited GME training programs in the third year that the hospital received payment for GME and the minimum accredited length for the type of program.

Comment: Some commenters stated that hospitals that did not receive GME payments prior to January 1, 1995, and subsequently become teaching hospitals by affiliating with an existing training program, should be eligible for GME payments if they incur substantially all of the costs of the resident training and the overall number of residents does not increase. In this situation, the location of settings in which residents receive training changes but there is no net increase in the number of residents. One commenter stated that the limit on resident growth in new hospitals to those from ''newly accredited programs'' severely limits flexibility of moving residents and requires a duplicative administrative burden to start new programs when sharing residents would work just as well. Another commenter asked whether new hospitals may include residents transferred from other hospitals if all parties concur. To ensure that this does not increase the number of resident slots, hospitals transferring residents would have their caps correspondingly reduced. Several commenters asked how the cap would apply to hospitals that decide to become teaching institutions and will have residency programs that will be a mix of new programs and programs currently running in another hospital.

Response: Under § 413.86(g)(4), hospitals that are part of the same affiliated group may elect to apply the FTE cap under section 1886(h)(4)(F) on an aggregate basis. If a hospital that did not receive direct or indirect GME payment prior to January 1, 1995, qualifies to be part of the same affiliated group with another hospital that

participates in residency training, these hospitals can, by mutual agreement, provide for adjustments to each respective hospital's FTE cap under an aggregate cap for the affiliated hospitals.

With regard to application of the cap for hospitals that become teaching institutions on or after January 1, 1995, and on or before August 5, 1997, our policy is that a hospital can receive an adjustment to its FTE cap for a new medical residency training program and can affiliate with hospitals that have existing medical residency training programs. Hospitals in urban areas that participate in medical residency training programs for the first time, after the August 5, 1997 enactment date of the BBA may receive an adjustment only for new medical residency training programs; they cannot affiliate with hospitals that have existing medical residency training programs. We are establishing this policy because of our concern that hospitals with existing medical residency training programs may affiliate with hospitals that establish new medical residency programs solely for the purpose of moving the new residency program to its own hospital and receiving an upward adjustment to its FTE cap under an affiliation agreement.

We will allow hospitals in rural areas that qualify for an adjustment to its FTE cap for new medical residency training programs to affiliate with hospitals in urban areas. However, we will only allow a rural hospital that qualifies for an adjustment to its FTE cap for a new medical residency training program to be a member of the same affiliated group with an urban hospital if the rural hospital provides training for the FTE equivalent of at least one third of the residents participating in the joint programs of the affiliated hospitals. We are allowing these affiliations between rural and urban hospitals to recognize that rural hospitals may not have sufficient patient care utilization to be able to establish a training program within the rural area to meet accreditation standards. However, we remain concerned that there needs to be a sizeable component of training in the rural area for the policy to provide appropriate consideration for hospitals meeting the needs of underserved rural areas. We believe that providing for at least one third of the training in rural area will allow programs which focus on, but are not exclusively limited to training in those areas.

Comment: One commenter argued that there is an inconsistency between the rules for teaching hospitals that had residents prior to January 1, 1995, and nonteaching hospitals that became teaching hospitals between January 1, 1995, and August 5, 1997. Hospitals in the former category may have their limits adjusted upward for all new programs established prior to August 5, 1997, while hospitals in the latter category are allowed an adjustment only for residents in the first program created even though additional programs may have been created prior to August 5, 1997. This commenter recommended that all hospitals be entitled to cap adjustment for programs created before August 5, 1997.

Response: We agree and will establish the FTE cap for a hospital which did not participate in residency training prior to January 1, 1995, based on the product of the minimum length for the type of program and highest number of residents in any program year for all residency programs created in the 3rd year after residents first begin training (§ 413.86(g)(60)(i) and (ii)). This policy addresses adjustments for all new medical residency programs established prior to August 5, 1997.

Comment: One commenter suggested (1) allowing a new hospital 5 years to build its residency programs, and not differentiating between new and established programs, (2) using the 3-year methodology outlined in the rule but not differentiating between new and established programs, or (3) allowing the cap to move with the residents when programs are transferred from one hospital to another. Another commenter suggested that permitting hospitals to transfer residency programs to other hospitals by mutual agreement is necessary to provide cooperating hospitals, or hospitals within networks, the necessary flexibility to determine requirements for a quality training program and how they will meet them.

Response: One of these commenters is suggesting three alternatives for establishing the FTE cap for a new hospital that establishes a medical residency training program. Under the first two options, the commenter is suggesting that we should not distinguish between whether the hospital's resident count is adjusted for new medical residency training programs or previously established programs where some or all of the residents are transferred to the new hospital. As stated earlier, hospitals that did not participate in a medical residency training program prior to August 5, 1997, and establish a new medical residency training program for the first time after the enactment date of BBA will have their FTE caps established in the third year in which they participate in residency training.

We are not allowing hospitals that first participate in medical residency training programs to affiliate with hospitals that already have an established FTE cap because of our concern that hospitals with existing medical residency training programs would affiliate with hospitals that do not currently train residents solely for purposes of establishing a higher FTE cap, which is inconsistent with sections 1886(d)(5)(B)(v) and (h)(4)(F) of the Act. As a result of this concern, we are reluctant to adopt the first two approaches suggested by this commenter for adjusting the FTE cap for a hospital which participates in medical residency training for the first time after August 5, 1997. This commenter has also suggested allowing the FTE cap to move between hospitals when programs are transferred. Hospitals that qualify to be members of the same affiliated group can mutually agree to adjustments in their respective FTE caps.

Comment: One commenter stated that the requirement that all new programs begin at the same time in new hospitals is contradictory to the Accreditation Council on Graduate Medical Education requirement that certain new programs be started in hospitals that already have other programs. Under HCFA's regulations, a new hospital must start all new programs at once in order to receive an adjustment to the FTE cap based on the number of residents participating in all of the hospital's accredited programs in the third year that the hospital participates in training. The commenter suggested that HCFA provide an adequate time period for new hospitals to build complementary residency programs that do not conflict with Accreditation Council on Graduate Medical Education requirements. One commenter stated that basing the resident cap for new residency programs on the first program(s) will inhibit growth of other primary care programs or the introduction of new primary care programs. One commenter stated that nothing in the statute suggests that recognition of new programs should be limited to the first program. This commenter stated that if an internal medicine program is accredited in April 1996 with its first residents in July and a specialty program is developed in 1997 with residents beginning in 1998, the cap should be adjusted to account for the additional residents in the second program. One commenter recommended that the cap for new programs be adjusted based on all programs established in the hospital's first year rather than the first programs simultaneously established. One

commenter suggested that the cap adjustment for new programs in hospitals should be available without a cut-off date. Another commenter recommended allowing hospitals a period of time, no less than 5 years, to establish their GME training programs. One commenter stated that the resident count should be determined in the third year of the program based on the number of residents in either the first, second, or third residency year, whichever is the highest. In addition, the regulations should allow the limits to be adjusted upward for each of the first two years of the program to permit payments for residents present during that period.

Response: We agree that hospitals that establish new medical residency programs will need time to establish complementary residency programs. Additionally, we are concerned that hospitals may be disadvantaged by basing the adjustment on the number of first year residents in the third year of the program's existence. Therefore, we are revising § 413.86(g)(6)(i) to state that the hospital's cap adjustment is based on the product of the minimum accredited length for the specialty program and the highest number of residents training in any program year during the 3rd year of the program's existence. For purposes of determining the FTE cap for hospitals which first participate in GME training on or after January 1, 1995, we will establish the hospital's FTE cap 3 years after the first medical residency program is established. The hospital's cap will reflect an adjustment based on the product of the minimum accredited length for the program and the highest number of residents in any program year for each new medical residency program in existence at the time the cap is established. The hospital's FTE cap may not exceed the number of accredited resident slots available to the hospital.

b. Hospitals with residents rrior to January 1, 1995 not located in rural areas. In the August 29, 1997 final rule with comment period, we also provided a special rule for the application of the FTE cap for hospitals that participated in GME training before January 1, 1995 and established medical residency training programs on or after January 1, 1995. Under this special rule, we allowed hospitals with new medical residency training programs established on or after January 1, 1995 and on or before August 5, 1997 to adjust their FTE caps. The hospital's FTE caps are adjusted for the incremental increase in residents participating in the new medical residency training program which are not reflected in the hospital's cost reporting period ending during calendar year 1996.

Comment: We received comments stating that an adjustment should be made to the FTE cap for programs established prior to January 1, 1995, that had not reached their third year or minimum accredited length for the type of program during the cost reporting period ending on or before December 31, 1996.

Response: Section 1886(h)(4)(H) states that the Secretary shall prescribe rules for application of the FTE cap and 3-year rolling average ''in the case of medical residency training programs established on or after January 1, 1995.'' Our policy of limiting adjustments to FTE caps for medical residency training programs established on or after January 1, 1995 is consistent with this statutory requirement.

Comment: We received comments stating that HCFA should allow adjustments to the FTE cap for new residency programs established on or after August 5, 1997 in hospitals with existing residency programs. Many commenters believed that the August 5, 1997 date was unfair to primary care programs since several new family practice programs were accredited in September 1997 and there are a number of additional programs that will be established in the next 1 to 2 years. According to these commenters, if a public policy goal is to increase the number of primary care physicians, HCFA should allow for adjustments for programs created before September, 1999. One comment stated that urban hospitals will be deterred from opening new, desirable residency programs such as ambulatory care training programs if they cannot receive an adjustment for programs established after August 5, 1997. If HCFA does not allow hospitals in urban areas to create additional programs after August 5, 1997, this commenter suggested that HCFA allow adjustments for primary care programs where the majority of training is in ambulatory care. One commenter requested that the Secretary consider the needs of elderly beneficiaries in rural areas and allow adjustments to a hospital's FTE cap for new medical residency training in geriatric medicine. Another commenter stated that the Secretary should be required to give special consideration to facilities that establish residency training programs on or after January 1, 1995 ''which meet the needs of geriatric populations, including mental health needs of the aged.''

Response: As we have stated earlier, sections 1886(d)(5)(B)(v) and 1886(h)(4)(F) limit the number of allopathic and osteopathic residents that a hospital may include in its FTE count for purposes of indirect and direct GME payments. The Conference Report further states that ''a facility limit on the number of residents was provided, rather than any direction on payments according to specialty of physicians in training, to specifically avoid the involvement by the Secretary in decision making about workforce matters. The Conferees emphatically believe that such decisions should remain within each facility, which is best able to respond to clinical needs and opportunities.''

Since sections 1886(d)(5)(B)(v) and 1886(h)(4)(F) provide for an FTE cap for medical residents in all allopathic and osteopathic specialties and the Conference Report states that the Secretary should not be involved in workforce matters, we disagree with these commenters that we should allow for adjustments to FTE caps for programs that train primary care residents, programs that focus on ambulatory training or geriatric training programs. We believe the statute anticipates that each facility, within its FTE cap, will make decisions about training programs based on the needs of its own institution.

c. Rural underserved areas. Consistent with section 1886(h)(4)(H), we provided a special rule for the application of the FTE cap to give special consideration to hospitals that meet the needs of underserved rural areas. Under this special rule, we provide adjustments to FTE caps for hospitals located in rural areas that established medical residency training programs on or after January 1, 1995. The caps can be adjusted for all programs created on or after January 1, 1995 including programs created after the enactment of BBA. The adjustment to an individual hospital's FTE cap is based on the product of the number of first year residents participating in the newly established program in the program's third year of existence and the minimum accredited length for the program.

Comment: Many commenters recommended that an exception to the FTE caps should be permitted to encourage existing programs to expand to meet the needs of rural, underserved areas. Several commenters also suggested providing an exception to the cap that would allow a geographic area with substantial population growth to expand existing medical residency training programs to hospitals which previously have not participated in residency training. Some commenters suggested that the needs of rural (and other underserved) areas are frequently met by facilities that do not exist within

those areas, but whose graduates subsequently practice there. This commenter requested that HCFA redesignate certain urban MSAs as rural for residency training purposes. One commenter suggested that the designation of programs in underserved areas receiving special consideration might better be phrased as ''programs whose graduates serve underserved areas,'' in order to be consistent with the purpose of this language. Many commenters stated that Congress' intent that special consideration be given to facilities that meet the needs of underserved rural areas was meant to include entire States that have low ''per population'' ratios of both physicians and residents. This commenter suggested that this special rule could be limited to the five States with lowest physician to population ratios.

One commenter stated that without an exception, the FTE cap could have a ''chilling'' effect on urban hospitals sending residents to rural settings. This commenter stated that there have been several recent expansions in family practice residency programs that include a rural training track, with residents located in outlying hospitals, or with satellite programs designed specifically to train residents to work in areas with underserved populations. The commenter suggested that urban hospitals should be eligible for exceptions to the cap if they place residents in rural, underserved areas. One commenter recommended that the FTE cap should be adjusted for urban programs that provide 25 percent of their training in rural areas that are designated as medically underserved areas and/or health professional shortage areas.

Another commenter stated that, given the value of rural training to the needs of underserved populations, HCFA should develop additional exception language for rural training tracks or programs that seek to train residents in working with underserved populations. The commenter recommended that HCFA consider, in designating rural and rural underserved areas, the population served by the program and where the graduates practice upon completion of the program rather than the location of the training of the residents. We received comments indicating that hospitals will be unlikely to benefit from the special rules for hospitals located in rural areas. The commenters believed that it is unlikely that a rural hospital will establish a residency program because the smallest program which may be accredited is for 12 residents. Another commenter stated that the majority of physicians will settle within 100 miles of their residency training location and suggested that programs which serve underserved rural areas should be defined as:

(a) Any residency program with more than 10 health professional shortage areas within 100 miles of the program;

(b) Residencies that have identified themselves prior to August 5, 1997 as having the mission of training rural physicians, and have placed more than 10 percent of residents in the preceding 2 years in rural underserved areas and more than 40 percent in rural areas; or

(c) Residencies within States where greater than 70 percent of the land mass is rural; and

(d) Programs meeting the above qualifications and those located within health professional shortage areas would be disqualified by being in a community of greater than 100,000.

Response: We believe that the Congress enacted sections 1886(d)(5)(B)(v) and 1886(h)(4)(F) because of a concern about the growing supply of physicians in combination with reports that the United States may be training too many physicians for practice in the 21st century. The Conference Report accompanying the BBA states that the ''conference agreement provides for a 'cap' or limit on the number of residents that may be reimbursed by the Secretary, on a national and a facility level.'' At the same time, the Conference Report acknowledged that the FTE caps could create problems in several circumstances. Accordingly, the statute provides for special rules for medical residency programs created on or after January 1, 1995, and directs the Secretary to ''give special consideration to facilities that meet the needs of rural underserved areas.''

Given the hospital specific FTE caps mandated by the statute and the Conference Report language that the number of FTE residents paid for by Medicare should not exceed current levels, we believe our policy with regard to medical residency training programs created on or after January 1, 1995, establishes an appropriate balance between the competing goals of limiting the number of residents in training nationally and making appropriate payments for necessary training. Although we acknowledge that GME programs that provide a component of training in rural areas also include significant training in hospitals located in urban areas, we are concerned about the impact of providing adjustments to the FTE limit for hospitals located in non-rural areas until we have more experience with the current special rules. As we stated above, we will make adjustments to the caps for rural hospitals that establish new medical residency training programs and will allow those hospitals to affiliate with hospitals in nonrural areas. Taken together, these policies allow rural hospitals, in combination with urban hospitals, to establish training programs which can receive Medicare payment for direct and indirect GME. Finally, based on a review of the 1997/1998 *Graduate Medical Education Directory,* we would note that, in limited circumstances, family practice programs of fewer than 12 residents that focus on rural training may be accredited.

Comment: One commenter suggested that many osteopathic training programs are located in underserved, urban areas called Empowerment Zones and that these programs should receive a waiver from the FTE caps. Another commenter recommends that exceptions be permitted for urban hospitals serving underserved populations.

Response: As stated above, sections 1886(d)(5)(B)(v) and 1886(h)(4)(F) cap the number of osteopathic and allopathic physicians a hospital may include in its FTE count. Section 1886(h)(4)(H)(i) requires the Secretary to prescribe special rules for application of the cap and the 3-year rolling average for medical residency training programs created on or after January 1, 1995, and states that the Secretary should give special consideration to hospitals that meet the needs of rural underserved areas in drafting these rules. The statute includes osteopathic medical residency training programs in the FTE caps and the Secretary is directed by the statute to give special preference only to rural underserved areas. Consistent with the statute, we are providing for adjustment to FTE caps for new medical residency training programs created on or after January 1, 1995 and are not providing for the types of adjustments suggested by these commenters.

Comment: Several commenters noted that medicine is constantly evolving, leading to new specialty training programs. According to the commenters, new specialties do not necessarily replace old specialties so absent explicit recognition of new specialties, the cap on resident training will hamper the ability of teaching institutions to implement new training programs without downsizing or eliminating existing programs. The commenters urged HCFA, in consultation with the medical profession, to look at constructive ways to address this issue.

Response: As we have stated earlier, sections 1886(d)(5)(B)(v) and (h)(4)(F) provide for limits on the number of

residents used in determining Medicare payment for indirect and direct GME. It does not preclude hospitals from establishing new medical training programs. Nevertheless, we do acknowledge that Medicare's payments for GME may be important in decisionmaking about training and the FTE caps mandated by the BBA may have an effect on the future developments in GME training. These issues would be appropriate consideration for Congress as well as the Medicare Payment Advisory Commission and the National Bipartisan Commission on the Future of Medicare. Section 4629 of the BBA requires the Medicare Payment Advisory Commission to report on the ''extent Medicare payment policies and other Federal policies regarding teaching hospitals and graduate medical education should be changed.'' Section 4021 of the BBA creates a National Bipartisan Commission on the Future of Medicare which is required to ''make recommendations regarding the financing of graduate medical education.''

Comment: One commenter stated that there are no instructions on how to apply for an exception to the FTE cap.

Response: Hospitals seeking to receive payments under the rules for a new medical residency training program should consult with and provide supporting documentation to their fiscal intermediary.

4. Aggregate Direct GME FTE Limit for Affiliated Institutions

Section 1886(h)(4)(H)(ii) of the Act permits but does not require the Secretary to prescribe rules that allow institutions that are members of the same affiliated group (as defined by the Secretary) to elect to apply the FTE resident limit on an aggregate basis. This provision would permit hospitals flexibility in structuring rotations within a combined cap when they share residents.

a. Definition of affiliated group. Pursuant to the broad authority conferred by the statute, in the August 29, 1997 final rule with comment period, we established criteria to define ''affiliated group''. We defined ''affiliated group'' as

- Hospitals in the same geographic wage area that rotate residents to other hospitals of the group during the course of the approved program; or
- Hospitals that are not located in the same geographic wage area and are jointly listed as ''major participating institutions'' as that term is used in the *Graduate Medical Education Directory* for one or more programs.

Comment: Some commenters requested that we clarify whether the term geographic wage area included reclassification for purposes of the wage index or the national standardized amounts or both. These commenters have questioned whether ''geographic wage area'' means a metropolitan statistical area (MSA) before the effect of reclassification and some commenters were unsure whether the term geographic wage area included the effect of reclassification for the standardized amount or the wage index or both.

Response: For purposes of defining an affiliated group, we are using the terms ''urban area'' and ''rural area'' before the effect of geographic reclassification under part 412. To avoid further confusion, we are revising § 413.86(b) to use the terms ''urban area'' and ''rural area'' (as those terms are defined in § 412.62(f)) for the purpose of defining an affiliated group. Section 412.62(f) states that an urban area means a metropolitan statistical area or New England County Metropolitan Area as defined by the Executive Office of Management and Budget. A rural area means any area outside of an urban area.

Comment: Some commenters recommended allowing hospitals to be part of an affiliated group if they are located in the same State or located in contiguous geographic wage areas.

Response: We agree with this recommendation and are revising the criteria specified in § 413.86(b) as follows. Specifically, we are revising this section to provide that hospitals in the same urban area or a contiguous urban area may be part of the same affiliated group if the hospitals participate jointly in training residents in at least one training program. If a hospital is located in a rural area, it may affiliate with any hospital in which it jointly participates in training residents in the same rural area or a contiguous area.

Comment: Many commenters disagreed with the limitation of affiliated group to geographic areas. Some commenters stated that hospital systems today are geographically diverse, the wage area distinction is dysfunctional, and the requirement that hospitals be located in the same geographic wage area or jointly listed as major participating institutions in the *Graduate Medical Education Directory* is too limited. These commenters requested that the wage area and joint listing requirements be eliminated.

Response: The criteria we established to determine whether two or more hospitals qualify to be an affiliated group were designed to identify hospitals that have relationships for training residents and to allow those hospitals to continue to have the flexibility to rotate residents under an aggregate FTE cap. By focusing on hospitals that rotate residents within a geographic area and on whether they are recognized for jointly participating in residency training by the accrediting body, we are identifying hospitals that are affiliated for purposes of GME training. We believe that our approach for identifying hospitals that require flexibility under an aggregate FTE cap is reasonable and consistent with section 1886(h)(5)(H) of the Act, which provides the Secretary with authority to define hospitals that are members of the same affiliated group. We believe that the geographic boundary provided by an urban or rural area is an appropriate basis upon which to identify hospitals that share residents for purposes of GME training. We agree, however, that focusing solely on hospitals located within an MSA is limiting and are making the qualifying criteria for being members of the same affiliated group less restrictive. Under this final rule, we are allowing hospitals to be members of the same affiliated group which jointly participate in residency training and are located in the same or a contiguous MSA or the same rural area and a contiguous area.

Comment: One commenter stated that the rules regarding ''major participating institution'' are disadvantageous to residency programs in small towns and relatively small geographic wage areas because the definition of ''major participating institution'' requires that the hospital provide rotations of at least one-sixth of the program length or 6 months. Since rural hospitals are more likely to sponsor shorter rotations, hospitals in rural areas would be much less able to meet the criteria to become part of an affiliated group. The commenter believes this does not meet with Congressional intent to provide special consideration for rural areas.

Response: As discussed above, we are modifying the definition of affiliated group to permit affiliations between hospitals located in rural areas and hospitals located in an area contiguous to the rural area.

Comment: Some commenters recommended allowing entities under common ownership or part of the same ''system'' to be an affiliated group for purposes of aggregating their caps. Another commenter recommended creating an additional ''affiliated group'' definition that would allow aggregation of FTE residents for hospitals under common ownership and operation with one or more medical schools (the program sponsors) provided such

hospitals are within the geographic border of a single state. Another commenter suggested that hospitals that certify they operate as a single health care system should be considered an affiliated group, regardless of the hospitals' geographic locations. These systems functionally operate coordinated and centrally controlled GME programs and often rotate their residents among their various facilities depending on training needs and other considerations.

Response: We agree with the commenters who suggested that hospitals that are under common ownership should be permitted to be part of the same affiliated group regardless of geographic boundaries and are modifying § 413.86(b) accordingly.

Comment: One commenter stated that Medicare's related party principle should be a basis for defining affiliated group because that would allow hospitals to better manage training of residents.

Response: We do not agree that Medicare's related party principle should govern which hospitals qualify to be part of the same affiliated group. The criteria for being part of an affiliated group are intended to identify a relationship among hospitals for sharing residents. The related party principle is used under principles of Medicare cost reimbursement to determine the costs of a related party which may be claimed on a hospital's cost report. Under the related party principle, hospitals may claim costs of a related party which may not be a hospital. For instance, a hospital may include the costs of a related medical school on its cost report. Since the related party principle is used in determining which costs of a related party a hospital is entitled to claim and is not indicative of joint participation in a training program, we do not believe the related party principle is appropriate criteria for determining whether hospitals may be part of the same affiliated group.

Comment: One commenter stated that the ''affiliation'' policy should allow for situations where not all affiliated institutions choose to elect to apply for an aggregate cap.

Response: Hospitals that could qualify to be part of an affiliated group do not have to affiliate. As we describe in more detail below, for purposes of applying an aggregate cap hospitals must affiliate by explicit agreement. If a hospital does not affiliate, that hospital will remain subject to a cap based on its FTE count in its most recent cost reporting period ending on or before December 31, 1996. The aggregate cap will only be applied for hospitals that elect to be part of an affiliated group.

Comment: Other commenters suggested that unrelated hospitals that jointly sponsor programs should be allowed to be part of the same affiliated group.

Response: Under our regulations, common sponsorship will qualify two or more hospitals to be part of the same affiliated group. We are revising § 413.86(b) to clarify that hospitals that are jointly listed for one or more medical residency training programs in the *Graduate Medical Education Directory* as a sponsor, primary clinical site or major participating institution may qualify to be an affiliated group for purposes of an aggregate FTE cap.

Comment: Many commenters stated that program sponsors should be able to make decisions about where training should occur and the hospital FTE caps should be adjusted accordingly. Several commenters stated that hospitals in an affiliated group should be allowed to arrange residencies in the manner that best fits their community. One commenter stated that we should permit adjustments to caps to reflect rotations resulting from restructuring training programs brought about by changes in provider affiliations, giving preference to the sponsoring teaching hospital to subsume residency positions that were previously in affiliated institutions.

Response: Although we agree that program sponsors are likely the best qualified to determine how and where training should occur, we do not believe that it would be appropriate to allow hospital specific adjustments to FTE caps based on unilateral decisions by program sponsors or the hospital which sponsors the training program. In situations where the sponsor of the program is a medical school and not a hospital, we do not believe it would be appropriate to make adjustments to hospital FTE caps based on the decision of an entity that has no relationship to the Medicare program. Furthermore, since medical schools do not provide cost reports or counts of FTE residents to Medicare, we do not believe there would be an appropriate mechanism for making adjustments to hospital FTE caps under the aggregate caps if decisions regarding affiliations and adjustments are not being made by hospitals. We would also note that hospitals may be involved in many medical residency training programs involving different program directors. Making adjustments to hospital caps based on the decisions of multiple people within the hospital would not be administratively feasible. Further, since hospitals may not sponsor all of the programs they participate in, we do not believe that it is appropriate to make downward adjustments in a hospital's FTE cap based on a unilateral decision of another hospital.

Comment: Several commenters noted that the *Graduate Medical Education Directory* does not include osteopathic training programs and requested a reference to an official listing of American Osteopathic Association approved training programs.

Response: We agree with the commenters who suggested that the regulation needs a comparable reference for osteopathic medical residency training programs to the *Graduate Medical Education Directory,* which only lists allopathic training programs. Medical residency programs accredited by the American Osteopathic Association are listed in a publication called *Opportunities, Directory of Osteopathic Postdoctoral Programs.* For purposes of this final rule, if two hospitals are not located in the same MSA or a contiguous MSA, they may qualify to be part of the same affiliated group if the hospitals are jointly listed for one or more programs in *Opportunities* as the sponsor or under the heading ''affiliations and outside rotations'' (413.86(b)).

Comment: One commenter stated that the American Osteopathic Association is requiring all accredited osteopathic GME programs to be part of an osteopathic postdoctoral training institution (OPTI) by July 1, 1999. There are several hospitals that are currently participating in an approved OPTI. The commenter was concerned that the OPTI is a consortium of providers and these consortia would not qualify as an affiliated group. The commenter recommended that HCFA recognize a formally organized osteopathic GME consortia without geographic limit. Further, the commenter stated that any affiliation should be recognized for aggregation purposes even if the hospitals are not in the same geographic wage area.

Response: We have reviewed materials regarding the OPTI concept from the American Osteopathic Association and note that an OPTI may include an ''associate institution'' that provides 6 months or more of training per year and an ''affiliate institution'' where less than 6 months of rotations per year are occurring. Since the OPTI concept is not yet fully implemented, we believe it would be premature to begin recognizing institutions which are part of an OPTI under the definition of affiliated groups for purposes of an aggregate FTE cap. However, we will continue to evaluate whether hospitals

participating in an OPTI could be part of an affiliated group, and we will specifically focus on the duration of rotations among hospitals within the OPTI in making this decision.

Comment: Several commenters stated that accreditation requirements mandated an increase in their hospital's FTE resident count due to the transfer of residents from a Veterans Affairs Medical Center or a Department of Defense facility. These commenters stated that an exception to the FTE cap should be allowed when a hospital's resident count increased in situations where the aggregate count of residents among the affiliated hospitals, including Veterans' Affairs Medical Centers, remains unchanged. Other commenters recommended that HCFA give program sponsors the ability to transfer residents from Veterans Affairs' hospitals to non-Veterans' Affairs hospitals.

Response: Sections 1886(d)(5)(B)(v) and (h)(4)(F) of the Act provide for FTE caps on the basis of a hospital's most recent cost reporting period ending on or before December 31, 1996. Section 1886(h)(4)(H) of the Act allows hospitals that are part of the same affiliated group to apply the FTE cap on an aggregate basis. Veterans' Affairs and Department of Defense hospitals do not have cost reporting periods for Medicare payment purposes and do not provide data on FTE resident counts to Medicare. We believe that hospitals that do not participate in Medicare should not be part of an affiliated group since the statute caps the number of residents based on the number of residents reported by the hospital in its Medicare cost reporting periods. In addition, hospitals that do not participate in Medicare do not submit cost reports to a fiscal intermediary; therefore, we would be unable to apply an aggregate FTE cap to an affiliated group that included these hospitals.

In summary, we are defining an affiliated group as follows:

- Hospitals in the same urban area or in contiguous urban areas which rotate residents to other hospitals of the group during the course of the program year;
- Hospitals located in the same rural area or in contiguous rural and urban areas that rotate residents to other hospitals of the group during the course of the program year; or
- Hospitals that are—

—Jointly listed as the sponsor, primary clinical site or major participating institution as those terms are used in the *Graduate Medical Education Directory* for one or more programs; or

—Jointly listed as the program sponsor or under affiliations and outside rotations in *Opportunities*, the directory of osteopathic graduate medical education programs; or

- Hospitals which are under common ownership.

b. Application of the FTE caps to an affiliated group. In the August 29, 1997 final rule, we addressed application of the FTE cap for hospitals which are members of the same affiliated group. Hospitals which qualify to be part of the same affiliated group may elect to have the individual FTE caps applied on an aggregate basis. This means that we would apply a cap to the group as a whole, and the cap for the group would equal the sum of the individual FTE caps for all hospitals that are part of the affiliated group. Indirect and direct graduate medical education payment would be based on hospital specific FTE counts under an aggregate FTE cap. In the August 29, 1997 final rule with comment period, we stated that the aggregate FTE cap for an affiliated group would be applied on an institution-wide basis. We recognize that hospitals may participate in many different speciality programs and may share residents for one specialty program with one hospital but share residents for a different program with another hospital, but we did not believe it would be administratively feasible to apply the FTE cap on a program by program basis. That is, the aggregate cap under the August 29, 1997 final rule with comment period would be the combined individual caps of each hospital that elects to be part of an affiliated group

Comment: One commenter stated that hospitals may have rotation relationships with a number of different hospitals. According to these commenters, aggregation of resident counts among all hospitals is not practical or feasible. Many commenters suggested that we should permit hospitals to aggregate resident numbers at the program level if the hospitals provide supporting documentation that the aggregate count of residents within the program remains unchanged. One commenter who supported affiliations at the program level stated that HCFA should require hospitals to report FTEs by program sponsor and include a separate count of each program on the Medicare cost report. Hospitals would have multiple FTE caps and would be responsible for reconciling each individual program cap with the intermediary. Several commenters stated that HCFA should allow affiliated hospitals to transfer programs and that each hospital's cap be adjusted based on a joint letter from the affected providers.

Response: As we stated in the August 29, 1997 final rule with comment period, we recognize that many hospitals may share residents for particular specialty programs. We stated that hospital affiliations must be on an institution-wide basis because of our concern about the administrative feasibility of allowing affiliations on a program-by-program basis. Although we continue to have concerns that program specific affiliations may generate enormous complexity in monitoring FTE resident counts for fiscal intermediaries and may impose significant documentation burdens on hospitals, we agree with the commenters that it would be appropriate for Medicare to accommodate agreements between individual hospitals for specific programs. A hospital could have an agreement with one hospital for a particular program and another hospital for a different program. An agreement between two hospitals does not mean only those hospitals are an affiliated group, if those hospitals also have agreements with other hospitals. Rather, the affiliated group includes the original two hospitals that have an agreement and every hospital that has an agreement with any of those hospitals. We will continue to apply the FTE cap on an aggregate basis for institutions that are part of an affiliated group. That is, we will combine the individual caps for each institution that has an agreement to be an affiliated group to verify that the sum total of the resident counts for all institutions does not exceed the aggregate cap. We will make payment to individual hospitals based on hospital specific FTE counts.

Each agreement must specify the adjustment to each hospital's FTE counts from the cost reporting period ending during calendar year 1996 for purposes of applying the aggregate FTE cap for the period of the agreement. The agreements must specify the adjustment to the IME and direct GME FTE counts separately since hospitals are subject to two different FTE counts for each respective cap. Since medical residency training programs generally follow a July 1 to June 30 residency training year, each agreement should specify adjustments to FTE counts on a 12-month basis from July 1 to June 30 of each year. The agreements must be for a minimum of one program year but may be for more than one year. A hospital will be permitted to engage in multiple agreements with different hospitals as illustrated below. For example, hospital A can have an agreement with hospital B for an

internal medicine program and another agreement with hospital C for emergency medicine. Although hospitals B and C do not have an agreement for any program, the affiliated group is A, B, and C, we will apply the cap on an aggregate basis for A, B, and C; that is the FTE resident counts at hospitals A, B, and C can not exceed the sum of the combined caps for the three hospitals.

If the combined FTE counts for hospitals A, B, and C does not exceed the aggregate cap, we will pay each hospital based on its hospital specific FTE count. If the combined FTE counts for hospitals A, B, and C exceed the aggregate cap, we need individual caps for each hospital in order to limit payment to the number of FTEs included under the aggregate FTE cap. In this situation, each hospital will be paid based on its actual FTE up to its individual FTE cap as adjusted per agreements. We will allow each respective institution's individual cap to reflect the adjustment per their individual agreements. However, we are requiring that agreements regarding application of the aggregate cap planned for the year be completed by the beginning of each residency training year (that is, July 1). The hospitals in the affiliated group may adjust the initial FTE counts by June 30 of each residency training year if actual FTE counts for the program year are different than projected in the original agreement.

If a hospital cost report does not correspond with a July 1 to June 30 residency training year, we will prorate the changes specified in the agreement to each hospital's FTE cap on the basis of a cost reporting period. In the example illustrated below, there is an agreement between hospitals A and B to allow hospital A an additional 10 residents that were previously included in hospital B's FTE count. Hospital B also has an agreement with hospital C to allow hospital B an additional five residents previously counted by hospital C. We are also assuming that these agreements are for two years. The aggregate FTE cap for hospitals A, B, and C will be the combined FTE cap for the these hospitals. For instance, if hospital A, B, and C each have an FTE cap of 100 residents, the aggregate cap will be 300 residents. The cap will be applied as follows per the planned changes assuming hospital A has a July 1 to June 30 cost reporting period and hospital B has a October 1 to September 30 cost reporting period and hospital C has a calendar year cost report:

Hospital	Cost reporting period	Planned change in FTE count (for 07/01–06/30)	Planned change for cost reporting period
Hospital A	07/01/98–6/30/99	+10 per agreement with B	+10.00
Hospital B	10/01/97–09/30/98	−10 per agreement with A	−2.50
	10/01/98–9/30/99		−10.00
Hospital B	10/01/97–09/30/98	+5 per agreement with C	+1.25
	10/01/98–09/30/99		+5.00
Hospital B (total)	10/01/97–09/30/98	−5 per total agreements	−1.25
	10/01/98–09/30/99		−5.00
Hospital C	01/01/98–12/31/98	−5 per agreement with B	−2.50
	01/01/99–12/31/99		−5.00

Since the agreements are effective July 1, 1998, the agreements are only in effect for 3 months or 25 percent of the year for hospital B's October 1, 1997 to September 30, 1998 cost report and the FTE reduction for the portion of the residency training year included in that cost report is a net −1.25 FTEs (−2.5 to 1.25) for agreements with hospitals A and C. The agreements are ongoing for the July 1, 1999 to June 30, 2000 residency training year and the adjustment to hospital B's cap is a net −5.0 FTEs for the October 1, 1998 to September 30, 1999 cost reporting period (effectively −3.75 for the October 1, 1998 to June 30, 1999 portion of the cost reporting period included in the residency training year and −1.25 for the July 1, 1999 to September 30, 1999 portion of the cost reporting period included in the residency training year). Similarly, a prorated portion of the FTE reduction for hospital C is included in the January 1, 1998 to December 31, 1998 cost reporting period for the agreement with hospital B. That is, the FTE reduction for the portion of the July 1, 1998 to June 30, 1999 residency training year included in hospital C's calendar year 1998 cost report is −2.5 FTE.

Since the agreement is ongoing for the July 1, 1999 to June 30, 2000 residency training year, there is a −5.0 FTE reduction for the calendar year 1999 cost report (effectively −2.5 for the January 1, 1999 to June 30, 1999 portion of the residency training year included in the cost report and −2.5 FTE for the July 1, 1999 to December 30, 1999 portion of the residency training year included in the cost report). If the group's actual FTE count exceeds the aggregate cap, which equals the combined individual caps for each hospital (hospitals A, B, and C in the example above), we will apply the individual FTE caps as adjusted per agreements. For instance, the combined individual caps for hospitals A, B, and C equals 300 residents. If the total number of residents for the cost reporting periods ending in 1999 for hospitals A, B, and C exceeds 300 residents, we will make payments to each hospital based on the individual cap as adjusted per agreements. Hospital A would be paid with a cap based on 110 residents (100 + 10) for its July 1, 1998 to June 30, 1999 cost reporting period. Hospital B would be paid based on a cap of 95 residents for its October 1, 1998 to September 30, 1999 cost reporting period. Hospital C would be paid based on 95 residents for its January 1, 1999 to December 31, 1999 cost reporting period. Each hospital that exceeds its individual cap after the adjustments per the agreements will be paid based on the methodology described in August 29, 1997 final rule with comment period (62 FR 46004 and 46005) and repeated in the table found in the Appendix to this final rule. That is, we will multiply the hospital's unweighted FTE cap (as adjusted per the agreements) by the ratio of the weighted to unweighted FTE's for the cost reporting period.

Each agreement must also specify the adjustment to each respective hospital cap in the event the agreement terminates, dissolves or, if the agreement is for a specified time period, for residency training years and cost reporting periods subsequent to the period of the agreement for purposes of applying the FTE cap on an aggregate basis. In the absence of an agreement on the FTE caps for each respective institution following the end of the

agreement, each hospital's FTE cap will be the indirect and direct medical education FTE count from each hospital's cost reporting periods ending in 1996 and the cap will not be applied on an aggregate basis. The net effect of adjustments to each hospital's FTE cap for each agreement must total zero on a program basis, as provided for in the above example. That is, if the agreement involves two hospitals, any positive adjustment for one hospital must be offset by a negative adjustment for the other hospital of at least the same amount.

We are allowing individual hospitals to enter into agreements with multiple hospitals, as illustrated above with hospital B. However, we are concerned about the administrative feasibility of monitoring the aggregate FTE caps under these agreements. The situation that concerns us is reconciling adjustments to FTE caps under an aggregate cap when the agreements involve hospitals with different fiscal intermediaries. For instance, in the situation where hospital A and hospital B are serviced by the same fiscal intermediary but hospital C has a different intermediary, hospitals A and B's fiscal intermediary will receive two agreements: one between hospital A and hospital B and one between hospital B and C. Hospital C's fiscal intermediary must receive the agreement between hospitals A and B as well as the agreement between hospitals B and C, for the adjustments to be reconciled in the aggregate. In the absence of the agreement between hospitals B and C, hospital C's fiscal intermediary would be unaware that a downward adjustment to hospital C's cap is required. In the absence of the agreement between hospitals A and B, hospital C's fiscal intermediary would be unable to reconcile the aggregate FTE cap between hospitals A, B, and C.

We believe the only way for aggregate FTE caps to be reconciled based on multiple agreements between hospitals is for each agreement to be sent to each hospital's fiscal intermediary. Attached to each agreement would be copies of other agreements that each hospital which is part of the original agreement has with other hospitals. This would require hospital A and B's fiscal intermediary to receive the agreements between hospitals A and B and hospitals B and C and any other hospitals which have agreements with those hospitals. Thus, if hospitals A, B, and C constitute the affiliated group, hospital A and B's fiscal intermediary would have to receive copies of the agreements between hospitals A and B and hospitals B and C. Hospital C's fiscal intermediary also would have to receive copies of the agreements between hospitals B and C and hospitals A and B. The original and subsequent agreements must include the provider number of each respective institution which is part of the agreement, signatures of each hospital representative, the date of the agreement, and the respective adjustment to each hospital's FTE cap for indirect and direct graduate medical education. Each agreement must indicate that copies are being sent to HCFA. Copies of the original agreement must be sent to: Division of Acute Care, C5–08–27, 7500 Security Boulevard, Baltimore, Maryland 21244. We will consider changes to the process described above if we find a less burdensome approach to reconciling individual FTE caps under aggregate caps.

We are establishing this process for application of an aggregate FTE cap pursuant to section 1886(h)(4)(H) of the Act, which states that the ''Secretary may prescribe rules which allow institutions which are members of the same affiliated group (as defined by the Secretary) to elect to apply'' the FTE caps on an aggregate basis. The statute provides the Secretary with broad authority to define what is an affiliated group and how to apply the FTE caps to members of that group and we are establishing the process described above under this broad authority. Our policy provides a mechanism to make payments to individual hospitals under an overall cap that is consistent with the caps of the individual hospitals included in the affiliated group. As we have stated earlier, although we have concerns about the ability to reconcile multiple agreements, we are providing this policy to allow hospitals that jointly participate in training the flexibility to change arrangements for training residents.

Comment: Some commenters stated that hospitals will not have incentives to form affiliated groups if one hospital will have to relinquish its FTEs included in its cap to another hospital. These commenters recommended that HCFA, through the aggregation rules, give program sponsors the ability to aggregate and then transfer residency positions between participating hospitals. Another commenter suggested that we consider allowing hospitals to aggregate FTEs at the level of the sponsoring institution. One commenter stated that medical schools that are not part of academic medical centers are at a particular disadvantage in assuring that they will be able to move their residents among affiliates.

Response: As we have stated previously, sections 1886(d)(5)(B)(v) and (h)(4)(F) of the Act limit the number of FTEs that hospitals can count for Medicare payment for indirect and direct GME, respectively. While Congress did extend authority to the Secretary to develop rules that allow hospitals that are part of the same affiliated groups to elect to apply the FTE cap on an aggregate basis, section 1886(h)(4)(H)(ii) of the Act states that ''institutions which are members of the same affiliated group'' may ''elect to apply the limitation of subparagraph (F) on an aggregate basis''. Since Medicare makes payment to hospitals and subparagraph (F) provides for the FTE cap on the basis of hospital cost reporting periods, we do not believe it would be appropriate to allow program sponsors that, as stated above, may or may not be hospitals to make decisions about hospital FTE caps for purposes of Medicare payment. Furthermore, participation in an affiliated group is voluntary. Even in situations where the program sponsor is a hospital, we believe it would be inappropriate to allow one hospital to make a decision about the application of individual FTE caps under an aggregate FTE cap, without the second hospital's agreement.

We recognize that hospitals may be reluctant to agree to lower individual FTE caps under an aggregate cap. However, the aggregate limit is a voluntary provision. Affiliation is an option that hospitals may ''elect,'' in accordance with rules established by the Secretary, to allow for the movement of residents among participating hospitals under an aggregate FTE cap.

Comment: One commenter stated that the IME resident-to-bed ratio and the FTE resident caps should be applied in the aggregate for institutions that are members of an affiliated group. The commenter believed that the application of the cap, as proposed, will have ''the unintended affect of discouraging multi-hospital and ambulatory site program configurations''. The commenter noted that there is no provision in the regulation which would allow an adjustment to the IME FTE and resident-to-bed ratio cap for affiliated groups.

Response: We agree that § 412.105 should reference § 413.86(g)(4) for purposes of applying the IME FTE cap on an aggregate basis. Section 412.105 should also be modified to reference § 413.86(g)(6) for purposes of adjusting the IME FTE cap for new medical residency training programs. We are including these references in § 412.105. However, we disagree that the intern and resident-to-bed ratio for an affiliated

group should be determined in the aggregate. Section 1886(h)(4)(H) of the Act gives the Secretary the authority to develop rules that allow affiliated hospitals to elect to apply the FTE caps on an aggregate basis. The statute applies the affiliation provision solely to the FTE cap.

Comment: One commenter requested that HCFA further clarify the aggregate adjustment to the caps for affiliated programs. The commenter asked how the aggregate cap would be calculated for an institution that has several GME programs but is affiliated with another institution for only one program. The commenter requested that HCFA provide several examples of aggregate limit calculations. One commenter asked whether, in determining the aggregate FTE resident count, affiliated hospitals will pool their total unweighted FTE count from their respective cost reports ending on or before December 31, 1996.

Response: We have provided more detailed information above on the application of the FTE caps for hospitals that are members of the same affiliated group.

Comment: Several commenters recommended that an adjustment be made for hospitals that jointly participated in a residency training program prior to December 31, 1996 and subsequently ended the arrangement. If a hospital ended a joint training agreement, the sponsor will have to find another training site but may not be able to find an alternative unless the FTEs of the previously affiliated hospital can be counted by the new hospital that affiliates with the sponsor. Similarly, one commenter suggested that a group of hospitals that is ''legally'' affiliated should be allowed to include the base year FTEs of all member hospitals in application of the cap, even if those hospitals are no longer involved in resident training and the programs are moved to other hospitals in the group. Another commenter stated that HCFA should apply both institutional and aggregate caps using a flexible methodology that recognizes changes in hospital clinical and teaching affiliations. This commenter stated that the application of the resident cap should be governed by a methodology that ensures fair and equitable treatment of providers whose resident counts change as a consequence of disaffiliation or other major programmatic changes. One commenter recommended that hospitals that disaffiliate have the option of determining the distribution of resident counts among each of the hospitals so long as the aggregate limit is not exceeded. If hospitals cannot reach an agreement, limits could be based on their respective base year resident counts.

Response: Hospitals that no longer have a relationship for training residents do not meet the criteria for being members of the same affiliated group even if those hospitals jointly participated in residency training in the past. The criteria for being members of the same affiliated group are intended to recognize that hospitals which have relationships for training residents need flexibility in those arrangements under an aggregate FTE cap. If hospitals no longer have a relationship for training residents, we do not believe there is a need for this same flexibility. We recognize there are situations where the sponsor of a training program terminated its relationship for training residents with a hospital after 1996 and, as a result, there may be fewer FTE residents that may be counted for indirect and direct graduate medical education payment purposes. However, this is a direct result of the Balanced Budget Act which specifically required FTE caps to be based on 1996 FTE counts.

Comment: One commenter requested instructions on how hospitals should apply to be part of an affiliated group.

Response: As stated above, hospitals seeking to receive payments as an affiliated group must provide agreements specifying adjustments to FTE caps by July 1 of each year for the contemporaneous residency training year.

In summary, we will apply the FTE caps for an affiliated group as follows:

- Hospitals that qualify to be members of the same affiliated group for the current residency training year and elect an aggregate cap must provide an agreement to the fiscal intermediary and HCFA specifying the planned changes to individual hospital counts under an aggregate FTE cap by July 1 for the contemporaneous (or subsequent) residency training year.
- Each agreement must be for a minimum of one year and may specify the adjustment to each respective hospital cap under an aggregate cap in the event the agreement terminates, dissolves or, if the agreement is for a specified time period, for residency training years and cost reporting periods subsequent to the period of the agreement. In the absence of an agreement on the FTE caps for each respective institution following the end of the agreement, each hospital's FTE cap will be the IME and direct GME FTE count from each hospital's cost reporting periods ending in 1996.
- Each agreement must specify that any positive adjustment for one hospital must be offset by a negative adjustment for the other hospital of at least the same amount.
- The original agreements must be signed and dated by representatives of each respective hospital that is a party to the agreement and that agreement must be provided to the hospital's fiscal intermediary with a copy to the HCFA. Copies of agreements that each hospital which is part of the original agreement has with other hospitals must also be attached.
- Hospitals that provided an earlier agreement for planned changes in hospital FTE counts may provide a subsequent agreement on June 30 of each year modifying the agreement for applying the individual hospital caps under an aggregate FTE cap.

If the combined FTE counts for the individual hospitals that are members of the same affiliated group do not exceed the aggregate cap, we will pay each hospital based on its hospital specific FTE count. If the combined FTE counts for the individual hospitals that are members of the same affiliated group do not exceed the aggregate cap, we will pay each hospital based on its FTE cap as adjusted per agreements.

O. Payment to Managed Care Plans for Graduate Medical Education

Section 4624 of the BBA amended section 1886(h)(3) of the Act to provide a 5-year phase-in of payments to teaching hospitals for GME associated with services to Medicare managed care discharges for portions of cost reporting periods occurring on or after January 1, 1998. The amount of payment is equal to the product of the per resident amount, the total weighted number of FTE residents working in all areas of the hospital (and nonhospital settings in certain circumstances) subject to the limit on number of FTE residents under section 1886(h)(4)(F) and the averaging rules under section 1886(h)(4)(G) of the Act, the ratio of the total number of inpatient bed days that are attributable to Medicare managed care enrollees to total inpatient days, and an applicable percentage. The applicable percentages are 20 percent in 1998, 40 percent in 1999, 60 percent in 2000, 80 percent in 2001, and 100 percent in 2002 and subsequent years.

In the August 29 final rule with comment period, we revised § 413.86(d)(2) to establish a 5-year phase-in payment methodology to hospitals for direct GME payments based on Medicare managed care enrollees for portions of cost reporting

periods beginning on or after January 1, 1998.

Section 4001 of the BBA adds section 1853(a)(3)(C) of the Act. New section 1853(a)(3)(C) requires the Secretary to implement a risk adjustment methodology that accounts for variations in per capita costs based on health status and other demographic factors in Medicare payments to managed care organizations by no later than January 1, 2000. The BBA also added section 1853(a)(3)(B) of the Act to require the Secretary to collect data necessary from managed care organizations to implement this provision.

Comment: One commenter supported using teaching hospitals, not managed care plans, as the source of statistics for indirect and direct GME payments for Medicare managed care beneficiaries. This commenter also supported including payments for Medicare managed care beneficiaries in periodic interim payments (PIP) made to hospitals because of the current lengthy delays in receiving payments from managed care organizations. Another commenter supported careful implementation of this provision and expressed particular concern about identifying and verifying managed care patients days and discharges. One commenter stated that HCFA should use data from ''no pay'' claims from hospitals to make GME payments for Medicare managed care beneficiaries. This commenter had strong concerns that an alternate claims submission and reporting mechanism which relies upon managed care entities to submit DRG and related patient information is fraught with potential problems which will likely affect data integrity and cash flow. One commenter suggested that HCFA utilize the expertise available in the hospital field to develop an administratively simple and low-cost mechanism to make GME payments to hospitals for Medicare managed care patients.

Response: As we stated in the final rule with comment published on August 29, 1997, section 4001 of the BBA requires the Secretary to implement a risk adjustment methodology that accounts for variations in per capita costs based on health status and other demographic factors in Medicare payments to managed care organizations. Section 1853(a)(3)(B) requires the Secretary to collect the necessary data to implement the provision. Under section 4622 and 4624 of the BBA, teaching hospitals may receive indirect and direct GME payments associated with Medicare+Choice discharges. Since publication of the final rule with comment on August 29, 1997, we have consulted with hospitals, managed care plans, and fiscal intermediaries for purposes of developing a process to implement these provisions.

We anticipate teaching hospitals will need to submit claims associated with Medicare+Choice discharges to the fiscal intermediaries for purposes of receiving indirect and direct medical education payments. When the claims are processed, the fiscal intermediaries will make the IME payment associated with a Medicare+Choice discharge directly to the teaching hospital. Teaching hospitals will also be required to submit bills associated with Medicare+Choice organizations to the managed care plans. The inpatient encounter data from these bills will be submitted by the managed care plans to HCFA for purposes of implementing the risk adjustment methodology. The fiscal intermediaries should revise interim payments to reflect the Medicare direct GME payment associated with Medicare+Choice discharges. However, until the fiscal intermediaries have more experience with paying hospitals for direct GME associated with Medicare+Choice discharges, we believe the fiscal intermediaries will have limited data upon which to base interim payment. We are making adjustments to the Medicare cost report to allow for settlement of the cost report reflective of direct GME payment associated with Medicare+Choice discharges.

P. Payment to Nonhospital Providers

Under section 4625 of the BBA, for cost reporting periods beginning on or after October 1, 1997, the Secretary is authorized but not required to establish rules for payment to ''qualified nonhospital providers'' for the direct costs of medical education incurred in the operation of an approved medical residency training program. Under the statute, qualified nonhospital providers include Federally Qualified Health Centers, Rural Health Clinics, Medicare+Choice organizations and such other nonhospital providers the Secretary determines to be appropriate. We invited comments on how to implement this provision, particularly on how to determine appropriate payment for ambulatory sites.

We recently published a proposed rule to implement section 4625 of the BBA.

Q. Payment for Combined Medical Residency Training Programs

1. Initial Residency Period

Under § 413.86(g)(2) residents within an initial residency period are weighted as 1.0 FTE for purposes of the direct GME payment. Section 413.86(g)(3) requires residents beyond the initial residency period to be weighted as 0.5 FTE for purposes of determining GME payment. The initial residency period is defined as the minimum number of years required to become board eligible in specialty and is determined at the time a resident enters a medical residency training program. In the August 30, 1996 final rule (61 FR 46211), we clarified that the initial residency period for residents in combined medical residency training programs is limited to the time required to complete the longer of the composite programs.

Effective for residents in or beginning training on or after July 1, 1997, section 4627 of the BBA amended section 1886(h)(5)(G) of the Act to require that for combined programs consisting only of primary care training, the initial residency period equals the longer of the composite programs plus one year. A primary care resident is a resident enrolled in an approved medical residency training program in family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, or osteopathic general practice. This provision also added one year to the initial residency period for combined primary care and obstetrics and gynecology programs. In the August 29 final rule with comment period, we amended § 413.86(g)(1) to implement the provisions of section 1886(h)(5)(G).

Comment: One commenter sponsors a dual program in Family Practice/Osteopathic Manipulative Medicine and noted that it was not recognized in the regulations as a combined primary care residency program that is eligible for an additional year in the initial residency period limit under the special rule for combined primary care medical residency programs.

Response: Section 1886(h)(5)(H) defines primary care resident to mean a resident enrolled in an approved medical residency training program in family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, or osteopathic general practice. Since osteopathic manipulative medicine is not included in the definition of a primary care resident, the special rule for primary care combined programs does not apply.

2. Effective Dates

Comment: One commenter stated that the effective dates for IME and direct GME are inconsistent; one is ''effective for discharges on or after October 1, 1997'' while the other is for ''cost reporting periods on or after October 1, 1997''.

Response: We have received a number of questions regarding the effective dates for the provisions of the BBA related to GME. Section 4621(b) of the BBA, which amended section 1886(d)(5)(B)(v)of the Act to establish the FTE cap for the indirect medical education adjustment, is effective for discharges occurring on or after October 1, 1997. The cap on the intern and resident to bed ratio mandated by section 1886(d)(5)(B)(vi) (as amended by section 4621(b) of the BBA) is effective beginning with the hospital's first cost reporting period occurring on or after October 1, 1997. Section 4623 of the BBA establishes the FTE cap for direct graduate medical education and is effective beginning with a hospital's first cost reporting period beginning on or after October 1, 1997.

3. Accrediting Body Reference

Comment: One commenter recommended that we revise our regulations to indicate that the accrediting body for dental residencies is the Commission on Dental Accreditation rather than the Council on Dental Education.

Response: We are amending § 415.152 to reflect this comment.

R. Special Categories of Excluded Hospitals (§ 412.23)

Section 4417(b) of the BBA allows certain hospitals with an average length of stay of less than 25 days to be excluded from the prospective payment system as a long-term care hospital. In order to be excluded under this provision, a hospital must have first been excluded as a long-term care hospital in calendar year 1986, have an average inpatient length of stay of greater than 20 days, and demonstrate that 80 percent or more of its annual Medicare inpatient discharges in the 12-month cost reporting period ending in Federal fiscal year 1997 have a principal diagnosis that reflects a finding of neoplastic disease. We revised § 412.23(e) to implement this provision.

Section 4418 of the BBA provides an additional category of hospitals that can qualify as cancer hospitals for purposes of exclusion from the prospective payment system. As amended, section 1886(d)(1)(B)(v) of the Act includes a hospital that meets the following criteria:

- The hospital was recognized as a comprehensive cancer center or clinical cancer research center by the National Cancer Institute of the National Institutes of Health as of April 20, 1983.
- The hospital must have applied for and been denied, on or before December 31, 1990, classification as a cancer hospital.
- The hospital was licensed for fewer than 50 acute care beds as of the date of enactment of this subclause (that is, August 5, 1997).
- The hospital is located in a State that, as of December 19, 1989, was not operating a demonstration project under section 1814(b) of the Act.
- The hospital demonstrates that, for the 4-year period ending on December 31, 1996, at least 50 percent of the hospital's total discharges have a principal finding of neoplastic disease; that is, the discharge has a principal diagnosis code of 140–239, V58.0, V58.1, V66.1, V66.2, or 990.

A hospital that meets these criteria is classified as an excluded cancer hospital for cost reporting periods beginning on or after January 1, 1991. In addition, for purposes of payment, the base period applicable to such a hospital is the hospital's cost reporting period beginning during FY 1990 or the period under new section 1886(b)(3)(F) of the Act. In the August 29 final rule with comment period, we revised the regulations at § 412.23(f) to incorporate this provision.

We received no public comments on these revisions.

S. Payment of Hospitals and Units Excluded from the Prospective Payment System (§ 413.40)

The BBA significantly altered the payment provisions for excluded hospitals and units. Prior to the passage of the BBA, the payment provisions for excluded hospitals and units applied consistently to all categories of excluded providers (that is, psychiatric, rehabilitation, long-term care, children's, and cancer). However, effective for cost reporting periods beginning on or after October 1, 1997, there are specific payment provisions for psychiatric, rehabilitation, and long-term care providers, and modifications to payment provisions for all excluded providers. We received 19 comments on our implementation of the BBA provisions for PPS-excluded hospitals and units. Below we discuss the statutory and regulatory provisions (see 62 FR 46016 through 46020), as well as our comments and responses.

1. Rate-of-Increase Percentages for Excluded Hospitals and Units (§ 413.40(c) and (g))

Section 4411 of the BBA amended section 1886(b)(3)(B) of the Act regarding the rate-of-increase percentages to be applied to target amounts. The applicable rate-of-increase percentage for the cost reporting period beginning during FY 1998 is 0 percent. For cost reporting periods beginning in FY 1999 through FY 2002, the applicable rate-of-increase percentage is the market basket rate of increase percentage minus a factor based on the percentage by which the hospital's operating costs exceed the hospital's ceiling for the most recent cost reporting period for which information is available.

Comment: One commenter requested that we clarify the data needed to calculate the applicable rate-of-increase percentages under section 4411(b).

Response: Under section 1886(b)(3)(B)(vi) of the Social Security Act, as added by section 4411 of the BBA, the update factor for a given cost reporting period is determined by comparing the hospital's allowable costs ''for the most recent cost reporting period for which information is available'' to the hospital's target amount ''for such cost reporting period.'' In the August 29, 1997 final rule with comment period, we provided four examples of the calculation of the applicable rate-of-increase percentages for cost reporting periods beginning in FY 1999. These examples reflect the information necessary to compute the applicable rate-of-increase percentages. The fiscal intermediary will compute the applicable rate-of-increase before the beginning of each cost reporting period, using the most recent cost report data.

2. Request for a new base period (§ 413.40(b))

Sections 4413(a) and 4413(b) of the BBA amended sections 1886(b)(3) of the Act in order to permit excluded hospitals and units to elect (''in a form and manner determined by the Secretary'') a rebasing of the target amount for the 12-month cost reporting period beginning during FY 1998 (October 1, 1997 through September 30, 1998).

Comment: One commenter argued that, if an excluded hospital or unit does not request a new base period under the new statutory payment methodologies of sections 4413(a) and (b), the hospital should nevertheless be permitted to obtain a new base period at any time pursuant to the previously published regulation at § 413.40(i) and to receive

payments under the payment methodology of the new statutory provision. Another commenter asserted a hospital should be allowed to choose the five cost reporting periods for calculating a rebased FY 1998 target amount per discharge, in order to reflect expected cost report reopenings.

Response: Under sections 4413(a) and (b) of BBA, an excluded hospital or unit may elect rebasing and receive a revised target amount for the hospital's 12-month cost reporting period beginning during FY 1998 (October 1, 1997 through September 30, 1998). As indicated in the August 29 final rule with comment period, this is a one time option (for FY 1998 only). If a hospital does not elect rebasing for the cost reporting period beginning during fiscal year 1998, it cannot elect rebasing at a later date for a later cost reporting period.

With regard to the suggestion of the commenter that we allow hospitals to choose which cost reports to use to calculate a rebased target amount, the statute requires the Secretary to use the five ''most recent settled cost reports as of the date of enactment'' of the BBA (August 5, 1997).

Comment: Three commenters believe that the timeframe for requesting a new base period under section 4413 is unduly short, arguing that the required information is difficult to obtain. One commenter suggested the timeframe be extended to 90 days after the beginning of the cost reporting period beginning in FY 1998.

Response: In the August 29 final rule with comment period, we stated that a hospital that elects rebasing must submit its request for rebasing by the later of November 1, 1997 or 60 days prior to the beginning of its cost reporting period beginning during FY 1998. We believe that this is a reasonable timeframe for a hospital to elect rebasing. The information required for an election includes the hospital's name, provider number, cost reporting period, and the cost per case from the hospital's five most recent settled cost reports. All of this information should be readily available to the hospital.

A hospital's target amount for a cost reporting period should be established before the beginning of the cost reporting period, so that, among other things, the hospital can appropriately structure its costs within the target amount. Due to the extremely short timeframe between the enactment of the BBA and the beginning of FY 1998, we established a special rule to address hospitals whose cost reporting periods begin early in FY 1998. As noted above, we believe our timeframes are reasonable and that is not necessary or appropriate to extend the timeframes.

Comment: One commenter asked that we further clarify the calculation of the disproportionate share percentage to determine whether a long-term care hospital is eligible for rebasing under section 4413(b) of the BBA.

Response: Under the statute, a long-term care hospital may elect rebasing under section 4413(b) of the BBA if, among other things, ''the hospital would have a disproportionate patient percentage of at least 70 percent (as determined by the Secretary under subsection (d)(5)(F)(vi)) if the hospital were a subsection (d) hospital.'' As stated both in the preamble of the final rule (62 FR 46018) and at § 413.40(v) of the regulation text (62 FR 46032), the calculation of the disproportionate patient percentage is addressed at § 412.106 of the Medicare regulations. Fiscal intermediaries are familiar with the calculation of the disproportionate patient percentage and can assist a long-term care hospital if necessary.

3. Limitation on the Target Amount for Excluded Hospitals and Units (§ 413.40(c))

Section 4414 of the BBA amended section 1886(b)(3) of the Act to establish caps on the target amounts for excluded hospitals or units for cost reporting periods beginning on or after October 1, 1997 through September 30, 2002. The statute directs the Secretary to calculate ''the 75th percentile of target amounts'' for three classes of hospitals—psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals—for ''cost reporting periods ending during fiscal year 1996.''

Similarly, section 4416 of the BBA (discussed further below) establishes a new statutory payment methodology for new excluded hospitals. To determine payments for a new excluded hospital, the statute directs the Secretary to calculate ''110 percent of the national median of target amounts for hospitals in the same class as the hospital for cost reporting periods ending during fiscal year 1996.'' The amount calculated in section 4416 is updated and adjusted for differences in area wage levels, and the resulting figure is a limit on payments for the new hospital or unit.

Thus, sections 4414 and 4416 both direct the Secretary to examine target amounts for three classes of hospitals for cost reporting periods ending during FY 1996. However, section 4416, unlike section 4414, requires that the calculation applicable to new hospitals reflect an adjustment for differences in area wage levels.

The 75th percentile of the target amounts for cost reporting periods ending during fiscal year 1996, as updated by the market basket up to FY 1998 (as corrected in a correction notice published March 6, 1998 (63 FR 11148)) are as follows:

(1) Psychiatric hospitals and units: $10,534
(2) Rehabilitation hospitals and units: $19,104
(3) Long-term care hospitals: $37,688

In the August 29, 1997 final rule with comment period, we stated that if a hospital has a target amount that is capped at the 75th percentile, the hospital would not be granted an exception payment as governed by §§ 413.40(a) and (g) based solely on a comparison of its costs or patient mix in its base year to its costs or patient mix in the payment year would be irrelevant. However, exception payments would still be available for hospitals that have target amounts that are determined by the hospital's costs in a base year and are unaffected by the 75th percentile cap.

Comment: One commenter suggested that § 413.40(c)(4)(iii) of the regulations be modified to clarify that in the case of a psychiatric hospital or unit, rehabilitation hospital or unit, or long-term care hospital, the target amount for FYs 1998 through 2002 is equal to the lower of—

- The hospital specific target amount (the net allowable costs in a base period increased by the update factor for the subject period); or
- The 75th percentile of target amounts for hospitals in the same class (psychiatric hospital or unit, rehabilitation hospital or unit, or long-term care hospital) for cost reporting periods ending during FY 1996, increased by the applicable market basket percentage for the subject period.

Response: We agree with the commenter and are modifying § 413.40(c)(4)(iii) to incorporate this clarification.

Comment: Five commenters argued that section 4414 requires the Secretary to estimate, but not implement, caps using the 75th percentile of the target amounts for psychiatric and rehabilitation hospitals or units, and long-term care hospitals. One commenter asserted that the Secretary should have waited for additional legislation to implement caps on the target amounts and then independently determine whether to implement in light of the impacts of other provisions of the BBA.

Response: The title of section 4414 of the BBA is ''Cap on the TEFRA limits.'' The Conference Report indicates that

the provision limits, or caps, target amounts for hospitals excluded from PPS. The statute requires us to calculate a cap for cost reporting periods beginning during fiscal year 1998, and requires updates to the caps for cost reporting periods beginning during fiscal years 1999 through 2002. We do not believe the Congress intended that we calculate these numbers but not apply them as a cap. Moreover, since the statute requires us to calculate a cap for cost reporting periods beginning during fiscal year 1998, we do not believe the application of the caps should be delayed until subsequent years.

Comment: Two commenters believe the payment caps on target amounts for rehabilitation hospitals and units and long-term care hospitals under section 4414 and section 4416 are not correct because separate caps were not established within each class of excluded hospital (in particular rehabilitation and long-term care hospitals) to reflect hospitals specializing in the treatment of high cost patients, such as a rehabilitation unit which specializes in treating Medicare patients with spinal cord injuries.

Response: Section 4414 provides that, ''In the case of a hospital or unit that is within a class of hospital described in clause (iv), the Secretary shall estimate the 75th percentile of the target amounts *for such hospitals within such class* * * *.'' Similarly, section 4416 provides that ''in the case of a hospital or unit that is within a class described in subparagraph (B) which first receives payments under this section on or after October 1, 1997,'' the amount of payment is based in part on ''110 percent of the national median of the target amount *for hospitals in the same class as the hospital* * * *.'' Both statutory provisions list three classes of hospitals and indicate that each ''shall be treated as a separate class of hospitals.'' We believe the best reading of the statutory language is that we calculate the caps for each class of hospital as a whole. If a hospital chooses to subspecialize in high cost patients, it will need to consider the impacts the caps on the target amounts will have on its reimbursement.

Comment: Four commenters believed the caps on the target amounts that were calculated under section 4414 are not correct because discharge weighting and wage adjustments were not applied to the FY 1996 target amounts in determining the 75th percentile caps on the target amounts.

Response: The statute directs the Secretary to ''estimate the 75th percentile of the target amounts'' for three classes of hospitals. Section 4414 does not direct the Secretary to estimate the 75th percentile of discharge-weighted target amounts.

Several commenters contended that we should implement a wage adjustment in applying the caps for individual hospitals. Under such a wage adjustment, the hospitals within a class of hospitals would be capped at different numbers, reflecting different wage adjustments for different geographic areas. Implementation of a wage adjustment would adversely affect some hospitals. In the August 29 final rule with comment period, we calculated the caps without wage adjustments. We continue to believe that our methodology for establishing the caps reflects the best interpretation of the statute. As discussed below, we believe that the statutory language, the statutory scheme, and the legislative history, viewed together, strongly argue against making a wage adjustment in applying the TEFRA caps.

Section 1886(b)(3)(H)(i) of the Act, as added by section 4414 of the BBA, states that, ''In the case of a hospital or unit that is within a class of hospital described in clause (iv), the Secretary shall estimate the 75th percentile *of the target amounts for such hospitals within such class for cost reporting periods ending during fiscal year 1996*.'' (Emphasis added.) Clause (iv), in turn, lists three classes of hospitals and indicates that each ''shall be treated as a separate class of hospital.'' Thus, the statute directs the Secretary to examine target amounts in a prior period and to calculate a single number—the 75th percentile of those target amounts—for each of three classes of hospitals.

Pursuant to this mandate, we examined the best available data to identify hospitals within each class of hospitals for the cost report period ending during fiscal year 1996, to identify those hospitals that were actually subject to a target amount for the cost reporting period ending during fiscal year 1996, and to determine the target amounts for those hospitals. We then calculated the 75th percentile of those target amounts for each class. Thus, we did exactly what the statute directs us to do.

The statutory language directs the Secretary to calculate the 75th percentile of target amounts, but it does not explicitly direct or even authorize the Secretary to make adjustments to that number after the number is calculated. Contrary to the belief of some commenters, our decision not to implement a wage adjustment is not based solely on the fact that the statute does not explicitly require one. We agree that the absence of an explicit instruction, in and of itself, does not necessarily mean that the Secretary cannot implement a wage adjustment. However, congressional ''silence'' on this issue must be construed in light of the statutory scheme and the legislative history, as well as policy considerations.

Two aspects of the statutory scheme argue against making a wage adjustment in applying the caps. First, as discussed above, section 4414 requires us to calculate a separate number for each class of hospitals. Congress has established a scheme which directs us to recognize differences across types of hospitals, but does not direct us to recognize differences in wages. If we were to calculate numbers as directed by Congress, and then adjust those numbers for factors that the Congress did not address, we would arguably undermine the scheme established by the Congress.

In addition to the ''scheme'' of section 4414 itself, one should also consider section 4414 in light of the other statutory provisions. Several commenters have pointed out that in several other statutory provisions the Congress did explicitly require a wage adjustment. We agree that this is significant, but unlike the commenters we believe it argues *against* making a wage adjustment in this context. We concluded that, because the Congress explicitly requires wage adjustments in some contexts, congressional failure to require a wage adjustment in this context reflects a judgment by the Congress that the agency should not make one here.

In addition to the statutory text and scheme, the legislative history also supports a single cap applied to all hospitals within each class of hospitals. The Conference Report indicates that, under the House Bill, a target amount for a PPS-exempt hospital ''could not be greater than the 90th percentile of the target amounts for cost reporting periods beginning during that fiscal year.'' This language indicates that all hospitals within a class would be capped at a single number (the 90th percentile). The Conference Report indicates that the Senate Amendment contained a similar provision ''except that the target amount could not be greater than the 75th percentile of the target amount for each class of hospitals.'' Again, this language indicates that all hospitals within a given class would be capped at the same number (in this case, the 75th percentile rather than the 90th percentile).

The Conference Report then indicates that ''[t]he conference agreement includes the House bill, with

amendments. The Secretary would be required to estimate the 75th percentile of the target amounts for each category of hospitals * * *.'' There is no reference anywhere in the Conference Report to a wage adjustment to the TEFRA caps.

Thus, we believe the statutory text, the statutory scheme, and the legislative history all support a cap that is not adjusted for wages. None of these factors by itself is necessarily dispositive, but taken together, we believe the best interpretation of the statute is that we should not make a wage adjustment.

While from a broad policy perspective a wage adjustment might be appropriate, policy considerations do not dictate a wage adjustment. While a wage adjustment might be preferable policy, the lack of a wage adjustment is not unreasonable. Congress could reasonably have made a judgment that all hospitals within a class should be subject to the same cap, whether for administrative ease, budgetary considerations, or some other reason.

Some commenters argue that failure to make a wage adjustment is inconsistent with other Medicare payment policies. But a payment *cap* is different from a payment *rate*. A payment cap does not affect every hospital, only hospitals that are above the cap. Therefore, a wage adjustment is less imperative in this context. And one could reasonably conclude that the Congress made a judgment that the 75th percentile reflects a reasonable cap regardless of geographic area. Although we believe implementation of the cap without a wage adjustment represents the best reading of the statute, we believe that accounting for area wage differences is an appropriate policy and would support a hospital sponsored legislative change. We would work with Congress to develop such a policy and its ramifications.

Taking into consideration the statutory language, the statutory scheme, and the legislative history, we believe the best reading of the statute enacted by the Congress is that we should calculate a single number for hospitals within each class and not apply a wage adjustment. We believe that, in any event, the Secretary's policy is consistent with the statute and is reasonable.

Comment: Three commenters objected to the data we used to calculate the caps on the target amounts for long-term care hospitals under section 4414. Six commenters objected to the data we used to calculate 110 percent of the national median of target amounts for long-term care hospitals under section 4416. The commenters asserted that the data set used to compute the cap incorrectly excluded hospitals, incorrectly included hospitals, and reflected inaccurate 1996 target amounts for Medicare certified long-term care hospitals. One commenter recommended that the caps on target amounts for long-term care hospitals be recalculated from ''time to time'' to reverify the data.

Response: As explained in the final rule with comment period (62 FR 46018), we developed the caps on the target amounts using the best available data to identify hospitals in each class that were subject to a target amount and to determine the target amounts for those hospitals. We verified the data to the extent possible during the extraordinarily short timeframe between the enactment of the BBA (August 5, 1997) and the required publication date of the final rule (August 29, 1997).

The commenters contended that the data we used to calculate the caps was faulty. First, they argue that we incorrectly excluded 20 hospitals that were subject to a target amount in 1996 from the calculation of the new hospital cap. We have determined that this argument is largely erroneous. In fact, 16 of these 20 hospitals were new hospitals in their exemption period during 1996; these hospitals were exempt from the target amount system and were not subject to a target amount in their cost reporting period ending during FY 1996. The statute directs us to calculate the 75th percentile ''of target amounts,'' so these hospitals were correctly excluded from the calculation.

Of the remaining four hospitals, two hospitals became PPS hospitals during or after FY 1996 but did have a target amount for the cost reporting period ending in FY 1996. When we were developing the August 29, 1997 rule, we believed that the two remaining hospitals were in their exemption period during FY 1996, but in light of the comments, we have determined that these hospitals were subject to a target amount during their cost reporting period ending during FY 1996. As discussed further below, we are revising the caps (prospectively) to reflect the target amounts for these four hospitals.

The commenters also asserted that the Secretary has the discretion to include an additional 15 target amounts for long-term care hospitals that were in their exemption period for the cost reporting period during FY 1996. The commenters argue that the cost reporting period ending during FY 1996 serves as the base period for these hospitals and thus the Secretary should include the data for these hospitals in the 110 percent of the median calculation. Based on the comments, we reexamined these hospitals and confirmed that these 15 hospitals were in their exemption period for the cost reporting period ending during FY 1996. If a hospital was within its exemption period, it was not subject to a target amount for the cost reporting period ending in FY 1996, whether or not that period was ultimately used as the hospital's base period for calculating the target amount for future years. Since the statute directs us to examine ''target amounts,'' the data for these hospitals were properly excluded from the calculations.

The commenters also contended that we inappropriately included hospitals with an average length of stay of less than 25 days in the 110 percent of the median calculation. Under the statute, a hospital may be excluded as a long-term hospital if its average length of stay is greater than 25 days. Under our implementing regulations, a hospital qualifies to be paid as a long-term care hospital for a given cost reporting period if its average length of stay for a prior period is greater than 25 days. Therefore, a hospital may be classified as a long-term care hospital for a given cost reporting period even if its average length of stay for that period ultimately turns out to be less than 25 days.

The hospitals cited by the commenters were classified as long-term care hospitals for the cost reporting period ending during FY 1996, and were paid under the target amount methodology. Accordingly, these hospitals were properly included in the calculations.

Thus, the commenter's assertions regarding our data were largely erroneous. Nevertheless, in light of the information that is now available to us, including information in the public comments, we are revising the calculations. We are revising the 110 percent of the median calculation to include the target amounts for the two hospitals described earlier that converted to PPS after the cost reporting ending during FY 1996, and the target amounts for the two hospitals that we originally believed to be in the exemption period in FY 1996. The target amounts for these hospitals appropriately should be included in the 110 percent of the median and 75th percentile calculation. The addition of these data did not change the 75th percentile calculation. We are also including the target amounts for three hospitals which were previously excluded because of a lack of wage index data. The target amounts for these three hospitals were already included in the 75th percentile calculation because

a lack of wage index data did not impact the calculation of the 75th percentile cap.

As a result of these revisions, the updated 110 percent of the national median target amounts for new long-term care hospitals is $21,494 for FY 1998. The labor-related share is $15,380 and non labor-related share $6,114.

We are applying these revised caps prospectively. For a new long-term care hospital whose cost reporting period began prior to the effective date of this final rule, the revised calculations would apply to the portion of the cost reporting period that occurs after the revision becomes effective. We note that these revised caps shall be the basis for the caps applicable for future cost reporting periods.

We are making a one-time mid-year revision to the caps because of the extraordinary circumstances presented by the timing of the enactment of the BBA. We do not agree with the commenter who argued that the caps on target amounts for long-term care hospitals should be recalculated from ''time to time'' in order to reverify the data. The statute provides that the cap in a future year shall be determined by taking the cap for the previous year and applying an update factor.

Comment: One commenter disagreed with the elimination of exception payments for a hospital with a target amount that was capped.

Response: Section 4414 of the BBA establishes a cap, that is, a limit, on the target amounts for rehabilitation hospitals and units, psychiatric hospitals and units, and long-term care hospitals. Generally, we believe it would be anomalous to set a cap on a hospital's target amount and then grant the hospital an exception so that it could receive payments above the cap.

4. Bonus and Relief Payments (§ 413.40(d))

a. Bonus payments. Section 4415 of the BBA 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 a bonus payment is the lower of the following:

(1) 15 percent of the difference between the inpatient operating costs and the ceiling, or

(2) 2 percent of the ceiling.

In addition, section 4415 of the BBA amended section 1886(b)(2) of the Act to provide for ''continuous improvement bonus payments'' for hospitals that meet certain criteria.

b. Relief payments. Section 4415 of the BBA amended section 1886(b)(1) of the Act to provide that for cost reporting periods beginning on or after October 1, 1997, if a hospital's operating costs are greater than the ceiling but less than 110 percent of the ceiling, payment will equal the ceiling. If a hospital's costs are greater than 110 percent of the ceiling, payment will equal the ceiling plus 50 percent of the costs in excess of 110 percent of the ceiling. Total payment may not exceed 110 percent of the ceiling. Because section 4415 of the BBA does not provide relief for costs that are within 110 percent of the ceiling, we made a corresponding change to the exception payment provision at § 413.40(g)(1) so that qualification for the amount of an exception payment does not encompass costs within 110 percent of the ceiling.

We received no public comments on this corresponding change.

5. New Excluded Hospitals and Units (§ 413.40(f))

With the enactment of sections 4416 and 4419 of the BBA, which amended section 1886(b)(4) of the Act and added section 1886(b)(7) of the Act, Congress established a new framework for payments for new excluded providers. First, section 4419(a) amended section 1886(b)(4)(A)(i) of the Act, to eliminate ''exemptions'' for all classes of excluded entities except children's hospitals. Second, section 4416 added a new section 1886(b)(7) of the Act to establish a new statutory payment methodology for psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals which first receives payments on or after October 1, 1997. For these hospitals, the amount of payment for each of the first two cost reporting periods is the lesser of (1) the operating costs per case, or (2) 110 percent of the national median of target amounts for the same class of hospitals for cost reporting periods ending during FY 1996, updated to the first cost reporting period and adjusted for differences in area wage levels. The target amount for the succeeding cost reporting periods will be based on the payment amount in the second 12-month cost reporting period increased by the applicable update factors.

Comment: One commenter requested clarification as to whether the 6-month qualification period, during which a long-term care hospital demonstrates an average length of stay of greater than 25 days, will be included as part of the 2-year exemption period for new excluded hospitals under section 4419.

Response: As explained in the August 29 final rule with comment period (62 FR 46019), section 4419 eliminates the 2-year exemption period for all classes of excluded hospitals except children's hospitals. Thus, effective October 1, 1997, we will no longer grant an exemption for new long-term care hospitals. If a hospital qualifies as a new-long term care hospital, the statutory payment methodology under section 4416 applies for the hospital's first two years as a long-term care hospital. A hospital is not classified as a long-term care hospital during the 6-month qualification period.

Comment: Two commenters suggested that § 413.40(f) of the regulations be modified to state that the new statutory payment methodology of section 4416 does not apply to a hospital or unit that changes the basis of its exclusion (for example, from long-term care to rehabilitation) on or after October 1, 1997. One commenter, a long-term care hospital chain, objected to our policy and asserted that we had engaged in retroactive rulemaking and incorrect statutory interpretation because an existing PPS hospital that is acquired and recertified as a long-term care hospital on or after October 1, 1997 will now be subject to lower new long-term care hospital caps.

Response: Section 1886(b)(7) of the Act, as amended by section 4416 of the BBA, applies ''in the case of a hospital or unit that is within a class of hospital described in subparagraph (B) which first receives payments on or after October 1, 1997.'' Thus, the statutory payment methodology of section 4416 of the BBA applies if two conditions are met: (1) the hospital or unit is within one of the classes of hospitals specified in the statute (psychiatric, rehabilitation, long-term care), and (2) the hospital ''first receives payments on or after October 1, 1997.'' We believe these two conditions should be read together. That is, section 4416 applies if the hospital first receives payments on or after October 1, 1997 *as a hospital within one of the excluded classes.*

Thus, if a hospital first receives payments on or after October 1, 1997 as a PPS-excluded hospital in one of the specified classes (psychiatric, rehabilitation, or long-term care), then it is subject to the statutory payment methodology for new excluded hospitals under section 1886(b)(7) of the Act. The methodology for new excluded hospitals applies if a hospital received payments as a PPS hospital before October 1, 1997 and became excluded on or after October 1, 1997. If a hospital received payments as a PPS-excluded hospital in one of the classes before October 1, 1997, the hospital would be subject to the cap for non-new hospitals under section 1886(b)(3)(H) of the Act, as added by section 4414 of the BBA.

6a. Grandfathering of Certain Hospitals-Within-Hospitals

Section 4417 of the BBA specifies that a hospital that was classified by the Secretary on or before September 30, 1995 as an excluded long-term hospital shall continue to be so classified, notwithstanding that it is located in the same building as, or on the same campus as another hospital. While this provision is specific to long-term care hospitals, we believe the considerations underlying the legislation also apply to other types of hospitals-within-hospitals. Therefore, as explained in the preamble to the August 29, 1997 interim final rule with comment period (62 FR 46014), we revised our regulations applicable to prospective payment system exclusions of ''hospitals within hospitals'' to implement section 4417 (a)(1) of the BBA, by specifying that if a hospital was excluded from the prospective payment system on or before September 30, 1995, the criteria applicable to hospitals within hospitals do not apply to it (see § 412.22(f)). We also noted that in light of this revision, we were withdrawing our earlier proposal to include a specific provision for State-owned hospitals-within-hospitals. That provision, described in the June 2, 1997 proposed rule (62 FR 29902), was designed to allow continued exclusion of State-owned facilities that had been operated for many years as hospitals-within-hospitals but had not been able to restructure themselves because of the requirements of State law.

Since publication of the August 29, 1997 final rule with comment period, some hospital managers and representatives have asked whether § 412.22(f) applies only to hospitals that were and were also organized as hospitals-within-hospitals on or before September 30, 1995, or to any hospitals that may have been excluded from the prospective payment system on or before that date.

We wish to clarify that the rule is a grandfathering provision that applies only to those hospitals that were excluded from the prospective payment system on or before September 30, 1995, and were also organized as hospitals-within-hospitals on or before that date. Hospitals that were PPS-excluded on or before September 30, 1995, but were not excluded as hospitals-within-hospitals at that time, do not qualify for exclusion under section 4417(a). If they choose to reorganize themselves in ways that result in application of the hospital-within-a-hospital criteria, they will have to meet these criteria to preserve their prospective payment system exclusion status. We are making changes in § 412.22(f) to clarify this point.

6b. Capital Payments for Excluded Hospitals and Units (§ 413.40(j))

Section 4412 of the BBA amended section 1886(g) of the Act to establish a 15 percent reduction on capital payments for certain hospitals and hospital distinct part units excluded from the prospective payment system for cost reporting periods beginning on or after October 1, 1997, through September 30, 2002. The capital reduction applies to psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals.

Comment: One commenter suggested that § 413.40(j) of the regulations be modified to state that the 15-percent reduction for capital-related costs required by section 4412 of the BBA does not apply to capital-related costs for outpatient services.

Response: We agree with the commenter and are modifying § 413.40(j).

7. Report on Adjustment Payments to the Ceiling (§ 413.40(g))

Section 4419(b) of the BBA amended section 1886(b)(4) of the Act to require the Secretary to publish annually, in the **Federal Register**, a report describing the total adjustment payments made to excluded hospitals and units for cost reporting periods ending during the previous fiscal year. We will publish this report in the annual rulemaking documents for the hospital inpatient prospective payment systems.

T. Limited-Service Rural Hospital Program

Prior to the BBA, the statute authorized a seven State Essential Access Community Hospital (EACH) and Rural Primary Care Hospitals (RPCH) program. RPCHs were limited-service rural hospitals that provided outpatient and short-term inpatient hospital care on an urgent or emergency basis and then released patients or transferred them to an EACH or other acute care hospital.

Montana also has a separate, limited service hospital program called the Medical Assistance Facility (MAF), that has been in operation since 1988 and operates under a demonstration waiver from HCFA. These limited service hospitals are reimbursed for providing treatment to Medicare beneficiaries even though they are not required to meet all requirements applicable to hospitals. A total of 12 MAFs have been licensed and certified.

The BBA replaced the EACH/RPCH program with the Medicare Rural Hospital Flexibility Program (MRHFP).

The MRHFP is available in any State that chooses to set up such a program and provides HCFA with the necessary assurances that it has developed, or is in the process of developing, a State rural health care plan meeting certain requirements, and that it has designated, or is in the process of designating, rural nonprofit hospitals or facilities as critical access hospitals (CAHs).

To be eligible as a CAH, a facility must be a rural public or nonprofit hospital located in a State that has established a MRHFP, and must be either located more than a 35-mile drive from any other hospital or CAH or certified by the State as being a necessary provider of health care services to residents in the area. In mountainous terrain or in areas with only secondary roads available, the mileage criterion is 15 miles. In addition, the facility must make available 24-hour emergency care services, provide not more than 15 beds for acute (hospital-level) inpatient care, and keep each inpatient for no longer than 96 hours, unless a longer period is required because of inclement weather or other emergency conditions, or a PRO or other equivalent entity, on request, waives the 96-hour restriction. An exception to the 15-bed requirement is made for swing-bed facilities, which are allowed to have up to 25 inpatient beds that can be used interchangeably for acute or SNF-level care, provided that not more than 15 beds are used at any one time for acute care. The facility is also required to meet certain staffing and other requirements that closely parallel the requirements for RPCHs.

The BBA also defined a rural health network as an organization consisting of at least one CAH and at least one acute care hospital, the members of which have entered into agreements with at least one other member regarding patient referral and transfer, the development and use of communications systems, and the provision of emergency and nonemergency transportation. In addition, each CAH in a network must have an agreement for credentialing and quality assurance with at least one hospital that is a member of the network, or with a PRO or equivalent entity, or with another appropriate and qualified entity identified in the rural health care plan for the State.

Under the BBA, no new EACH designations will be made, but rural hospitals designated as EACHs under previous statutory provisions may continue to be paid as sole community

hospitals. The previous payment provisions applicable to RPCHs are repealed, and the statute instead provides that CAHs will be paid on a reasonable cost basis for their inpatient and outpatient services. The statute specifically provides that existing RPCHs and MAFs will be deemed as CAHs if these facilities or hospitals are otherwise eligible to be designated by the State as CAHs. Under a special provision applicable to the MAF program, the MAF demonstration project is extended until at least October 1, 1998, to allow for an appropriate transition between the MAF and CAH programs.

The BBA also provided considerable flexibility to a CAH with a swing-bed agreement to use inpatient beds for either SNF or acute care, as long as the total number of inpatient beds does not exceed 25 and the number of beds used at any one time for acute care does not exceed 15.

To allow the changes made by the enactment of the BBA to be implemented by the statutory effective date of October 1, 1997, we published the August 29, 1997 final rule with comment period that retained the provisions of then existing RPCH regulations, except where the BBA clearly required us to make a change. In the August 29 final rule with comment period, we described in detail the substantive changes that we made to parts 409, 410, 412, 413, and 485 to implement the section 4201 amendments (62 FR 46008). We also made nomenclature changes to reflect the statutory change from RPCHs to CAHs.

In the August 29 final rule with comment period, we discussed in detail the process for review and acceptance of State assurances from States interested in establishing a MRHFP (62 FR 46009). Specifically, we described the assurances and information that must be included in a State's application. We solicited comments on whether the information and assurances were sufficient, or whether other information or assurances are needed.

Section 1820(k) of the Act, as in effect prior to the enactment of the BBA, explicitly authorized States with EACH programs to designate facilities in adjacent States as EACHs or RPCHs if certain conditions were met. Section 4201 of BBA revoked that authority. Therefore, a facility can be designated as a CAH only by a State in which it is located. We revised § 485.606 to remove any reference to this authority.

Section 1820(f)(1)(B) of the Act, as in effect prior to the enactment of the BBA, explicitly allowed, under certain circumstances, States with EACH programs to designate facilities as RPCHs even though the facilities had closed and were no longer functioning as hospitals at the time they applied for RPCH status. The BBA removed that authority so there is now no basis on which a closed facility can be designated as a CAH. We revised § 485.612 to reflect this change.

We received 33 letters of comment. We summarize the comments and give our responses below.

1. State Rural Health Care Plan Review and Approval

Comment: One commenter stated that in view of differences between the various States that may set up a MRHFP, HCFA should not impose common standards or criteria on all State plans or, if some common standards are needed, should give States advance notice of the standards and how they will be applied. Other commenters stated that the regulations regarding the development of State rural health plans should allow States maximum flexibility in the development of CAHs in rural areas of the State. Specifically, the commenters suggested that the reference to ''certain requirements'' for the State rural health care plan be clarified. The commenters believed that States should be given maximum flexibility within a defined format to plan for their rural heath care access needs. Also, since the creation of a State rural health care plan is reflective of the needs of the health care recipients in a given State, the commenters believed it would be appropriate to give the regional offices authority to approve these State plans. Another commenter stated the CAHs need to be designed to permit as much flexibility as possible and to allow linkages with other programs to maximize their abilities to serve the frontier areas of the individual state. The State rural health care plan must address the unique needs and conditions of the particular rural settings within their boundaries.

Response: We recognize that the factors limiting access to care can vary from State to State, and even from one rural area to another within a State. To account for this diversity, we agree that States should be allowed as much flexibility as possible to tailor plans to meet the unique needs of their residents and the conditions of the particular rural setting, including the needs of those living in frontier areas. We also agree that CAHs within a State be given as much flexibility as possible. At the same time, however, the BBA requires that all State rural health care plans meet certain minimum requirements.

Regarding State responsibilities, the statute specifies that the rural health care plan must provide for the creation of one or more rural health networks, promote regionalization of rural health services in the State, and improve access to hospital and other health services for rural residents of the State. In addition, the statute requires the State to develop the rural health care plan in consultation with the hospital association of the State, rural hospitals located in the State, and the State office of rural health. We intend to impose the common standards for State rural health care plans only to the extent that they are mandated by statute. If HCFA develops any additional common standards for the State rural health care plan beyond those mandated by the current statute to ensure that the new legislation is administered in a fair and predictable way, those requirements would be communicated through regulation. Regarding regional office approval, we agree that the regional offices should have authority to approve the State rural health care plans, and have issued instructions that allow them to do this. We do, of course, expect that the regional offices will consult with HCFA's central office on any issues having national policy significance.

Comment: Other commenters stated that given their experience under the RPCH program, they recommend greater emphasis on the creation and maintenance of a rural health network. They suggested that the MRHFP will be better served by more fully defining network requirements and mandating network membership for CAHs. Another commenter noted that the financial incentives used for network formation benefit Medicare beneficiaries. They stated that their rural health network has been extremely helpful as an enhancement to the care they can provide. One commenter suggested that there needs to be a better definition of the network described in the regulations, regarding the actual functions of the network.

Response: We support the creation of rural health networks as envisioned in the legislation. However, the legislation does not preclude an otherwise eligible hospital from becoming a CAH solely because it is not a network member. In view of this, we do not believe it would be appropriate at this point to mandate network membership. We also note that section 1820(d) of the Act defines ''rural health network'' and does not explicitly authorize the imposition of any additional requirements on networks. In view of these considerations, at this point, we have decided not to mandate network membership for CAHs or

impose further requirements on networks.

Comment: Given the fragile and unstable financial condition of small rural hospitals, a lengthy process for reviewing and approving State rural health care plans is untenable. Several commenters suggested that HCFA should set a 30 or 60 day time limit for review and approval of State rural health care plans, and allow States to proceed to designate and certify facilities as CAHs based on assurances in a draft rural health plan, as long as the State pledges to complete the plan in a timely fashion. Another commenter did not specify a timeframe for action, but emphasized that HCFA should act quickly on State rural health care plans and that all requests for additional information should be reasonable in scope, with consistency among regional offices as to the type and extent of additional information requested.

Response: We agree that State rural health care plans should be reviewed and approved as quickly as possible, and that requests for additional information should be reasonable and specific, so that the approval process is not unduly delayed. However, we do not believe a self-imposed deadline would be useful to help achieve an expedited approval process. States are free to designate facilities under a draft plan, but no facility will be assigned a CAH provider number and give a provider agreement until the State rural health care plan has been approved and the CAH is certified as meeting all the requirements following an initial survey by the State agency.

Comment: Because changes in their circumstances may affect rural hospitals' interest in participating in the MRHFP, any list of facilities that the State has designated or plans to designate as CAHs will not be static, but will change frequently. Commenters suggested that instead of requiring the State to submit such a list, HCFA should simply ask for a description of the process for State designation, and of the criteria used to select hospitals for designation.

Response: We recognize that there may be frequent changes in any list of facilities that the State plans to designate, and agree that it is important for the State to describe its selection process and criteria clearly. However, we continue to believe a list of current and prospective designees is useful in developing an overall view of the State program.

Comment: Some commenters stated that HCFA should allow States great flexibility in making ''necessary provider'' certifications, and in defining key terms such as ''mountainous terrain'' or ''secondary roads.'' The commenter recommended that States be allowed to perform these functions without special waivers or centralized review. One commenter asked that we refer to States as ''designating'' rather than certifying necessary providers. Another commenter stated that the statute gives States broad authority to designate facilities as CAHs, even if they do not meet statutory requirements such as distance. Still another commenter suggested that necessary provider status be dependent solely on State designation with no Federal oversight. However, one commenter took the opposite view, stating that it is important that HCFA provide clear implementation instructions that allow providers and HCFA staff to know whether the criteria are met. This commenter believed that unless such criteria are developed and issued, there could be confusion as to what constitutes mountainous terrain or secondary roads.

Response: We agree that States should have great flexibility in making these certifications and in determining how to apply the distance requirements in making State designations. However, consistent implementation of the statute requires that the regional office also exercise oversight over these functions through the State rural health care plan approval process, and by ensuring that hospitals are given CAH status by the Secretary only if they meet applicable statute and regulations. To emphasize the importance of complying with applicable statute and regulations, we are revising § 485.606(b)(1) to specify that facilities (other than grandfathered facilities) will be recognized as CAHs by HCFA only after they have been surveyed and found to meet applicable requirements.

We are also revising the section heading for § 485.606 and the paragraph for § 485.606(b) to refer to ''certification'' rather than designation by HCFA. This change in terminology is being made for consistency with section 1820(e) of the Act which also refers to certification by the Secretary.

Regarding the terms used to describe State findings of necessary provider status, we will continue to refer to hospitals ''certified'' by the State as necessary providers because that is the term used in the statute (section 1820(c)(2)(B)(i)(II) of the Act) and because designation is used in another context to denote a finding by the State that the hospital meets all requirements to be a CAH under its plan, not merely the location requirements (sections 1820(b)(2) and (c)(1) and (2) of the Act).

2. Criteria for Designation as a CAH

Comment: One commenter stated that the existence of the 35-mile restriction fails to recognize the value of providing services even when certain rural providers are within 35 miles of another hospital, and that it fails to take into account the significantly greater population density of these rural areas and the importance of maintaining service for an older and poorer population where no significant transportation systems are in place. The commenter encouraged HCFA to reconsider its policy encouraging such limits as the 35-mile and rather encourage overall implementation of CAH status for many rural hospitals in the country. Commenters also noted that in some States there are no hospitals located more than 35 miles from others, and recommended that the regulations be revised to allow States to develop alternative mileage criteria for State designations.

Response: The statute at section 1820(c)(2)(B)(i)(I) of the Act specifically includes the requirement that a hospital seeking CAH status be more than 35 miles (or, in mountainous areas or those with only secondary roads, 15 miles) from the nearest other hospital or CAH, and HCFA does not have the authority to allow States to substitute another standard. However, the statute also authorizes States to designate otherwise eligible facilities that do not meet the standard as CAHs if the State finds the facility is a ''necessary provider''. We believe this provision allows States adequate flexibility to deal with specific situations in which access is limited even though the prospective CAH is within 35 miles of another hospital.

Comment: One commenter was concerned about the location requirements at § 485.610(b)(4) which provide that a CAH must be located more than a 35-mile drive from a hospital or another CAH or the CAH must be certified by the State as being a necessary provider of health care services to residents in the area. The commenter interpreted this provision to mean that either the quantified criteria fit a particular situation or it is left to the State to determine the appropriateness of the necessary provider situation. The commenter also stated that the second means of establishing CAH eligibility is not a waiver of the first standard; it simply stands apart from the mileage criteria.

Response: As stated previously, section 1820(c)(2)(B)(i)(I) of the Act includes a general requirement that a hospital seeking CAH status be more than 35 miles (or, in mountainous areas

or those with only secondary roads, 15 miles) from the nearest hospital or CAH. Section 1820(c)(2)(B)(i)(II) provides an exception to that general requirement for a hospital that is certified by the State as a necessary provider of health care services to residents in the area. We do not agree with the commenter's view that the provision for ''necessary provider'' certification somehow stands apart from the basic requirement. On the contrary, it clearly is set up as an alternative method of qualifying for a facility which cannot meet the basic mileage rule. In this context, we also wish to clarify that the necessary provider certification must be specific to each hospital, and that we would not accept a blanket statement, unsupported by any other information, to the effect that a State considers all hospitals it has designated as CAHs to be ''necessary providers.'' We would expect that State criteria for making the ''necessary provider'' certification will be defined in the State rural health care plan. The States can make the designation of necessary provider of health care services to residents of an area, however, this is just one of several criteria the facility must satisfy to qualify as a CAH. The assertion that these other criteria have been met is subject to Secretarial review and approval. Section 1820(b)(3) makes it clear that the Secretary may require, as part of the application process, ''other information and assurances.'' As to the ''necessary provider'' determination, the Secretary may require the State to submit the information that formed the basis of the State's determination.

Comment: One commenter suggested that the regulations be clarified to allow a State's ''necessary provider'' certification as an alternative to the distance criteria. The commenter believed that State criteria should be related to community needs and access issues, and State criteria should be outlined in the State rural health care plan.

Response: While we agree that the State should outline its criteria in its plan, the regulations at § 486.610(b)(4) already provide for certification by the State of a ''necessary provider'' in place of the distance requirement and we believe no further clarification is necessary.

Comment: One commenter stated that a per-stay limitation on the length of inpatient stay, such as the 96-hour limit imposed under the MRHFP, may be more restrictive than the average length of stay rule applicable to RPCHs. The commenter noted that PROs are authorized to waive the per-stay limit for particular cases, but suggested that obtaining such waivers would be burdensome for both the facility and the PRO and therefore should be used only rarely. Therefore, the commenter indicated an interest in seeking a legislative change to return to a rule based on a facility-wide average length of stay, saying that such a limit would allow CAHs greater flexibility to serve patients.

Response: Because a change in the statute would be needed to authorize use of a length-of-stay limit based on facility averages, we have not revised the regulations based on this comment. We will, of course, consider the commenter's views in deciding whether to support any proposed amendments to the provisions imposing a per-stay limit.

Comment: One commenter noted that the definition of ''rural'' used under both the RPCH and MRHFP regulations, which is the same definition used for other Medicare payment purposes, considers each individual county to be either ''urban'' or ''rural'' in its entirety. The commenter pointed out that there are some large counties that encompass both densely populated urban areas and very small, remote rural areas. Another commenter expressed the view that the statute should be changed to allow use of a definition that recognizes some areas of such counties as being ''rural,'' and asked that we support such a change. Another commenter simply asked that the implementing regulation at § 485.610(b)(2) be changed to reflect this type of situation.

Response: We agree that a change in the statute would be needed to authorize such a definition, since section 1820(c)(2)(B)(i) of the Act mandates use of the ''rural'' definition in section 1886(d)(2)(D) of the Act. Thus we did not revise the regulations based on these comments.

Comment: One commenter stated that in order to extend acute care services to areas that have not previously had access to these services, facilities other than hospitals should be considered eligible for designation as critical access hospitals. The commenter suggested that Congress intended that this be done so that extremely remote areas, such as some parts of Alaska, would have access to hospital-level services for the first time through the MRHFP.

Response: We do not agree that the intent of the legislation as enacted was to expand acute care capacity into new areas. On the contrary, we believe it is intended to preserve existing acute care capacity by encouraging appropriate downsizing and reduction in the scope of services in order to use the remaining capacity in the most efficient manner. Furthermore, we note that section 1820(c)(2)(B)(i) of the Act, specifies that a State may designate a facility as a CAH only if the facility is a hospital. In view of the specificity of the statute on this point, we do not believe that either the States or HCFA have discretion to designate nonhospital facilities as CAHs.

3. Grandfathering/Transition Issues

Comment: One commenter asked that we clarify the statutory language that would allow RPCHs to be grandfathered as CAHs. A commenter suggested that the regulations be revised to grandfather all existing RPCHs as CAHs immediately, and all MAFs as CAHs effective October 1, 1998, following the phaseout of the MAF program. Another commenter suggested that existing RPCHs be grandfathered as CAHs without regard to whether they are otherwise eligible for State designation. Another commenter expressed concern regarding the interpretation of the term ''otherwise eligible''; the intent being that RPCH facilities that do not meet all the new requirements will not be grandfathered in. They believe that automatic designation of all existing MAFs and RPCHs as CAHs is the only approach that reflects the common meaning of the term ''grandfathering.'' One commenter believed all existing RPCH facilities must be grandfathered and be consistent with the current rules that were in effect when the facility was designated as such.

Response: Under section 1820(h) of the Act, grandfathering is available only to MAFs operating in Montana and to RPCHs designated as such by the Secretary under section 1820 prior to enactment of the BBA (August 5, 1997), if they are otherwise eligible for designation by the State under section 1820(c). We have no authority to extend grandfathering to other facilities that do not meet these requirements. Moreover, when a State represents that a facility should qualify as a grandfathered CAH, HCFA may request data to support that representation pursuant to section 1820(b)(3) of the Act.

Comment: One commenter suggested that some special provision be made for facilities that were designated as RPCHs under previous legislation, but cannot meet the 35-mile distance criterion imposed by the new legislation. The commenter noted that such facilities will likely be designated as CAHs under the new legislation, and suggested that they continue to be treated as RPCHs at least until the State has submitted a rural health care plan under the new MRHFP.

Response: As noted in previous responses, the statute has provided

States with the authority to certify facilities as ''necessary providers'' if the 35-mile criterion is not met. However, for a RPCH to be treated as a CAH (assuming it meets the other statutory requirements) in lieu of the 35 mile criterion, it will need to be certified by the State as being a necessary provider of health care services to residents in its area by the beginning of its next cost reporting period. However, section 1820(h) of the Act allows grandfathering of a MAF or RPCH only if the facility or hospital is otherwise eligible and we intend to implement this provision of the statute.

4. Payment Issues

Comment: Under the EACH/RPCH program, EACHs participating in the program received sole community status as an incentive for participating as a member of a EACH/RPCH network. One commenter pointed out that while the regulations allow for the continuation of enhanced reimbursement to EACHs, there is no such enhanced payment to acute care facilities serving as resources to CAH facilities. The commenter recommended sole community reimbursement to those acute care hospitals that will assist CAHs.

Response: Section 4201(c)(4) of the BBA authorized the continuation of payment for those hospitals who had participated as EACHs in the EACH/RPCH program and, thus, were designated sole community hospitals. The regulations reflect this statutory provision. However, we have no statutory authority to adopt the commenter's recommendation of allowing sole community status for those hospitals assisting the CAHs under the MRHFP.

Comment: One commenter stated that the amendments made by the BBA do not necessarily eliminate the all-inclusive payment option for outpatient services that was explicitly provided for under prior law (section 1834(g)(1)(B) of the Act, as in effect before enactment of the BBA). The commenter noted that section 1834(g) of the Act was amended to provide for payment of the reasonable cost of the CAH in providing the outpatient services, and suggested that the all-inclusive rate method, as a cost-based method, would be permitted by the new legislation. Commenters also argued that the all-inclusive rate method furthers one of the goals of the BBA, in that it encourages the development of integrated rural health networks. Thus, the commenter recommended that the regulations be revised to again make the all-inclusive rate method available for outpatient services. Another commenter also recommended that the all-inclusive rate option be made available to critical access hospitals or, as an alternative, that the RPCHs that had elected the all-inclusive method continue to be paid under that method at least until October 1, 1998.

One commenter stated that some facilities that had operated provider-based rural health clinics in the past closed those clinics and instead elected payment under the all-inclusive rate option, thereby benefiting by being able to claim payment at levels of cost higher than would be permitted under the physician fee schedule. The commenter stated that such facilities may choose to reopen their rural health clinics if they are not allowed to continue to claim payment under the all-inclusive rate method. The commenter suggested that reopening the facilities as RHCs would entail considerable administrative expense for the facility and suggested that this could be avoided if the all-inclusive option were retained. One commenter stated that because of the all-inclusive method they have been able to enter into legally binding contracts with health professionals to provide skilled medical services. To interrupt these contracts (by discontinuing the all-inclusive method) could result in the discontinuation of these services to their patients and could prove financially detrimental to the well-being of the hospital.

Other commenters also expressed concern regarding the elimination of the all-inclusive method. Of these commenters, one stated that this method enabled small rural hospitals to recruit and retain physicians because they could integrate the physician and hospital payments. Another stated that this method simplified the billing process because, by combining the professional portion of an encounter with the technical service, time and paperwork are reduced. Several commenters stated that elimination of the all-inclusive method will have significant financial implications, prevent some hospitals who would otherwise benefit from the program from participating, and many rural patients will lose access to specialists because this option strengthened the ability to recruit traveling physician clinics. Another commenter stated that the all-inclusive-rate method should be reinstated or, at a minimum, a professional fee should be included in the facility cost structure for CAHs.

Response: We reviewed the commenters' concerns carefully, but we do not agree that we have discretion to retain the all-inclusive rate option. Under Medicare, physician services to hospital patients are not paid through the hospital, but are billed separately to the Medicare carrier and paid for under the physician fee schedule (sections 1832(a)(1), 1861(s)(1), and 1842 of the Act). Facility services are billed to the Medicare intermediary. Previous law (specifically, section 1834(g)(1)(B) of the Act, as in effect before the enactment of the BBA), explicitly authorized an exception to this practice, in that it permitted RPCHs to elect to be paid for services to outpatients under an all-inclusive rate method, described in that section, which reflects the costs of both facility and physician services.

The BBA amended section 1834(g) of the Act to eliminate the RPCH payment methods, including the all-inclusive rate option. Under the statute, as amended, the option of paying for physician services to hospital patients through payment to the CAH for its costs no longer exists. On the contrary, CAHs are to be paid for their reasonable costs of facility services. Physician services will be billed separately to the Medicare Part B carrier, and payment will be made under the physician fee schedule. We also considered the proposal that RPCHs that had elected to be paid for outpatient services under the all-inclusive rate method be allowed to continue receiving payment under that method until October 1, 1998. At this time, we are allowing existing RPCHs that are to be grandfathered as CAHs to continue to receive payment under the all-inclusive payment until each facility's first cost reporting period beginning after October 1, 1997. However, since the statute made no provision for extension of this payment methodology for CAHs, this payment methodology will be eliminated at the end of the period stated above. Continuation of previous payment methods for MAFs through September 30, 1998, is possible because section 4201(c)(6) of the BBA explicitly authorizes such a transition period for them. However, there is no similar provision for RPCHs.

Regarding RHC conversions, we do not accept the commenter's claim that eliminating the all-inclusive payment method will force hospitals to set up RHCs. Physicians who provide services to outpatients of CAHs are entitled to bill for these services on the same *basis* as if they *had been* furnished in a hospital outpatient department.

We agree that one major goal of the legislation is to foster networking and appropriate integration of services. However, we believe that integration of services through improved coordination, sharing of patient information, and other clinical measures does not require that physician billing

and facility billing be integrated, nor that such financial integration necessarily encourages clinical integration.

Comment: Several commenters requested that HCFA clarify that coinsurance amounts for CAH services are to be determined based on the hospital's charges, as is the case for full-service hospitals and most other providers.

Response: We agree and have made appropriate revisions to § 410.152(k) in these final rules.

Comment: The principle of lesser of cost or charges was not applied to RPCH payment determinations under previous statutory provisions. Commenters recommended that HCFA clarify that this principle also does not apply in determining the amount of payment for CAH services.

Response: We agree and have made revisions to §§ 413.13(c)(2) and 413.70 to specify that this principle does not apply to CAH payment determinations.

Comment: One commenter stated that some CAHs may need to use locum tenens (temporary substitute) physicians to maintain the availability of emergency services on a 24-hour basis. The commenter recommended that the regulations be revised to state that costs of locum tenens physicians are allowable.

Response: As is the case for full-service hospitals, standby costs of emergency room physicians who are present at the emergency room are allowable costs and will, to the extent they are reasonable in amount, be taken into account in computing Medicare payment. However, Medicare does not recognize costs of ''on-call'' physicians as allowable costs of operating a CAH.

Comment: One commenter asked for clarification as to which specific reasonable cost payment principles will be applied in determining payment to CAHs. Specifically the commenter asked whether, for inpatient services, CAHs would be subject to the principles of lesser of cost or charges, ceilings on the rate of hospital cost increases, limits on payment for services of physical, occupational, and other therapy services furnished under arrangements, reasonable compensation equivalent (RCE) limits on payments for services of physicians to providers, and the SNF routine nursing service cost limits. With respect to outpatient services, the commenter asked whether payment would be subject to the principles of lesser of cost or charges, reasonable compensation equivalent (RCE) limits on payments for services of physicians to providers, the 5.8 percent operating cost reduction, the capital cost reduction, blended payment amounts for ASC, radiology, and other diagnostic services, and the fee schedule for clinical laboratory tests.

Response: We plan to apply the limits on physical, occupational, speech, and other therapy services furnished under arrangements in determining the reasonableness of costs of both inpatient and outpatient services. We do not plan to apply the principles of lesser of cost or charges; ceilings on the rate of hospital cost increases; any type of reductions of operating or capital costs under § 413.24 or § 413.130(j)(7); the blended payment amounts for ambulatory surgical centers (ASC) services, radiology, and other diagnostic services; or the clinical laboratory fee schedule. We do not plan to apply RCE limits on payments of physicians to providers. However, we note that the costs of these services will be subject to both the prudent buyer principle (section 2103 of the Medicare Provider Reimbursement Manual) and the requirement that costs not be ''substantially out of line'' with those of other, similar institutions (§ 413.9(c)(2)). Intermediaries are authorized to examine all claimed costs to make sure they are not substantially out of line. An intermediary might in this respect refer to the RCE limits as one guide as to what may be reasonable in a given case. We have not specified that the SNF routine cost limits do not apply to CAHs, since this is self-evident.

Comment: One commenter suggested that, to ensure that payment policies are applied uniformly in all States and to make it easier for critical access hospitals to have questions answered and problems resolved, a single national intermediary should be designated to handle all CAH payment.

Response: In the case of both hospitals and CAHs, the intermediary for a particular facility is determined by the location of the facility. In general, each facility is serviced by a nonprofit or commercial insurance plan that also administers other health insurance programs for facilities in the State, and is familiar with characteristics of health care delivery systems in that State. Therefore, use of the existing intermediaries to make payment to CAHs should help contribute to an orderly transition to the new program, since the intermediary servicing a facility as a CAH would also have serviced it as a hospital or RPCH and would be fully familiar with the facility's operation and cost characteristics. However, we agree that use of a single national intermediary (or regional intermediaries) would appear to have some advantages in terms of ensuring that payment is made uniformly and consistently. We will consider this suggestion further and evaluate the feasibility of a single national intermediary at some time in the future.

5. Other Issues

Comment: One commenter stated that both the RPCH and CAH regulations allow facilities to close at times when there are no inpatients, as long as the emergency services requirements in § 485.618 are met. The commenter stated that existing regulations allow emergency services to be provided through a triage and on-call system, while anti-dumping requirements under section 1867 of the Act require that all patients coming to the emergency room be seen by a physician or midlevel practitioner. The commenter stated that compliance with the provisions of section 1867 of the Act will increase a CAH's cost of operating an outpatient department and suggested that retention of the all-inclusive rate is needed to meet the added cost.

Response: The emergency services requirements for CAHs are exactly the same as they were for RPCHs, as are the section 1867 provisions on examination and treatment for emergency medical conditions and women in labor (as implemented under §§ 489.20(q) and 489.24). Except for the change in terminology from RCPH to ''critical access hospital'', the regulations at § 485.618 were not changed in any way. With respect to personnel, these regulations provide (in paragraph (d)) that there must, on a 24-hour a day basis, be a practitioner with training and experience in emergency care on call and immediately available by telephone or radio contact, and available on site within 30 minutes. The practitioner referred to may be an M.D. or D.O, a physician assistant, or a nurse practitioner. Within this minimum staffing requirement, the CAH is obligated by the regulations at § 489.24 to provide an appropriate medical screening examination and, if necessary, stabilizing treatment to any person who comes to the emergency room and requests examination or treatment, or has such a request made on his or her behalf. As noted in § 489.24, these services need only be provided within the capability of the CAH's emergency department. Thus, the transition to CAH status should not generate any additional costs for the facility.

Comment: One commenter stated that Congress clearly intended to allow CAHs to maintain swing beds, and suggested that restricting CAH swing-bed agreements to those facilities that

had such agreements as full-service hospitals or as RPCHs would be unfair to other hospitals and former RPCHs, and could limit access to skilled nursing services for Medicare patients. Therefore, the commenter suggested that we revise the regulations to make it clear that hospitals or RPCHs that do not have swing-bed agreements at the time they become CAHs are free to enter into those agreements later, if they meet the requirements in § 485.645.

Response: We agree and have revised § 485.645(a)(1) to eliminate the requirement that a facility have had a hospital swing-bed agreement when it applied for CAH designation.

Comment: One commenter recommended that, for purposes of waiving the 96-hour length of stay restriction under § 482.620(b), we provide that peer review organizations (PROs) should have discretion to base decisions only on clinical judgment of specific cases, without having to follow guidelines imposed by HCFA. One commenter also states that the 96 hours length of stay should be an average of 96 hours.

Response: We agree that PROs will necessarily have to make case-specific clinical judgements to implement this waiver provision, and do not plan to release any guidelines to them in the near future. However, further experience with the program may indicate a need for centralized guidelines to ensure that the waiver provision is implemented uniformly in all States, and if such guidelines are needed they will be issued. As to an average of 96 hours length of stay, the statute is clear that the longest stay permitted will be a 96-hour period, that is, the 96-hour limit will be applied on a per-stay basis rather than to the facility-wide average length of stay. Consequently, we made no changes in the regulations based on this comment.

Comment: One commenter stated that revised § 485.612 (''Compliance with hospital requirements at time of application'') would effectively eliminate participation in the CAH program by hospitals that are licensed but not certified. The commenter believed the intent of Congress was to limit CAH candidates to only hospitals in full compliance with the Medicare/Medicaid conditions of participation at the time of application.

Response: We agree, the MRHFP was established through changes to the Medicare law and its purpose is to preserve access to services by Medicare beneficiaries. Hospitals that do not participate in Medicare cannot be paid for nonemergency services to Medicare patients, and thus do not serve as a source of care for most Medicare services. In view of this, we do not believe there is any basis for making CAH designations available to these hospitals. This approach is consistent with previous RPCH policy and with the statutory requirement that only hospitals be designated as CAHs.

Comment: One commenter stated that it would serve the Medicare program well to permit CAHs more flexibility in the realm of surgery. As a RPCH, they performed only ambulatory type surgeries, while as an acute care hospital they performed several types of low complexity general surgeries. These low complexity cases were done safely, economically, and close to home. They believe that this flexibility would serve to enhance their ability in emergency cases.

Response: Under previous statute and regulations (section 1820(f)(1)(F)(ii) and 42 CFR 485.614(b)(3)), RPCHs were restricted to certain types of inpatient surgical and other services requiring general anesthesia, except in emergency cases where the attending physician certified that the risk of transfer to a hospital outweighed the benefits of the transfer. This restriction was removed by the BBA, and § 485.614 was also removed in the August 29, 1997 final rule with comment period. Of course, CAHs are still required to comply with any State licensure laws affecting their scope of services.

Comment: One commenter stated that CAH legislation requires credentialing and quality assurance review to be done by another facility. Currently, many providers that might seek CAH designation do their own credentialing and quality assurance review. The commenter believes that requiring outside performance of these functions would be unreasonable and would recommend some type of grandfathering of these responsibilities.

Response: The commenter correctly notes that the statute requires that a network CAH's credentialing and quality assurance review be done by an outside entity. We have amended § 485.603(c) to reflect this and require all network CAHs to have an agreement for credentialing and quality assurance with at least one hospital that is a network member, one PRO or equivalent entity, or one other appropriate and qualified entity identified in the State rural health care plan. We have also made a conforming change and have revised § 485.641(b)(4) to allow the same three options for the review of the quality and appropriateness of the diagnosis and treatment furnished by doctors of medicine or osteopathy at the CAH. We recognize that where a facility is located in an extremely remote area, performance review and credentialing by an outside entity can present practical problems. On the other hand, given the small numbers of practitioners furnishing services in a CAH, it may be difficult or impossible to achieve objective in-house review. The majority of CAHs have a limited number of staff and resources to accomplish credentialing and quality assurance in an efficient and effective manner. Assistance from a knowledgeable source outside the facility will enable the CAH to be more efficient in the utilization of their immediate resources. We encourage CAHs to develop strategies for electronic sharing of patient records and other data related to practitioner performance and quality assurance.

Comment: One commenter noted that the statutory provision authorizing grandfathering of essential access community hospitals (EACHs) required only that the hospitals have been designated by the Secretary as EACHs under the statute in effect on September 30, 1997 (section 1886(d)(5)(D) of the Act, as amended by section 4201(c)(4) of the BBA). In this commenter's view the revised regulations at § 412.109(a) are more restrictive, in that they would require the hospital, to retain its EACH status, to comply with the terms, conditions, and limitations that were applicable when HCFA designated the hospital as an EACH. The commenter noted that the definition of ''network'' under the new legislation differs from the regulatory criteria for EACH designation that were in effect before October 1, 1997, in that previously regulations required the EACH to provide emergency and medical backup services to RPCHs participating in the network of which it is a member as well as to other RPCHs throughout its service area, while the new statutory definition of a ''network'' does not include a specific requirement for emergency and medical backup services. The commenter stated that an EACH should not lose its EACH designation solely because it changes its network agreements to conform to the new statutory requirements.

Response: This commenter is correct in noting that the network definition under the current statute differs from the EACH designation criteria previously in effect. We agree that network agreements entered into after the effective date of the new provision (October 1, 1997) should reflect current statutory requirements. However, it does not necessarily follow that a hospital should be able to change the terms of its agreements made under a previous statutory provision, while maintaining

an advantageous level of payment available under that same previous statutory provision. Thus, if a hospital designated as an EACH under prior statute wants to retain its sole community hospital status, it will have to abide by the agreements it made in order to obtain its EACH designation. If the hospital wants to scale down its responsibilities to the level required by current statute for an acute care hospital that is a network member, it is free to do so but will no longer be able to claim sole community hospital status. The hospital clearly will not be permitted to scale down its obligations but continue to be paid as if it were assuming those responsibilities.

Comment: Two commenters asserted that managed care involvement should be allowed with recognition and protection for low volume. They recommended that Medicare+Choice plans should allow for CAH participation.

Response: There is no prohibition on the use of CAH services under managed care or Medicare+Choice. However, we have no authority to mandate the level of payment by these plans to the CAHs.

Comment: Two commenters recommended that CAHs be allowed to link formally with other Federal programs such as Rural Health Clinics, Public Health, and emergency medical service.

Response: Under the new legislation, a new MRHFP was established. Under this program, States are encouraged to set up rural health networks. These networks are defined as an organization consisting of at least one CAH and at least one full-service hospital. As to the CAH linking with other types of organizations, there is no statutory prohibition against a State establishing these linkages under its rural health care plan, and there is nothing in the regulations that precludes CAHs from participating in other Federal programs. Each program would be required to independently meet the applicable Federal regulations. A CAH that participates in any additional Federal programs would be responsible for compliance with all the Medicare CAH requirements and any other program requirements in which it participates.

Comment: Communities with CAHs should receive an exception to the EMS restrictions, since they do not have the funds to provide quality EMS service.

Response: We do not believe our emergency medical service requirements are complicated or complex requirements. Rather, in our development of the original conditions of participation, we attempted to be flexible and sympathetic to the need of these facilities. We do not believe we can be any more flexible and remain within the confines of the statute.

Comment: Several commenters requested additional funding to support survey and certification activities. They believe that Federal grant funding should be used to support survey and certification activities, combined CAH and hospital surveys should be allowed, and States should recognize CAH participation in EMS and trauma planning.

Response: Congress did not authorize an appropriation of additional funds to survey critical access hospitals. CAH initial surveys will be scheduled and conducted by the State survey agencies in accordance with national priorities which reflect statutorily mandated workload requirements and budget realities. Federal grant funding is not authorized to support survey and certification activities. In addition, CAH and hospital surveys would not be combined, as these providers are statutorily and categorically different entities and subject to separate requirements. We do not see the added value of attempting to combine hospital and CAH surveys. Regarding the comment that States should recognize CAH participation in EMS and trauma planning, we believe this comment is addressed to the States rather than to HCFA in implementation of the MRHFP.

Comment: Some commenters recommended that HCFA take action to increase understanding of the Medicare Rural Hospital Flexibility Program and simplify its implementation.

Response: We agree, and have attempted to provide interim guidance wherever possible to clarify the requirements of the Medicare Rural Hospital Flexibility Program legislation. For example, we recently provided our regional offices with guidance on implementing the requirement that a hospital seeking CAH designation provide not more than 15 (or, in the case of a swing-bed facility, 25) acute care inpatient beds. Because of the specificity of the law on this point, a State rural health care plan would not be approvable unless it specified that potential CAHs would provide not more than the allowed number of acute care inpatient beds, and a hospital that provided more than the allowed number of beds would not be eligible for State designation as a CAH, and could not be certified by the Secretary as a CAH. CAHs are, as limited-service facilities, subject to less rigorous standards than full-service hospitals and it is important to ensure that they are truly low-volume, short-stay facilities as envisioned in the statute. However, this does not mean that each hospital seeking CAH designation must necessarily reduce its State licensure to the 15 or 25-bed level. It does mean the hospital must reduce its number of Medicare certified beds to the allowed level (15 or 25 beds) and that it has to actually provide no more than the number of inpatient acute beds for which it is Medicare-certified, or risk termination of its Medicare participation agreement and loss of all Medicare revenue. Since the CAH designation is related to how the facility is certified for participation under the Medicare program, we believe the use of Medicare certified beds is appropriate. Further, the use of Medicare certified beds is consistent with the policies on hospital and CAH swing-beds (see §§ 482.66 and 485.645).

We note that for cost reporting and certain payment provisions (for example, Medicare-dependent hospitals and the indirect medical education adjustment), a facility's bed size is based on the average number of beds available and maintained over the cost reporting period. We do not believe it would be appropriate to use this measure of bed size for purposes of CAH certification. First, it is based on an average number of beds that are available over the cost reporting period. The statute establishes an absolute limit on the number of beds that may be provided at any point in time during the cost reporting period. Secondly, this measure can only determine bed size retrospectively and is not useful as a prospectively applicable measure of compliance with the limits on beds provided by CAHs.

Comment: Two commenters suggested that CAHs and their communities that have been given incentives to provide services in underserved areas (HPSAs or MUAs) should be allowed to keep those incentives after the need for them has passed, so the practitioners recruited through the incentives do not leave, leading to new shortages.

Response: With regard to the commenters' concern regarding previously given incentives, such incentives were not granted by us, and therefore; we have no authority to permit the continuance of such incentives. The MRHFP was established to assist such rural hospitals that may need the support of other facilities by setting up networks with agreements with full service facilities concerning transportation and communications, not as an incentive for recruitment of practitioners.

III. Provisions of the Final Rule

In summary, in this final rule, we are making changes to the following regulations in 42 CFR as described in the preceding portions of this preamble:

- Section 410.152
- Section 412.105
- Section 413.13
- Section 413.40
- Section 413.70
- Section 413.86
- Section 415.152
- Section 485.603
- Section 485.641
- Section 485.645

Technical Corrections

- Regarding the Medicare geographic classifications, we are making two technical changes:

—In § 412.230, paragraph (e)(3), the phrase ''If a hospital is a rural referral center,'' is revised to read ''If a hospital was ever a rural referral center''.

—In § 412.256, paragraph (a)(2), the phrase ''the month preceding'' is revised to read ''the 13-month period preceding''.

- In regard to inpatient hospital capital costs, we are making a cross-reference change in § 412.322(a)(1) to change the phrase ''under § 412.105(g)'' to read ''under § 412.105(f)''.

IV. Impact Statement

We have examined the impact of this final rule as required by Executive Order 12866 and the Regulatory Flexibility Act (RFA) (Public Law 96–354). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects; distributive impacts; and equity). The Regulatory Flexibility Act (RFA) requires agencies to analyze options for regulatory relief for small businesses, unless we certify that the regulation would not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, most hospitals, and most other providers, physicians and health care suppliers are small entities, either by nonprofit status or by having revenues of $5 million of less annually.

Also, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a final 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 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA). Section 601(g) of the Social Security Amendments of 1983 (Public Law 98–21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the prospective payment system, we classify these hospitals as urban hospitals. We are not preparing an analysis for section 1102(b) of the Act because we have determined, and we certify, that this final rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

In the August 29, 1997 final rule with comment period, we discussed in detail the impact of the provisions of the BBA (62 FR 46115). We stated that several provisions of the statute made significant changes in inpatient hospital payments for the operating and capital prospective payment systems during FY 1998. The major portion of this final rule merely responds to comments on the August 29 final rule with comment period and makes clarifying changes. However it does make a few policy changes that have an impact on hospitals as follows:

1. Graduate Medical Education

Section 4623 of the BBA established a limitation on the number of residents that a hospital can receive Medicare direct and indirect medical education payments. This final rule will provide hospitals with more opportunities to receive adjustments to the FTE caps for GME for medical residency programs established on or after January 1, 1995. While this may result in Medicare paying for more residents than under the policies announced in the August 29, 1997 final rule with comment period, we anticipate this impact will be modest. In addition, hospitals that are members of the same affiliated group will also have more flexibility relative to the August 29, 1997 final rule with comment period under an aggregate FTE cap. We believe that these changes will have a minimal (if any) financial impact on the Medicare program.

2. Excluded Hospitals and Units

a. Limitations on the Target Amount

In accordance with section 4416 of the BBA, we calculated a cap on the TEFRA target amounts for new PPS-excluded hospitals. This cap is set at 110 percent of the median target amount for each type of hospital. We have recalculated the 110 percent of the median target amount for new long-term care hospitals, based on a review of the data. As a result the limit will be revised from $18,947 to $21,494. Therefore, fewer new long-term care hospitals will be adversely affected by the cap. Although we do not know the precise financial impact of this change, we estimate that any additional costs to the Medicare program will be small given the small number of long-term care hospitals that could potentially be affected.

b. Critical Access Hospitals—Credentialing and Quality Assurance

We are requiring all CAHs to have an agreement for credentialing and quality assurance with at least one hospital that is a network member, one PRO or equivalent entity, or one other appropriate and qualified entity identified in the State rural health care plan. For facilities located in an extremely remote area, performance review and credentialing by an outside entity can present practical problems. However, given the small numbers of practitioners furnishing services in a CAH, it may be difficult or impossible to achieve objective in-house review. Therefore, making the requirements consistent will allow the providers more flexibility in selecting an entity to perform the credentialing and quality assurance functions. We believe that this requirement would not present an additional financial burden to the provider.

c. Critical Access Hospitals—Swing-Bed Agreements

Previously, swing-bed agreements were restricted to those facilities that had hospital swing-bed agreements at the time of their becoming a CAH. However, due to comments received, we have changed the regulations to clarify that hospitals or rural primary care hospitals that do not have swing-bed agreements at the time they become CAHs may enter into such agreements at a later time if they meet the swing-bed requirements. This change will increase the number of CAHs that may qualify for swing-bed agreements, and thus may lead to additional utilization of SNF-level services and higher costs. However, at this time, we are unable to estimate the number of facilities that will request participation in the swing-bed program, or estimate whether or not utilization and costs will increase.

For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside a Metropolitan Statistical Area and has

fewer than 50 beds. We are not preparing an analysis for section 1102(b) of the Act because we have determined, and we certify, that this final rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

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

List of Subjects

42 CFR Part 410

Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, 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 415

Health facilities, Health professions, Medicare, 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:

A. Part 410 is amended as set forth below:

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

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 1395(hh)), unless otherwise indicated.

Subpart I—Payment of SMI Benefits

§ 410.152 [Amended]

2. In § 410.152, paragraph (k), second sentence, the phrase ''coinsurance amounts, as described in § 413.70(b)(3) of this chapter'' is revised to read ''coinsurance amounts with Part B coinsurance being calculated as 20 percent of the customary (in so far as reasonable) charges of the CAH for the services''.

B. Part 412 is amended as set forth below:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

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

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

Subpart B—Hospital Services Subject to and Excluded From the Prospective Payment System for Inpatient Operating Costs and Inpatient Capital-Related Costs

2. In § 412.22, paragraph (f) is revised to read as follows:

§ 412.22 Excluded hospitals and hospital units: General rules.

* * * * *

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

* * * * *

Subpart G—Special Treatment of Certain Facilities Under the Prospective Payment System for Inpatient Operating Costs

3. In § 412.105, the last sentence of paragraph (a)(1) is revised, the parenthetical phrase in the last sentence of paragraph (f)(1)(v) is revised, and new paragraphs (f)(1)(vi) and (vii) are added to read as follows:

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

* * * * *

(a) * * *

(1) * * * Except for the special circumstances for affiliated groups and new programs described in paragraphs (f)(1)(vi) and (f)(1)(vii) of this section, for a hospital's cost reporting periods beginning on or after October 1, 1997, this ratio may not exceed the ratio for the hospital's most recent prior cost reporting period.

* * * * *

(f) * * *

(1) * * *

(v) * * * (subject to the requirements set forth in paragraphs (f)(1)(ii)(C) and (f)(1)(iv) of this section) * * *

(vi) Hospitals that are part of the same affiliated group (as described in § 413.86(b)) may elect to apply the limit at paragraph (f)(1)(iv) of this section on an aggregate basis.

(vii) If a hospital establishes a new medical residency training program, the hospital's FTE cap may be adjusted in accordance with the provisions of § 413.86(g)(6)(i) through (iv).

* * * * *

Subpart L—The Medicare Geographic Classification Review Board

§ 412.230 [Amended]

4. In § 412.230, paragraph (e)(3), the phrase ''If a hospital is a rural referral center,'' is revised to read ''If a hospital was ever a rural referral center''.

§ 412.256 [Amended]

5. In § 412.256, paragraph (a)(2), the phrase ''the month preceding'' is revised to read ''the 13-month period preceding''.

Subpart M—Prospective Payment System for Inpatient Hospital Capital Costs

§ 412.322 [Amended]

6. In § 412.322(a)(1), the phrase ''under § 412.105(g)'' is revised to read ''under § 412.105(f)''.

C. Part 413 is amended as set forth below:

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

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

Authority: Secs. 1102, 1861(v)(1)(A), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395x(v)(1)(A), and 1395hh).

Subpart A—Introduction and General Rules

2. In section 413.13, a new paragraph (c)(2)(iv) is added to read as follows:

§ 413.13 Amount of payment if customary charges for services furnished are less than reasonable costs.

* * * * *

(c) * * *

(2) * * *

(iv) *Critical access hospital (CAH) services.* The lesser of costs or charges principle does not apply in determining payment for inpatient or outpatient services furnished by a CAH under § 413.70.

* * * * *

Subpart C—Limits on Cost Reimbursement

3. Section 413.40 paragraphs (c)(4)(iii) and (j) are revised to read as follows.

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

* * * * *

(c) * * *

(4) * * *

(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—

(A) The hospital-specific target amount (the net allowable costs in a base period increased by the applicable update factors); or

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

(*1*) For cost reporting periods beginning during fiscal year 1998, the 75th percentile of target amounts for hospitals in the same class (psychiatric hospital or unit, rehabilitation hospital or unit, or long-term care hospital) for cost reporting periods ending during FY 1996, increased by the applicable market basket percentage up to the first cost reporting period beginning on or after October 1, 1997.

(*2*) For cost reporting periods beginning during fiscal years 1999 through 2002, the amount determined under paragraph (c)(4)(iii)(B)(*1*) of this section, increased by the market basket percentage up through the subject period, subject to the provisions of paragraph (c)(4)(iv) of this section.

* * * * *

(j) *Reduction to capital-related costs.* For psychiatric hospital and units, rehabilitation hospitals and units, and long-term care hospitals, the amount otherwise payable for capital-related costs for hospital inpatient services is reduced by 15 percent for portions of cost reporting periods occurring on or after October 1, 1997 through September 30, 2002.

Subpart E—Payments to Providers

4. Section 413.70 is revised to read as follows:

§ 413.70 Payment for services of a CAH.

(a) Except as provided in paragraph (b) of this section, payment for inpatient and outpatient services of a CAH is the reasonable costs of the CAH in providing such services, as determined in accordance with section 1861(v)(1)(A) of the Act and the applicable principles of cost reimbursement in this part and in part 415 of this chapter.

(b) The following payment principles are excluded when determining payment for CAH inpatient and outpatient services:

(1) For inpatient services—

(i) Lesser of cost or charges;

(ii) Ceilings on hospital operating costs; and

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

(2) For outpatient services—

(i) Lesser of costs or charges;

(ii) RCE limits;

(iii) Any type of reduction to operating or capital costs under § 413.124 or § 413.130(j)(7) of this part;

(iv) Blended payment amounts for ASC, radiology, and other diagnostic services; and

(v) Clinical laboratory fee schedule.

Subpart F—Specific Categories of Costs

5. In § 413.86, the definition of ''affiliated group in paragraph (b) is revised, paragraph (g)(5) is amended by adding new sentences at the end of the paragraph, and paragraphs (g)(6)(i), (g)(6)(ii), and (g)(7) are revised to read as follows:

§ 413.86 Direct graduate medical education payments.

* * * * *

(b) * * *

Affiliated group means—

(1) Two or more hospitals located in the same urban or rural area (as those terms are defined in § 412.62(f) of this subchapter) or in contiguous areas if individual residents work at each of the hospitals during the course of the program; or

(2) If the hospitals are not located in the same or a contiguous urban or rural area, the hospitals are jointly listed—

(i) As the sponsor, primary clinical site or major participating institution for one or more of the programs as these terms are used in *Graduate Medical Education Directory, 1997–1998;* or

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

(3) The hospitals are under common ownership.

* * * * *

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

* * * * *

(5) * * * If a hospital qualifies for an adjustment to the limit established under paragraph (g)(4) of this section for new medical residency programs created under paragraph (g)(6) of this section, the count of residents participating in new medical residency training programs above the number included in the hospital's FTE count for the cost reporting period ending during calendar year 1996 is added after applying the averaging rules in this paragraph for a period of years. Residents participating in new medical residency training programs are included in the hospital's FTE count before applying the averaging rules after the period of years has expired. For purposes of this paragraph, the period of years equals the minimum accredited length for the type of program. The period of years begins when the first resident begins training.

(6) * * *

(i) If a hospital had no residents before January 1, 1995, and it establishes a new medical residency training program on or after that date, the hospital's unweighted FTE resident cap under paragraph (g)(4) of this section may be adjusted based on the product of the highest number of residents in any program year during the third year of the first program's existence for all new residency training programs and the number of years in which residents are expected to complete the programs based on the minimum accredited length for the type of program. For these hospitals the cap will only be adjusted for the programs established on or after January 1, 1995. Except for rural hospitals, the cap will not be revised for new programs established after the 3 years. Only rural hospitals that qualify for an adjustment to its FTE cap under this paragraph are permitted to be part of the same affiliated group for purposes of an aggregate FTE limit.

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

* * * * *

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

* * * * *

D. Part 415 is amended as set forth below:

PART 415—SERVICES FURNISHED BY PHYSICIANS IN PROVIDERS, SUPERVISING PHYSICIANS IN TEACHING SETTINGS, AND RESIDENTS IN CERTAIN SETTINGS

1. The authority citation for Part 415 continues to read as follows:

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

Subpart D—Physician Services in Teaching Settings

§ 415.152 [Amended]

2. In § 415.152, under the definition of ''approved graduate medical education (GME)'', the phrase ''Council on Dental Education of the American Dental Association'' is revised to read ''Commission on Dental Accreditation of the American Dental Association'.

E. Part 485 is amended as set forth below:

PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

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

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

Subpart F—Conditions of Participation: Critical Access Hospitals (CAHs)

2. Section 485.603 is amended by revising paragraph (c) to read as follows:

§ 485.603 Rural health network.

* * * * *

(c) Each CAH has an agreement with respect to credentialing and quality assurance with at least—

(1) One hospital that is a member of the network when applicable;

(2) One PRO or equivalent entity; or

(3) One other appropriate and qualified entity identified in the State rural health care plan.

3. In 485.606, the section heading, the heading and introductory text of paragraph (b), and paragraph (b)(1) are revised to read as follows:

§ 485.606 Designation and Certification of CAHs

* * * * *

(b) Criteria for HCFA certification. HCFA certifies a facility as a CAH if—

(1) The facility is designated as a CAH by the State in which it is located and has been surveyed by the State survey agency or by HCFA and found to meet all conditions of participation in this Part and all other applicable requirements for participation in Part 489 of this chapter.

* * * * *

4. In § 485.641 the introductory text of paragraph (b) is republished and paragraph (b)(4) is revised to read as follows:

§ 485.641 Condition of participation: Periodic evaluation and quality assurance review.

* * * * *

(b) *Standard: Quality assurance.* The CAH has an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and of the treatment outcomes. The program requires that—

* * * * *

(4) The quality and appropriateness of the diagnosis and treatment furnished by doctors of medicine or osteopathy at the CAH are evaluated by—

(i) One hospital that is a member of the network, when applicable;

(ii) One PRO or equivalent entity; or

(iii) One other appropriate and qualified entity identified in the State rural health care plan; and

* * * * *

5. Section 485.645 is revised to read as follows:

§ 485.645 Special requirements for CAH providers of long-term care services (''swing-beds'')

A CAH must meet the following requirements in order to be granted an approval from HCFA to provided post-hospital SNF care, as specified in § 409.30 of this chapter, and to be paid for SNF-level services, in accordance with paragraph (c) of this section.

(a) *Eligibility.* A CAH must meet the following eligibility requirements:

(1) The facility has been certified as a CAH by HCFA under § 485.606(b) of this subpart; and

(2) The facility provides not more than 25 inpatient beds, and the number of beds used at any time for acute care inpatient services does not exceed 15 beds. Any bed of a unit of the facility that is licensed as distinct-part SNF at the time the facility applies to the State for designation as a CAH is not counted under paragraph (a) of this section.

(b) *Facilities participating as rural primary care hospitals (RPCHs) on September 30, 1997.* These facilities must meet the following requirements:

(1) Notwithstanding paragraph (a) of this section, a CAH that participated in Medicare as a RPCH on September 30, 1997, and on that date had in effect an approval from HCFA to use its inpatient facilities to provide post-hospital SNF care may continue in that status under the same terms, conditions and limitations that were applicable at the time those approvals were granted.

(2) A CAH that was granted swing-bed approval under paragraph (b)(1) of this section may request that its application to be a CAH and swing-bed provider be reevaluated under paragraph (a) of this section. If this request is approved, the approval is effective not earlier than October 1, 1997. As of the date of approval, the CAH no longer has any status under paragraph (b)(1) of this section and may not request reinstatement under paragraph (b)(1) of this section.

(c) *Payment.* Payment for inpatient RPCH services to a CAH that has qualified as a CAH under the provisions in paragraph (a) of this section is made in accordance with § 413.70 of this chapter. Payment for post-hospital SNF-level of care services is made in accordance with the payment provisions in § 413.114 of this chapter.

(d) *SNF services.* The CAH is substantially in compliance with the following SNF requirements contained in subpart B of part 483 of this chapter:

(1) Residents rights (§ 483.10(b)(3) through (b)(6), (d) (e), (h), (i), (j)(1)(vii) and (viii), (l), and (m) of this chapter).

(2) Admission, transfer, and discharge rights (§ 483.12(a) of this chapter).

(3) Resident behavior and facility practices (§ 483.13 of this chapter).

(4) Patient activities (§ 483.15(f) of this chapter), except that the services may be directed either by a qualified professional meeting the requirements of § 485.15(f)(2), or by an individual on the facility staff who is designated as the activities director and who serves in consultation with a therapeutic recreation specialist, occupational therapist, or other professional with experience or education in recreational therapy.

(5) Social services (§ 483.15(g) of this chapter).

(6) Comprehensive assessment, comprehensive care plan, and discharge planning (§ 483.20(b), (d), and (e) of this chapter).

(7) Specialized rehabilitative services (§ 483.45 of this chapter).

(8) Dental services (§ 483.55 of this chapter).

(9) Nutrition (§ 483.25(i) of this chapter).

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance)

Dated: April 24, 1998.

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

Dated: May 1, 1998.

Donna E. Shalala,

Secretary.

Note: The following appendix will not appear in the Code of Federal Regulations.

Appendix: Illustration of Determination of GME Payment

HOSPITAL COST REPORTING PERIOD ENDING 12/31/96

Type of FTE	Number of FTEs
Unweighted	[1] 100

HOSPITAL COST REPORTING PERIOD ENDING 12/31/96—Continued

Type of FTE	Number of FTEs
Weighted	[1] 90

[1] Allopathic and Osteopathic Residents.

HOSPITAL COST REPORTING PERIOD BEGINNING 1/12/97

Type of FTE	Number of FTEs
Unweighted	[1] 110
Weighted	[1] 100
Adjusted Weighted	[2] 100.00
Dentists and Podiatrists	5.00
Total	105.00

[1] Allopathic and Osteopathic Residents.
[2] Since the FTE cap does not apply until 01/01/98 the adjusted weighted FTEs are equal to the weighted FTEs.

HOSPITAL COST REPORTING PERIOD BEGINNING 1/12/98

Type of FTE	Number of FTEs
Unweighted	[1] 110
Weighted	[1] 100
Adjusted Weighted	[2] 90.91
Dentists and Podiatrists	5.00
Total	95.91

[1] Allopathic and Osteopathic Residents.
[2] The adjusted weighted=((Current year's Weighted FTEs/Current year's Unweighted FTEs) * FTE cap)=((100/110) * 100).

HOSPITAL COST REPORTING PERIOD BEGINNING 1/12/99

Type of FTE	Number of FTEs
Unweighted	[1] 90
Weighted	[1] 90
Adjusted weighted	90
Dentists and podiatrists	5.00
Total	95.00

[1] Allopathic and Osteopathic Residents.

DETERMINATION OF PAYMENTS FOR HOSPITAL COST REPORTING PERIOD BEGINNING 1/12/99

Type of resident	Per resident amount	FTEs	Total resident amount
Primary Care	$50,000	80.00	$4,000,000
Other	47,000	15.00	705,000
		95.00	4,705,000

Total resident amount	Total number of FTEs	Average per resident amount
$4,705,000	95.00	[1] $49,526

Total # of FTEs (for 01/01/97)	Total # of FTEs (for 01/01/98)	Total # of FTEs (for 01/01/99)	3-year average FTEs
105.00	95.91	95.00	[2] 98.64

Average per resident amount	3-Year average FTEs	Aggregate approved amount
$49,526	98.64	[3] $4,885,096

Aggregate approved amount	Medicare patient load	Direct GME payment
$4,885,096	0.5	[4] $2,442,548

[1] The Average Per Resident Amount = (Total Resident Amount/Total number of FTEs).
[2] The 3-Year Average = (the sum of the Total number of FTEs for 3 cost reporting periods/3).
[3] The Aggregate Amount = (Average Per Resident Amount * 3-year Average FTEs).
[4] The Direct GME Payment = (Aggregate Approved Amount * Medicare Patient Load).

[FR Doc. 98–12231 Filed 5–8–98; 8:45 am]

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