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Part II

Department of Health and Human Services

Health Care Financing Administration

42 CFR Part 410, et al.

Medicare Program; Provisions of the Balanced Budget Refinement Act of 1999; Hospital Inpatient Payments and Rates and Costs of Graduate Medical Education; Final Rules

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 410, 412, 413, 482, and 485

[HCFA–1131–IFC]

RIN 0938–AK20

Medicare Program; Provisions of the Balanced Budget Refinement Act of 1999; Hospital Inpatient Payments and Rates and Costs of Graduate Medical Education

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

ACTION: Interim final rule with comment period.

SUMMARY: This interim final rule with comment period implements, or conforms the regulations to, certain statutory provisions relating to Medicare payments to hospitals for inpatient services that are contained in the Medicare, Medicaid, and State Children's Health Insurance Program Balanced Budget Refinement Act of 1999 (Public Law 106–113). These provisions relate to reclassification of hospitals from urban to rural status, reclassification of certain hospitals for purposes of payment during Federal fiscal year 2000, critical access hospitals, payments to hospitals excluded from the hospital inpatient prospective payment system, and payments for indirect and direct graduate medical education costs.

Many of the provisions of Public Law 106–113 modify changes to the Social Security Act made by the Balanced Budget Act of 1997 (P.L. 105–33). These provisions are already in effect in accordance with Public Law 106–113.

DATES: *Effective Date:* This interim final rule with comment period is effective on August 1, 2000.

Comment Period: Comments will be considered if received at the appropriate address, as provided below, no later than 5 p.m. on August 31, 2000.

ADDRESSES: Mail written comments (an original and three copies) to the following address only: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA–1131–IFC, P.O. Box 8010, Baltimore, MD 21244–1850.

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

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

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

Comments mailed to the indicated addresses may be delayed and could be considered late.

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code HCFA–1131–IFC.

Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room 443–G of the Department's offices at 200 Independence Avenue, SW, Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: (202) 690–7890).

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

Health Care Financing Administration, Office of Information Services, Security and Standards Group, Division of HCFA Enterprise Standards, Room N2–14–26, 7500 Security Boulevard, Baltimore, Maryland 21244–1850. Attn: John Burke HCFA–1131-IFC; and

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 3001, New Executive Office Building, Washington, DC 20503, Attn: Allison Herron Eydt HCFA–1131–IFC, HCFA Desk Officer

FOR FURTHER INFORMATION CONTACT:

Steve Phillips, (410) 786–4531, Operating Prospective Payment, Wage Index, and Reclassifications

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

SUPPLEMENTARY INFORMATION:

Availability of Copies and Electronic Access

Copies: To order copies of the **Federal Register** containing this document, send your request to: New Orders, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250–7954. Specify the date of the issue requested and enclose a check or money order payable to the Superintendent of Documents, or enclose your Visa or Master Card number and expiration date. Credit card orders can also be placed by calling the order desk at (202) 512–1800 or by faxing to (202) 512–2250. The cost for each copy is $8.00. As an alternative, you can view and photocopy the **Federal Register** document at most libraries designated as Federal Depository Libraries and at many other public and academic libraries throughout the country that receive the **Federal Register**.

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I. Background: Program Summary

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

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

reasonable costs subject to a hospital-specific annual limit.

Under sections 1814(l) and 1834(g) of the Act, payments are made to critical access hospitals (CAHs) (that is, rural nonprofit hospitals or facilities that meet certain statutory requirements) for inpatient and outpatient services on a reasonable cost basis. Reasonable cost is determined under the provisions of section 1861(v)(i)(A) of the Act and existing regulations under 42 CFR Parts 413 and 415.

Under section 1886(a)(4) of the Act, costs of approved educational activities are excluded from the operating costs of inpatient hospital services. Hospitals with approved GME programs are paid for the direct costs of GME in accordance with section 1886(h) of the Act; the amount of payment for direct GME costs for a cost reporting period is based on the hospital's costs per resident in a base year and the hospital's number of residents in that period.

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

II. Provisions of the Interim Final Rule With Comment Period

On November 29, 1999, the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Balanced Budget Refinement Act of 1999 (Pub. L. 106–113) was enacted. Public Law 106–113 made a number of changes to the Act affecting Medicare payments to hospitals for inpatient services. Many of the provisions of Public Law 106–113 are modifications to provisions of the Act included in the Balanced Budget Act of 1997 (Pub. L. 105–33). Some of the provisions of Public Law 106–113 became effective prior to, or shortly after, its passage on November 29, 1999. Other provisions do not become effective until Federal fiscal year (FY) 2001 or later. The provisions of Public Law 106–113 that are effective beginning October 1, 2000, were included in the proposed rule for FY 2001 Medicare hospital inpatient prospective payment system published in the **Federal Register** on May 5, 2000 (65 FR 26281) which is being finalized in this issue of the **Federal Register**.

The following is a summary of the policy changes we are implementing in this interim final rule with comment period as a result of Public Law 106–113:

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

- *Reclassification of Certain Counties.* We are implementing the provisions of section 152(a) of Public Law 106–113 that reclassified hospitals in certain designated counties for purposes of making payments to those hospitals under section 1886(d) of the Act for FY 2000. The counties affected by this provision are identified under section III of this preamble.
- *Wage Index.* We are implementing sections 153 and 154 of Public Law 106–113 that contain provisions affecting the wage indexes of specific Metropolitan Statistical Areas (MSA). Under section 153, the Hattiesburg, Mississippi FY 2000 wage index is to be calculated including wage data from Wesley Medical Center. Under section 154, the Allentown-Bethlehem-Easton, Pennsylvania MSA FY 2000 wage index is to be calculated including wage data for Lehigh Valley Hospital.
- *Reclassification of Certain Urban Hospitals as Rural Hospitals.* We are implementing section 401 of Public Law 106–113 which directed the Secretary to treat certain hospitals located in urban areas as being located in the rural area of their State if the hospital meets statutory criteria and files an application with HCFA. This provision is effective on January 1, 2000.
- *Indirect Medical Education (IME) Adjustment.* We are implementing section 111 of Public Law 106–113 which provides for an additional payment to teaching hospitals equal to the additional amount the hospitals would have been paid for FY 2000 if the IME adjustment formula (which reflects the higher indirect operating costs associated with GME) for FY 2000 had remained the same as for FY 1999.
- *Medicare-Dependent, Small Rural Hospitals.* We are implementing section 404 of Public Law 106–113 which extends the Medicare-dependent, small rural hospital (MDH) program and its current payment methodology for an additional 5 years, from FY 2002 through FY 2006.

B. Additional Changes Relating to Direct GME and Indirect Medical Education

- *Initial Residency Period for Child Neurology Residency Programs.* We are implementing section 312 of Public Law 106–113 which provides that in determining the number of residents for purposes of GME and IME payments, the period of board eligibility and the initial residency period for child neurology is the period of board eligibility for pediatrics plus 2 years. This provision applies on and after July 1, 2000, to residency programs that began before, on, or after November 29, 1999.
- *Residents on Approved Leave of Absences.* We are implementing section 407(a) of Public Law 106–113 which provides that, for purposes of determining a hospital's full-time equivalent (FTE) cap for direct GME payments and the IME adjustment, a hospital may count an individual to the extent that the individual would have been counted as a primary care resident for purposes of the FTE cap but for the fact that the individual was on maternity or disability leave or a similar approved leave of absence. The provision relating to direct GME is effective with cost reporting periods beginning on or after November 29, 1999. The provision relating to the IME adjustment applies to discharges occurring in cost reporting periods beginning on or after November 29, 1999.
- *Expansion of Number of Unweighted Residents in Rural Hospitals.* We are implementing section 407(b) of Public Law 106–113 which provides that a rural hospital's resident FTE count for direct GME and IME may not exceed 130 percent of the number of unweighted residents that the rural hospital counted in its most recent cost reporting period ending on or before December 31, 1996. The provision relating to direct GME applies to cost reporting periods beginning on or after April 1, 2000. The provision relating to the IME adjustment applies to discharges occurring on or after April 1, 2000.
- *Urban Hospitals with Rural Training Tracks or Integrated Rural Tracks.* We are implementing section 407(c) of Public Law 106–113 which allows an urban hospital that establishes separately accredited approved medical residency training programs (or rural training tracks) in a rural area or has an accredited training program with an integrated rural track to receive an FTE cap adjustment for purposes of direct GME and IME. The provision is effective with cost reporting periods beginning on or after April 1, 2000, for direct GME, and with discharges occurring on or after April 1, 2000, for IME.
- *Residents Training at Certain Veterans Affairs Hospitals.* We are implementing section 407(d) of Public Law 106–113 which provides that a non-Veterans Affairs (VA) hospital may receive a temporary adjustment to its FTE cap to reflect residents who were training at a VA hospital and were transferred on or after January 1, 1997, and before July 31, 1998, to the non-VA

hospital because the program at the VA hospital would lose its accreditation by the Accreditation Council on Graduate Medical Education if the residents continued to train at the facility. This provision applies as if it was included in the enactment of Public Law 105–33, that is, for direct GME, with cost reporting periods beginning on or after October 1, 1997, and for IME, for discharges occurring on or after October 1, 1997. If a hospital is owed payments as a result of this provision, payments must be made immediately.

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

We are implementing section 541 of Public Law 106–113 which provides an additional payment to hospitals that receive payments under section 1861(v) of the Act for approved nursing and allied health education programs to reflect utilization of Medicare+Choice enrollees. This provision is effective for portions of cost reporting periods in a year beginning with calendar year 2000.

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

We are implementing section 121 of Public Law 106–113 which amended section 1886(b)(3)(H) of the Act to direct the Secretary to provide for an appropriate wage adjustment to the caps on the target amounts for psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals for cost reporting periods beginning on or after October 1, 1999.

E. Changes Relating to Critical Access Hospitals (CAHs)

We are implementing—

- Section 401(b)(2) of Public Law 106–113, which contains a conforming change to incorporate the reclassifications made by section 401(a) of Public Law 106–113 to the CAH criteria (section 1820(c)(2)(B)(i) of the Act). This provision is effective beginning on January 1, 2000.
- Section 403(a) of Public Law 106–113, which deletes the 96-hour length of stay restriction on inpatient care in a CAH and authorizes a period of stay that does not exceed, on an annual, average basis, 96 hours per patient. This provision is effective beginning on November 29, 1999.
- Section 403(b) of Public Law 106–113, which allows for-profit hospitals to qualify for CAH status. This provision is effective beginning on November 29, 1999.
- Section 403(c) of Public Law 106–113, which allows hospitals that have closed within 10 years prior to November 29, 1999, or hospitals that downsized to a health clinic or health center, to be designated as CAHs if they satisfy the established criteria for designation, other than the requirement for existing hospital status.
- Section 403(e) of Public Law 106–113, which eliminates the Medicare Part B deductible and coinsurance for clinical diagnostic laboratory tests furnished by a CAH on an outpatient basis. This provision is effective with respect to services furnished on or after November 29, 1999.
- Section 403(f) of Public Law 106–113, entitled ''Participation in Swing Bed Program,'' which amended sections 1883(a)(1) and (c) of the Act.

F. Changes Relating to Hospital Swing Bed Program

We are implementing section 408(a) of Public Law 106–113 which eliminates the requirement for a hospital to obtain a certification of need to use acute care beds as swing beds for skilled nursing facility (SNF) level of care patients; and section 408(b) of Public Law 106–113 which eliminates constraints on the length of stay in swing beds for rural hospitals with 50 to 100 beds. These provisions are effective on the first day after the expiration of the transition period for prospective payments for covered SNF services under the Medicare program (that is, at the end of the transition period for the SNF prospective payments system that began with the facility's first cost reporting period beginning on or after July 1, 1998 and extend through the end of the facility's third cost reporting period after this date).

III. Reclassification of Certain Counties

Under section 152(a) of Public Law 106–113 hospitals in certain counties are deemed to be located in specified areas for purposes of payment to the hospitals under the hospital inpatient prospective payment system, for discharges occurring during FY 2000. For payment purposes, hospitals under section 152(a) are to be treated as though they were reclassified for purposes of both the standardized amount and the wage index. We have calculated FY 2000 wage indexes for hospitals in the affected counties. These wage indexes are listed below. No other hospitals' FY 2000 wage indexes were affected, including those hospitals in the areas to which these affected hospitals were reclassified, as well as nonreclassified hospitals located in the areas from which these hospitals were reclassified.

Section 152(a) provides that, for purposes of making payments under section 1886(d) of the Act for FY 2000—

- To hospitals in Iredell County, North Carolina, Iredell County is deemed to be located in the Charlotte-Gastonia-Rock Hill, North Carolina-South Carolina MSA;
- To hospitals in Orange County, New York, Orange County is deemed to be located in the New York, New York MSA;
- To hospitals in Lake County, Indiana and Lee County, Illinois, Lake County and Lee County are deemed to be located in the Chicago, Illinois MSA;
- To hospitals in Hamilton-Middletown, Ohio, Hamilton-Middletown is deemed to be located in the Cincinnati, Ohio-Kentucky-Indiana MSA;
- To hospitals in Brazoria County, Texas, Brazoria County is deemed to be located in the Houston, Texas MSA;
- To hospitals in Chittenden County, Vermont, Chittenden County is deemed to be located in the Boston-Worcester-Lawrence-Lowell-Brockton, Massachusetts-New Hampshire MSA.

In accordance with section 153 of Public Law 106–113, for discharges occurring during FY 2000, the Hattiesburg, Mississippi MSA wage index was recalculated by including the wage data for Wesley Medical Center. In accordance with section 154(a), the Allentown-Bethlehem-Easton, Pennsylvania MSA FY 2000 wage index was recalculated by including the wage data for Lehigh Valley Hospital.

The following table shows the changes to the FY 2000 wage index values and geographic adjustment factors for capital payments for the hospitals in the affected areas. Hospitals affected by section 152(a) of Public Law 106–113 will now also be considered reclassified for purposes of the standardized amount.

County or MSA	New MSA (for wage index and standardized amount)	New wage index	New geographic adjustment factor (GAF)
Iredell County, NC	1520	0.9434	0.9609

County or MSA	New MSA (for wage index and standardized amount)	New wage index	New geographic adjustment factor (GAF)
Orange County, NY	5600	1.4342	1.2801
Lake County, IN	1600	1.0750	1.0508
Lee County, IL	1600	1.0750	1.0508
Hamilton-Middletown, OH	1640	0.9419	0.9598
Brazoria County, TX	3360	0.9388	0.9577
Chittenden County, VT	1123	1.1359	1.0912
Hattiesburg, MS MSA	MSA is not new	0.7634	0.8312
Allentown-Bethlehem-Easton, PA MSA	MSA is not new	1.0228	1.0156

IV. Reclassifications of Hospitals (Sections 401(a) and (b) of Public Law 106–113 and 42 CFR 412.63(b), 412.90(e), 412.102, and New 412.103)

A. Permitting Reclassification of Certain Urban Hospitals as Rural Hospitals

Under Medicare law, the location of a hospital can affect its payment methodology as well as whether the facility qualifies for special treatment both for operating and for capital payments. Whether a facility is situated in an urban or a rural area will, for example, affect payments based on the wage index values and Federal standardized amounts specific to the area. Similarly, the percentage increase in payments made to hospitals that treat a disproportionate share of low-income patients is based, in part, on its urban/rural status, as are determinations regarding a hospital's qualification as a sole community hospital (SCH), rural referral center (RRC), CAH, or other special category of facility. Section 1886(d)(2)(D) of the Act defines an ''urban area'' as an area within a MSA as defined by the Office of Management and Budget. The same provision defines a ''large urban area,'' with respect to any fiscal year, as an urban area that the Secretary determines (in the publications described in section 1886(e)(5) of the Act before the fiscal year) has a population of more than 1 million as determined based on the most recent available published Census Bureau data. Section 1886(d)(2)(D) of the Act further defines a ''rural area'' as an area that is outside of a ''large'' urban area or ''other'' urban area. Since FY 1995, the average standardized amount for hospitals located in rural areas and ''other'' urban areas has been equal, as provided for in section 1886(b)(3)(B)(i)(X) of the Act.

Several provisions of the Act provide procedures under which a hospital can apply for reclassification from one geographic area to another: section 1886(d)(8)(B) of the Act, which provides that if certain conditions are met, the Secretary shall treat a hospital located in a rural county adjacent to one or more urban areas as being located in the urban area to which the greatest number of workers in the county commute; and section 1886(d)(10) of the Act, which establishes the Medicare Geographic Classification Review Board (MGCRB) process to permit hospitals to be reclassified for purposes of the standardized amount or the wage index if they meet criteria established by the Secretary.

Section 401(a) of Public Law 106–113, which amended section 1886(d)(8) by adding a new paragraph (E), directs the Secretary to treat any subsection (d) hospital located in an urban area as being located in the rural area of the State in which the hospital is located if the hospital files an application (in the form and manner determined by the Secretary) and meets one of the following criteria:

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

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

The Goldsmith Modification, one of the qualifying statutory criteria, evolved from an outreach grant program sponsored by the Office of Rural Health Policy of the Health Resources and Services Administration (HRSA). The program's purpose was to establish an operational definition of rural populations lacking easy geographic access to health services. Using 1980 Census Bureau data, Dr. Harold F. Goldsmith and his associates created a methodology for identification of census tracts that were located within a large metropolitan county of at least 1,225 square miles but were so isolated from the metropolitan core by distance or physical features as to be more rural than urban in character. The most important criterion used to identify these census tracts is the comparatively few residents in these areas, less than 15 percent of the labor force, who commute to work in the metropolitan core and suburbs. Appendix A of this interim final rule with comment period lists the identified urban counties with census tracts that may qualify as rural under the most recent Goldsmith Modification (January 1, 2000). The amendments made by section 401 of Public Law 106–113 enable a hospital located in one of these areas to be treated as if it were situated in the rural area of the State in which it is located. In making determinations under section 1886(d)(8)(E) of the Act, we will utilize the most recent Goldsmith Modification which reflects data based on the 1990 census.

Additionally, section 401(a) of Public Law 106–113 includes hospitals ''* * * located in an area designated by any law or regulation of such State as a rural area (or is designated by such State as a rural hospital).'' We are requiring that a hospital's designation as rural be in the form of either State law or regulation if it is the basis for a hospital's request for urban to rural reclassification under section 1886(d)(8)(E) of the Act. We believe this will help ensure that the provision is implemented consistently among States.

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

Although the statute authorizes the Secretary to specify further qualifying criteria for a section 1886(d)(8)(E) reclassification, we do not believe that additional criteria are warranted at this

time. However, we invite comment specifically on whether the criteria in this interim final rule are sufficient at this time, and if not, what additional criteria should be incorporated.

Section IV.C. of this preamble contains information on the application process for requesting reclassification under the section 401 provision.

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

B. Conforming Changes Under Section 401(b) of Public Law 106–113

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

- Section 401(b)(1) provides that if a hospital is being treated as being located in a rural area under section 1886(d)(8)(E) of the Act (for purposes of section 1886(d) of the Act), the hospital will also be treated under section 1833(t) of the Act as being located in a rural area. This provision is being addressed in a separate document.
- Section 401(b)(2) amends section 1820(c)(2)(B)(i) of the Act by extending the reclassification provisions of section 401(a) to the CAH program. A hospital that otherwise would have fulfilled the requirements for designation as a CAH had it been located in a rural area is now eligible for consideration as a CAH if it is treated as being located in a rural area under section 1886(d)(8)(E) of the Act, as added by section 401(a) of Public Law 106–113. (A list of certain existing hospitals that have been identified as being located in Goldsmith areas is included in Appendix B of this interim final rule with comment period.) A more detailed discussion of the effect on the CAH program in light of this provision, as well as the additional amendments to section 1820(c)(2)(B)(i) of the Act included in Public Law 106–113, is provided in section X.B. of this preamble.

C. Application Procedures

The statute provides that a hospital seeking reclassification from urban to rural under section 1886(d)(8)(E) of the Act must submit an application ''in a form and manner determined by the Secretary.'' We are providing that a facility seeking reclassification under section 401(a) or (b) of Public Law 106–113 must apply in writing to the HCFA Regional Office and include documentation satisfying the criteria on which its request is based. For information about where to submit an application, hospitals may contact their fiscal intermediaries or utilize the HCFA website at <www.hcfa.gov/medicare/regions/default.htm>. The application must be mailed; facsimile or other electronic means are not acceptable.

1. Qualification Through the Goldsmith Modification Criteria

We are specifying that hospitals seeking reclassification through the Goldsmith Modification criteria must include specific census tract information with their application that can be obtained through the following steps:

(a) The hospital must determine whether it is located within one of the urban counties containing one or more Goldsmith areas included in Appendix A of this interim final rule with comment period.

(b) Since only certain census tracts within these listed counties qualify as Goldsmith areas, a hospital that identifies its county in the listing must find the tract number assigned to its specific street location by the U.S. Census Bureau. One way to determine this is through an interactive website provided by the U.S. Census Bureau: <http:/tier2.census.gov/ctsl/ctsl.htm>.

(c) The hospital must include the 4-digit census tract number in its application to the HCFA Regional Office. The HCFA Regional Office will utilize census tract data to determine whether the census tract in which the hospital is located is situated in a Goldsmith area.

2. Qualification by State Designation

For hospitals selecting reclassification under qualification by State designation, we are providing that the hospital's application must include a copy of the State law or regulation that verifies either the requesting hospital is situated in an area designated rural by the State or that the hospital has been designated as a rural hospital. The application must also note the effective date of the rural designation.

3. Qualification as an RRC or as an SCH

For hospitals seeking reclassification under qualification as an RRC or as an SCH, we are providing that the hospital's application must include documentation that supports the hospital's assertion that, other than its urban location, it satisfies the criteria set forth in section 1886(d)(5)(C) of the Act as an RRC, as implemented in regulations at § 412.90; or as an SCH as set forth in section 1886(d)(5)(D) of the Act and implemented in regulations at § 412.92. The HCFA Regional Office will review the application in a manner consistent with its current procedures in the case of a hospital in a rural area that applies for RRC or SCH status (except for the requirement that the hospital be located in a rural area).

D. Filing and Effective Dates

We are establishing the date of receipt of the application by the HCFA Regional Office as the filing date. The HCFA Regional Office will review the application and forward its approval or disapproval to the hospital within 60 calendar days from the filing date. The HCFA Regional Office also will forward a copy of its decision to the HCFA Central Office and the fiscal intermediary. A hospital that satisfies any of the criteria for rural reclassification under section 401(a) of Public Law 106–113 will be treated as being located in the rural area of the State in which it is located as of its application filing date.

The statutory effective date of the amendments made by section 401 of Public Law 106–113 is January 1, 2000. To allow hospitals a grace period for filing applications to accommodate this effective date, we are providing that a qualifying hospital whose application is received by HCFA on or before September 1, 2000, will be considered as being located in the rural area of its State for purposes of section 1886(d) of the Act as of January 1, 2000. Following that grace period, a hospital's filing date is the date on which a complete application is received by HCFA. A qualifying hospital that bases its application for rural reclassification under section 1886(d)(8)(E) of the Act on its satisfaction of either SCH or RRC criteria, and that files on or before September 1, 2000, will benefit from the grace period and will be considered as being located in the rural area of its State as of January 1, 2000, unless the hospital withdraws its request as described in section IV.D.3 of this preamble. Once the hospital is rural, it may seek either an SCH or an RRC status by following a two-step process described respectively, in sections IV.D.1 and IV.D.2 of this preamble. The process for approval of the hospital as either an SCH or an RRC must be consistent with the processes currently in place for approving these applications. We note that whereas SCH designation is effective 30 days after written notification of HCFA's approval,

under § 412.92(b)(2)(i), the effective date of RRC designation, under 1886(d)(5)(C)(i) of the Act, is linked to the beginning of a hospital's reporting period.

1. A Hospital Reclassified as Rural Seeking Designation as an SCH

A hospital that bases its application for rural reclassification on its satisfaction of all SCH criteria set forth in § 412.92, except rural location, may seek subsequent designation as an SCH if HCFA determines that it qualifies to be treated as rural under section 1886(d)(8)(E) of the Act. The hospital must indicate this intent on its application for rural reclassification. Designation as an SCH for such hospital, therefore, would be a two-step process: (1) The hospital's reclassification as rural for all payment purposes as of its filing date under section 1886(d)(8)(E) of the Act; and (2) the now-rural hospital's request for SCH status, which would be effective 30 days following the date of HCFA's written notification of approval, as set forth in the regulations at § 412.92(b)(2)(i).

In order to implement section 401(a) of Public Law 106–113 in the most expeditious and efficient manner, allowing for necessary payment system modifications, for the grace period which extends from January 1, 2000 to September 1, 2000, we are bundling the above two operations: the rural reclassification of a hospital, under section 401(a) of Public Law 106–113, and the designation of the hospital as an SCH. A hospital that has applied for rural status based on its eligibility as an SCH and also is applying to become an SCH, will be granted SCH status as of January 1, 2000, if it satisfies the conditions for SCH designation in § 412.92, except for rural location as of January 1, 2000, and its application is filed by September 1, 2000.

2. Hospitals Reclassified as Rural Seeking Designation as a RRC

A hospital qualifying for rural reclassification under section 401(a) of Public Law 106–113 because it satisfies RRC criteria under § 412.96, except for rural location, will be considered rural for all payment purposes as of January 1, 2000, if its application is received by September 1, 2000. After September 1, 2000, when the grace period expires, the filing date is the date HCFA receives the hospital's complete application. If the hospital seeks designation as a RRC, the hospital must state its intent to apply for RRC status on its application for rural reclassification under section 1886(d)(8)(E) of the Act. Designation as an RRC for such a hospital, therefore, is a two-step process: (1) The hospital's classification as rural for all payment purposes as of its filing date under section 1886(d)(8)(E) of the Act; and (2) the now rural hospital's request for RRC status by way of a letter to the Regional Office during the quarter preceding the start of a cost reporting period, referencing the data it previously submitted for rural status. If approved, the hospital is designated an RRC at the start of the hospital's next cost reporting period under section 1886(d)(5)(C)(i) of the Act (55 FR 36059). Therefore, whereas the grace period would grant rural status under section 1886(d)(8)(E) of the Act to such a hospital filing on or before September 1, 2000, statutory requirements preclude us from granting RRC status simultaneously as we are able to do in the case of SCHs described above.

3. Withdrawal of an Application for Rural Reclassification

A hospital may withdraw an application for rural reclassification at any time prior to the date of HCFA's decision on whether or not the hospital qualifies for rural reclassification under section 1886(d)(8)(E) of the Act.

4. Cancellation of Rural Reclassification

We are specifying that a hospital seeking cancellation of rural status established under section 1886(d)(8)(E) of the Act must submit its written request to HCFA not less than 120 days prior to the end of its current cost reporting period. With the beginning of the hospital's next cost reporting period, the hospital will be treated as being located in an urban area.

E. Changes in the Regulations

We are adding a new § 412.103 to incorporate the provisions on the urban to rural reclassification options set forth in section 1886(d)(8)(E) of the Act, as added by section 401(a) of Public Law 106–113, and the application procedures for requesting reclassification. A formula for transition payments to hospitals located in an area that has undergone geographic reclassification from urban to rural is set forth in section 1886(d)(8)(A) of the Act and implemented in regulations at §§ 412.90 and 412.102. We are revising existing §§ 412.63(b)(1) and 412.90(e) and the title of § 412.102 to clarify the distinction between hospital reclassification from urban to rural and the geographic reclassification (or redesignation) of an urban area to rural.

We are revising § 485.610 by redesignating paragraph (b)(4) as paragraph (b)(5) and adding a new paragraph (b)(4) to reflect the conforming provision of section 401(b)(2) of Public Law 106–113.

V. Medicare-Dependent, Small Rural Hospitals (Section 404 of Public Law 106–113 and 42 CFR 412.90(j) and 412.108)

Section 404 of Public Law 106–113 added a 5-year extension of the Medicare-dependent, small rural hospital (MDH) program (FY 2002 through FY 2006). This category of hospitals was originally created by section 6003(f) of the Omnibus Budget Reconciliation Act of 1989 (Public Law 101–239), which added section 1886(d)(5)(G) to the Act.

As set forth in section 1886(d)(5)(G) of the Act, in order to be classified as an MDH, a hospital must meet all of the following criteria:

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

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

- The national Federal rate applicable to the hospital.
- The updated hospital-specific rate using FY 1982 cost per discharge.
- The updated hospital-specific rate using FY 1987 cost per discharge.

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

Section 4204(a)(3) of Public Law 105–33 reinstated the MDH special payment for discharges occurring on or after October 1, 1997 and before October 1, 2001, but did not revise either the

qualifying criteria for these hospitals or the payment methodology.

Section 404(a) of Public Law 106–113 extended the MDH provision to discharges occurring on or after October 1, 2002 and before October 1, 2006.

We are revising §§ 412.90(j) and 412.108 to reflect the extension of the MDH program.

VI. Changes to the IME Adjustment (Section 111 of Public Law 106–113 and 42 CFR 412.105(d)(3))

Section 1886(d)(5)(B) of the Act provides that prospective payment hospitals that have residents in an approved GME program receive an additional payment to reflect the higher indirect operating costs associated with GME. The regulations regarding the calculation of this additional payment, known as the IME adjustment, are located at § 412.105.

Section 111(a) of Public Law 106–113 amended section 1886(d)(5)(B) of the Act by modifying the transition for the IME adjustment. The IME adjustment factor is calculated using a formula multiplier that is represented as c in the following equation: $c \times [(1 + r)^{.405} - 1]$. The variable r represents the hospital's resident-to-bed ratio.

Public Law 105–33 established the formula multiplier for discharges occurring during FY 2000 at 1.47. However, section 111(b) of Public Law 106–113 provides for special payments to each hospital to reflect the amount of IME payments if c equaled 1.6 for discharges occurring during FY 2000, rather than 1.47. In accordance with section 111(b)(2) of Public Law 106–113, these special payments will not affect any other payments, determinations, or budget neutrality adjustments under section 1886(d) of the Act.

Under amendments enacted by section 111(a) of Public Law 106–113, for discharges occurring during FY 2001, the formula multiplier is 1.54. Changes to the factor for discharges occurring in FY 2001 were addressed in the proposed rule on FY 2001 hospital inpatient prospective payment system rates and changes that was published in the **Federal Register** on May 5, 2000 (65 FR 26281) and that will be finalized by August 1, 2000. Changes to the factor for discharges occurring in FY 2002 and thereafter are discussed in the final rule to be published by August 1, 2000.

We are amending § 412.105(d)(3) to reflect the additional payment provided for discharges occurring during FY 2000 under section 111(b)(1) of Public Law 106–113.

VII. Payment for Costs of GME

Under section 1886(h) of the Act, Medicare pays hospitals for the direct costs of GME. The payments are based on the number of residents trained by the hospital. Section 1886(h) of the Act, as revised by Public Law 105–33, caps the number of residents a hospital may count for direct GME and IME. In general, the total number of residents in the fields of allopathic or osteopathic medicine in a hospital may not exceed the number of such FTE residents in the hospital with respect to the hospital's most recent cost reporting period ending on or before December 31, 1996. In the regulations we published on August 29, 1997 (62 FR 46003), May 12, 1998 (63 FR 26327), July 31, 1998 (63 FR 40986), and July 30, 1999 (64 FR 41517), we established special rules for adjusting the FTE resident caps for indirect and direct GME for new medical residency programs. Public Law 106–113 further revised sections 1886(d) and 1886(h) of the Act to allow a hospital's caps to be adjusted if certain additional criteria are met.

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

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

The statute allows a hospital to receive an adjustment for those residents to its individual FTE cap of up to three additional FTE residents. We are providing in this interim final rule with comment period that, in order for a hospital to receive this adjustment, the leave of absence must have been approved by the residency program director to allow the residents to be absent from the program and return to the program after the absence. We are requiring that no later than 6 months after the date of publication of this interim final rule, the hospital must submit a request to the fiscal intermediary for an adjustment to its FTE cap and must provide contemporaneous documentation of the approval of the leave of absence by the residency program director, specific to each additional resident that is to be counted for purposes of the adjustment. For example, a letter to the resident by the residency program director before the resident takes the leave would be sufficient documentation of prior approval of the leave of absence.

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

We are adding new §§ 412.105(f)(1)(xi) and 413.86(g)(9) to incorporate the provisions of section 407(a) of Public Law 106–113.

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

Public Law 105–33 included several provisions with the intent of encouraging physician training and practice in rural areas. Section 1886(h)(4)(H)(i) of the Act, as added by section 4623 of Public Law 105–33, directed the Secretary, in promulgating rules for the purpose of the FTE cap, to give special consideration to facilities that meet the needs of underserved rural areas. Consistent with the intent of this provision, section 407(b) of Public Law 106–113 provides a 30-percent expansion of a rural hospital's direct and indirect FTE count for purposes of establishing the hospital's individual FTE cap. Specifically, section 407(b) provides that, effective for direct GME with cost reporting periods beginning on or after April 1, 2000, and for IME, with discharges occurring on or after April 1, 2000, the FTE count may not exceed 130 percent of the number of unweighted residents the rural hospital counted in its most recent cost reporting period ending on or before December 31, 1996.

For example, if a hospital located in a rural area had 10 unweighted FTEs for its count for both direct GME and IME in its most recent cost reporting period

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

We are incorporating the provisions of section 407(b) of Public Law 106–113 in §§ 412.105(f)(1)(iv) and 413.86(g)(4).

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

Section 407(c) of Public Law 106–113 amended section 1886(h)(4)(H) of the Act to add a provision that, in the case of a hospital that is not located in a rural area but establishes separately accredited approved medical residency training programs (or rural tracks) in a rural area or has an accredited training program with an integrated rural track, an adjustment may be made to the hospital's cap on the number of residents in order to encourage the training of physicians in rural areas. For direct GME, the amendment applies to payments to hospitals for cost reporting periods beginning on or after April 1, 2000; for IME, the amendment applies to discharges occurring on or after April l, 2000.

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

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

We are amending § 413.86 to add paragraph (g)(11) (and amending § 412.105 to add paragraph (f)(1)(x)) to specify that, for direct GME, for cost reporting periods beginning on or after April 1, 2000, (or, for IME, for discharges occurring on or after April 1, 2000), an urban hospital that establishes a new residency program, or has an existing residency program, with a rural track (or an integrated rural track) may include in its FTE count residents in those rural tracks, in addition to the residents subject to the FTE cap at § 413.86(g)(4). An urban hospital may count the residents in the rural track up to a ''rural track FTE limitation'' for that hospital. We are defining this rural track FTE limitation at § 413.86(b) as the maximum number of residents (as specified at § 413.86(g)(11)(i) through (vi)) training in a rural track residency program that an urban hospital may include in its FTE count, that is in addition to the number of FTE residents already included in the hospital's FTE cap.

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

We are specifying that urban hospitals that wish to count FTE residents in rural tracks, up to a rural track FTE limitation, must comply with the conditions discussed below:

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

We are specifying at § 413.86(g)(11)(i) that if an urban hospital rotates residents in the rural track program to a rural hospital(s) for at least two-thirds of the duration of the program, the urban hospital may include those residents in its FTE count for the time the rural track residents spend at the urban hospital. The urban hospital may include in its FTE count those residents in the rural track training at the urban hospital, not to exceed its rural track FTE limitation, determined as follows:

- For the first 3 years of the rural track's existence, the rural track FTE limitation for each urban hospital will be the actual number of FTE residents training in the rural track at the urban hospital.
- Beginning with the fourth year of the rural track's existence, the rural track FTE limitation is equal to the product of: (a) The highest number of residents in any program year who, during the third year of the rural track's existence, are training in the rural track at the urban hospital or the rural hospital(s) and are designated at the beginning of their training to be rotated to the rural hospital(s) for at least two-thirds of the duration of the program; and (b) the number of years those residents are training at the urban hospital.

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

We note that if the residents in the rural track are rotating to a rural hospital(s), the rural hospital(s) may be eligible to count the residents as part of

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

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

We are specifying at § 413.86(g)(11)(ii) that if an urban hospital rotates residents in the rural track program to a rural nonhospital site(s) for at least two-thirds of the duration of the program, the urban hospital may include those residents in its FTE count, subject to the requirements under existing § 413.86(f)(4). The urban hospital may include in its FTE count those residents in the rural track, not to exceed its rural track FTE limitation, determined as follows:

- For the first 3 years of the rural track's existence, the rural track FTE limitation for each urban hospital will be the actual number of FTE residents training in the rural track at the urban hospital and the rural nonhospital site.
- Beginning with the fourth year of the rural track's existence, the rural track FTE limitation is equal to the product of: (a) The highest number of residents in any program year who, during the third year of the rural track's existence, are training in the rural track at the urban hospital and are designated at the beginning of their training to be rotated to a rural nonhospital site(s) for at least two-thirds of the duration of the program and the rural nonhospital site(s); and, (b) the number of years in which the residents are expected to complete each program based on the minimum accredited length for the type of program.

We note that we specify at § 413.86(g)(11)(ii) that an urban hospital may include in its FTE count those residents in the rural track rotating to a rural nonhospital site, subject to the requirements under § 413.86(f)(4). The regulations at § 413.86(f)(4) provide, in part, that a hospital that incurs ''all or substantially all'' of the costs of training residents in a nonhospital site may include those residents in determining the number of FTE residents (not to exceed the FTE cap) for that hospital. Under this new rural track policy, where the urban hospital rotates residents for at least two-thirds of the residency program to a rural nonhospital site, the urban hospital would be eligible to include in its FTE count residents training in the rural track up to its rural track FTE limitation, but the urban hospital must still reimburse the rural nonhospital site for the costs of training those residents, as specified under § 413.86(f)(4).

An example of this second scenario is where urban hospital A has a new internal medicine residency program that was established July 1, 1998, and rotates six PGY (program year) 2s and five PGY 3s in the third year of the program to rural nonhospital site B. In the third year of the program, five PGY 1s who will subsequently rotate to the rural nonhospital site are training at hospital A. If hospital A is complying with the requirements at § 413.86(f)(4) by incurring all or substantially all of the cost of the training at rural nonhospital site B, beginning with the fourth year of the program, hospital A will receive a rural track FTE limitation of 18 FTEs, because the highest number of residents training at either hospital A or rural nonhospital site B is six PGY 2s at rural nonhospital site B and the minimum accredited length for internal medicine is 3 years (thus, six PGY 2s × 3 years = 18 FTEs). (Note that for the first 3 years of the new rural track program, the actual count of residents training in the rural track at both hospital A and rural nonhospital site B will be hospital A's rural track FTE count (and rural track FTE limitation for the first 3 years of the new rural track program).)

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

We are specifying at § 413.86(g)(11)(iii) that if an urban hospital rotates residents in the rural track program to a rural hospital(s) for periods of time that are less than two-thirds of the duration of the program, the urban hospital may not include those residents in its FTE count (if the urban hospital FTE count exceeds the urban hospital FTE cap), nor may the urban hospital include those residents when calculating its rural track FTE count. However, we note that, in this scenario, if the rural track residency program is a new residency program as specified in redesignated § 413.86(g)(12), the rural hospital may be eligible to receive an FTE cap adjustment for those residents training in the rural track, in accordance with the provisions of existing § 413.86(g)(6)(iii). If the rural track residency program is an existing residency program, a rural hospital may count the FTE residents training in the rural track at the rural hospital(s), in accordance with the provisions of § 413.86(g)(4), as amended, to incorporate the provisions of section 407(b)(1) of Public Law 106–113.

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

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

We are specifying at § 413.86(g)(11)(iv) that if an urban hospital rotates residents in the rural track program to a rural nonhospital site(s) for periods of time that are less than two-thirds of the duration of the program, the urban hospital may include those residents in its FTE count, subject to the requirements under existing § 413.86(f)(4). The urban hospital may include in its FTE count those residents in the rural track, not to exceed its rural track FTE limitation, determined as follows:

- For the first 3 years of the rural track's existence, the rural track FTE limitation for the urban hospital will be the actual number of FTE residents training in the rural track at the rural nonhospital site.
- Beginning with the fourth year of the rural track's existence, the rural track FTE limitation is equal to the product of: (a) the highest number of residents in any program year who, during the third year of the rural track's existence, are training in the rural track at the rural nonhospital site(s); and (b) the length of time in which the residents are being trained at the rural nonhospital site(s).

We note that, in this situation, an urban hospital would not be able to count the FTE for the rural track

resident while the resident is training at the urban hospital (unless the urban hospital's FTE count does not exceed its FTE cap). The rural track FTE count and the rural track FTE limitation for the urban hospital would be limited to account for the residents training at the rural nonhospital site.

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

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

An example of this last scenario would be in the situation where urban hospital C establishes a new residency program in FY 2001 by training six PGY 1s in the first year of the program's existence at the urban hospital. In the second year of the program, urban hospital C trains six PGY 1s and rotates the (now) six PGY 2s to rural nonhospital site D. In the third year of the program, urban hospital C trains seven PGY 1s, zero PGY 2s (rotating the six PGY 2s to rural nonhospital site D) and six PGY 3s. Urban hospital C would receive a rural track FTE limitation of zero FTEs in the first year of the program's existence, since urban hospital C did not rotate any residents to a rural nonhospital site in that first year; in the second year of the program, urban hospital C may count six FTE residents above its FTE cap as its second year rural track FTE limitation, since it rotated six PGY 2s to rural nonhospital site D in that second year; in the third year of the program, urban hospital C may count six FTE residents above its FTE cap as its third year rural track FTE limitation, as well, since it rotated six PGY 2s to the rural nonhospital site D in the third year. Finally, beginning with the fourth year of the rural track program's existence, urban hospital C will receive a rural track FTE limitation of seven FTEs (seven PGY 1 residents training at urban hospital C that are designated to rotate for one year of their training to rural nonhospital site D × 1 year of training at rural nonhospital site D), assuming urban hospital C complies with the requirements at § 413.86(f)(4) that urban hospital C incurs all or substantially all of the costs of training the six residents in rural nonhospital site D.

5. Conditions That Apply to All Urban Hospitals

We are specifying that all urban hospitals that wish to count FTE residents in rural tracks, not to exceed their respective rural track FTE limitations, must comply with each of the following conditions, as stated at §§ 413.86(g)(11)(v) and (vi):

(a) A hospital may not include in its rural track limitation or its FTE count (assuming the hospital's FTE count exceeds its cap), FTE residents who are training in a rural track residency program that were already included as part of the hospital's FTE cap (if the rural track program was in existence during the hospital's most recent cost reporting period ending on or before December 31, 1996).

(b) A hospital must base its count of residents in a rural track on written contemporaneous documentation that each resident enrolled in a rural track program at the urban hospital intends to rotate for a portion of the residency program to a rural area. For example, written contemporaneous documentation might be a letter of intent signed and dated by the rural track residency program director and the resident at the time of the resident's entrance into the rural track program as a PGY 1.

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

(d) If HCFA finds that residents who are included by the urban hospital as part of its FTE count did not actually complete the training in the rural area, HCFA will reopen the urban hospital's cost report within the 3-year reopening period (as specified in § 405.1885) and adjust the hospital's Medicare GME payments (and, where applicable, the hospital's rural track FTE limitation).

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

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

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

Under section 407(d)(3) of Public Law 106–113, this policy is effective as if included in the enactment of Public Law 105–33, that is, for direct GME, with cost reporting periods beginning

on or after October 1, 1997, and for IME, discharges occurring on or after October 1, 1997. If a hospital is owed payments as a result of this provision, payments must be made immediately.

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

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

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

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

We are revising § 413.86(g)(1) to reflect that, effective on or after July 1, 2000, for residency programs that began before, on, or after November 29, 1999, the period of board eligibility and the initial residency period for child neurology is now the period of board eligibility for pediatrics plus 2 years. We note that the initial residency period is the same for all child neurology residents, regardless of whether or not the resident completes the first year of training in pediatrics or neurology.

Following are four examples of how a child neurology resident's FTE status would be determined:

Example 1: Assume the resident completes 2 years of training in pediatrics followed by 3 years of training in child neurology.

Before Public Law 106–113:

Year 1: July 1, 1997–June 30, 1998. 1.0 FTE
Year 2: July 1, 1998–June 30, 1999. 1.0 FTE
Year 3: July 1, 1999–June 30, 2000. 1.0 FTE
Year 4: July 1, 2000–June 30, 2001. 0.5 FTE
Year 5: July 1, 2001–June 30, 2002. 0.5 FTE

After Public Law 106–113:

Year 1: July 1, 1997–June 30, 1998. 1.0 FTE
Year 2: July 1, 1998–June 30, 1999. 1.0 FTE
Year 3: July 1, 1999–June 30, 2000. 1.0 FTE
Year 4: July 1, 2000–June 30, 2001. 1.0 FTE
Year 5: July 1, 2001–June 30, 2002. 1.0 FTE

Example 2: Assume the resident completes 2 years of training in pediatrics followed by 3 years of training in child neurology.

Before Public Law 106–113:

Year 1: July 1, 1996–June 30, 1997. 1.0 FTE
Year 2: July 1, 1997–June 30, 1998. 1.0 FTE
Year 3: July 1, 1998–June 30, 1999. 1.0 FTE
Year 4: July 1, 1999–June 30, 2000. 0.5 FTE
Year 5: July 1, 2001–June 30, 2001. 0.5 FTE

After Public Law 106–113:

Year 1: July 1, 1996–June 30, 1997. 1.0 FTE
Year 2: July 1, 1997–June 30, 1998. 1.0 FTE
Year 3: July 1, 1998–June 30, 1999. 1.0 FTE
Year 4: July 1, 1999–June 30, 2000. 0.5 FTE
Year 5: July 1, 2000–June 30, 2001. 1.0 FTE

Example 3: Assume the resident completes 1 year of neurology training, followed by 1 year of pediatrics training, followed by 3 years of child neurology training.

Note: The initial residency period for neurology is currently 4 years.

Before Public Law 106–113:

Year 1: July 1, 1997–June 30, 1998. 1.0 FTE
Year 2: July 1, 1998–June 30, 1999. 1.0 FTE
Year 3: July 1, 1999–June 30, 2000. 1.0 FTE
Year 4: July 1, 2000–June 30, 2001. 1.0 FTE
Year 5: July 1, 2001–June 30, 2002. 0.5 FTE

After Public Law 106–113:

Year 1: July 1, 1997–June 30, 1998. 1.0 FTE
Year 2: July 1, 1998–June 30, 1999. 1.0 FTE
Year 3: July 1, 1999–June 30, 2000. 1.0 FTE
Year 4: July 1, 2000–June 30, 2001. 1.0 FTE
Year 5: July 1, 2001–June 30, 2002. 1.0 FTE

Example 4: Assume the resident completes 1 year of neurology training, followed by 1 year of pediatrics training, followed by 3 years of child neurology training.

Note: The initial residency period for neurology is currently 4 years.

Before Public Law 106–113:

Year 1: July 1, 1996–June 30, 1997. 1.0 FTE
Year 2: July 1, 1997–June 30, 1998. 1.0 FTE
Year 3: July 1, 1998–June 30, 1999. 1.0 FTE
Year 4: July 1, 1999–June 30, 2000. 1.0 FTE
Year 5: July 1, 2000–June 30, 2001. 0.5 FTE

After Public Law 106–113:

Year 1: July 1, 1996–June 30, 1997. 1.0 FTE
Year 2: July 1, 1997–June 30, 1998. 1.0 FTE
Year 3: July 1, 1998–June 30, 1999. 1.0 FTE
Year 4: July 1, 1999–June 30, 2000. 1.0 FTE
Year 5: July 1, 2000–June 30, 2001. 1.0 FTE

F. Technical Amendment

It has come to our attention that the first sentence of existing § 413.86(g)(1) contains a technical error. The first sentence of this paragraph reads ''For purposes of this section, an initial residency period is the number of years necessary to satisfy the minimum requirements for certification in a specialty or subspecialty, plus one year.'' This section of the regulation was revised as a result of section 13563(b) of Public Law 103–66, and was effective only until June 30, 1995. Generally, effective July 1, 1995, an initial residency period is defined as the minimum number of years required for board eligibility. Therefore, we are revising the first sentence of paragraph (g)(1) of § 413.86 accordingly. The remainder of paragraph (g)(1) of § 413.86 is unchanged.

VIII. Additional Payment to Hospitals That Operate Approved Nursing and Allied Health Education Programs (Section 541 of Public Law 106–113 and 42 CFR 413.86(d) and new 413.87)

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

Section 1886(h)(3)(D) of the Act, as added by section 4624 of Public Law 105–33, provides a 5-year phase-in of payments to teaching hospitals for direct costs of GME associated with

services to Medicare+Choice (managed care) enrollees for portions of cost reporting periods occurring on or after January 1, 1998. The amount of payment for direct GME is equal to the product of the PRA, the number of FTE residents working in all areas of the hospital (and nonhospital sites, if applicable), the ratio of the number of inpatient bed days that are attributable to Medicare+Choice enrollees to total inpatient bed days, and an applicable percentage. The applicable percentages are 20 percent for portions of cost reporting periods occurring in calendar year 1998, 40 percent in calendar year 1999, 60 percent in calendar year 2000, 80 percent in calendar year 2001, and 100 percent in calendar year 2002 and subsequent years. (Section 1886(d)(11) of the Act, as added by section 4622 of Public Law 105–33, provides a 5-year phase-in of payments to teaching hospitals for IME associated with services to Medicare+Choice enrollees for portions of cost reporting periods occurring on or after January 1, 1998, as well. However, the Medicare+Choice IME payments are irrelevant for the purposes of this section of the interim final rule, because although section 541 of Public Law 106-113 affects the payments for Medicare+Choice direct GME, it in no way affects the payments for Medicare+Choice IME.)

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

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

We are implementing section 541 by establishing regulations at new § 413.87 to incorporate the provisions of section 1886(l) of the Act. We are specifying the rules for a hospital's eligibility to receive the additional payment under section 1886(l), the requirements for determining the additional payment to each eligible hospital, and the methodologies for calculating each additional payment and for calculating the payment ''pool.'' These provisions are discussed below:

A. Qualifying Conditions for Payment

We are providing that, for portions of cost reporting periods occurring on or after January 1, 2000, a hospital that operates a nursing or allied health education program in accordance with § 413.85 may receive an additional payment amount associated with Medicare+Choice utilization if it meets two conditions.

First, section 541 of Public Law 106–113 directs the Secretary to determine the amount of payment for each hospital based on an ''* * * estimate of the ratio of the amount of payments made under section 1861(v) to the hospital for nursing and allied health education activities for the hospital's cost reporting period ending in the *second preceding fiscal year* to the *total of such amounts for all hospitals for such cost reporting periods.*'' (Emphasis added). Accordingly, we are providing that the hospital must have received reasonable cost Medicare payment for a nursing or allied health education program(s) in its cost reporting period(s) ending in the fiscal year that is 2 years prior to the current calendar year. For example, if the current calendar year is calendar year 2000, the fiscal year that is 2 years prior to calendar year 2000 is FY 1998. In this example, if a hospital did not receive reasonable cost payment for approved nursing or allied health education programs in FY 1998, but first establishes these programs and receives such payment as specified in § 413.85 after FY 1998, the hospital will only be eligible to receive an additional payment amount in the calendar year that is 2 years after the respective fiscal year. For example, if the hospital establishes a nursing or allied health program in FY 1999, it will first be eligible to receive an additional payment amount in calendar year 2001.

Second, section 541 of Public Law 106–113 states, ''For portions of cost reporting periods occurring in a year (beginning with 2000), the Secretary shall provide for an additional payment amount for any hospital that *receives* payments for the costs of approved educational activities for nurse and allied health professional training * * *.'' (Emphasis added). Accordingly, we are specifying that the hospital also must be receiving reasonable costs payment for its nursing or allied health education program(s) in the current calendar year to receive these additional payments for nursing and allied health training.

B. Calculating the Additional Payment Amount

The Medicare fiscal intermediary will determine if the hospital is eligible to receive the additional payment by applying the two criteria specified in section VIII.A.1. of this preamble. For portions of cost reporting periods occurring on or after January 1, 2000, an eligible hospital will receive the additional payment amount calculated according to the following steps:

Step 1: Determine the hospital's total Medicare payments received for approved nursing or allied health education programs based on data from the settled cost reports for the period(s) ending in the fiscal year that is 2 years prior to the current calendar year.

For example, if the current calendar year is 2000, determine the hospital's total nursing or allied health education payments made in its cost reporting period ending in FY 1998. If a hospital

has more than one cost reporting period ending in that fiscal year, the fiscal intermediary will sum the nursing and allied health payments made to the hospital over those cost reporting periods.

Step 2: Determine the ratio of the individual hospital's total nursing or allied health payments from Step 1, to the total of all nursing and allied health education program payments made across all hospitals for all cost reporting periods ending in the fiscal year that is 2 years prior to the current calendar year.

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

Each calendar year, HCFA will determine and publish in a proposed rule and a final rule the total amount of nursing and allied health education payments made across all hospitals during the fiscal year that is 2 years prior to the current calendar year.

Step 3: Multiply the ratio calculated in step 2 by the Medicare+Choice nursing and allied health payment ''pool'' (described under section VIII.C. of this preamble) that is determined by HCFA for the current calendar year.

The resulting product is each respective hospital's additional payment amount. We note that, as evidenced by the methodology outlined above, in accordance with section 541 of Public Law 106–113, Congress is not requiring each hospital's additional payment amount for a given period to be based on the hospital's Medicare+Choice utilization in that period.

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

In accordance with section 1886(l) of the Act, each calendar year, HCFA estimates a total amount, not to exceed $60 million, which is the basis for determining the additional payments for nursing and allied health education associated with Medicare+Choice enrollees to hospitals that operate approved nursing or allied health education programs. The total amount is calculated in the following manner:

Step 1: We determine the ratio of projected total Medicare+Choice direct GME payments across all hospitals in the current calendar year to projected total direct GME payments across all hospitals in the current calendar year.

Step 2: We multiply the ratio calculated in step 1 by projected total nursing and allied health education reasonable cost payments across all hospitals in the current calendar year.

The resulting product of Step 1 and Step 2, not to exceed $60 million, is the Medicare+Choice nursing and allied health payment ''pool'' for the current calendar year.

The projections of Medicare+Choice direct GME, direct GME, and nursing and allied health payments for a calendar year are based on such payments from the best available cost report data from the HCRIS. (For example, for calendar year 2000, the projections are based on the best available cost report data from HCRIS 1998). These payment amounts are then increased to the appropriate calendar year using the increases allowed by section 1886(h) of the Act for these services (using the percentage applicable for the current calendar year for Medicare+Choice direct GME and the Consumer Price Index (CPI) increases for direct GME, and assuming nursing and allied health remains a constant percentage of inpatient hospital spending).

D. Proportional Reduction to Medicare+Choice Direct GME Payments

In order for the Secretary to make the additional payments to eligible hospitals operating approved nursing or allied health education programs, section 1886(h)(3)(D) of the Act, as amended by section 541(b) of Public Law 106–113, specifies that the Secretary will carve out an estimated percentage of payments that are made to teaching hospitals for direct GME associated with services to Medicare+Choice enrollees. Specifically, the law provides that the estimated reductions in Medicare+Choice direct GME payments must equal the estimated total additional Medicare+Choice nursing and allied health education payments. Because the data for the components of the formula used to calculate this percentage will change each year (due to percentage changes in the Medicare+Choice direct GME phase-in, changes in direct GME payment amounts, and changes in nursing and allied health education payment amounts), we will calculate and publish the applicable percentage reduction each year in the proposed rule and the final rule for the annual update to the hospital inpatient prospective payment system rates. The percentage is estimated by calculating the ratio of the Medicare+Choice nursing and allied health payment ''pool'' for the current calendar year to the projected total Medicare+Choice direct GME payments made across all hospitals for the current calendar year.

E. Calculation of Amounts for Calendar Year 2000

The total amount of nursing and allied health education payments made across all hospitals for cost reporting periods ending in FY 1998, that is, 2 fiscal years prior to calendar year 2000, is estimated at $220,622,805. We have calculated this amount for FY 2000 based upon data from hospitals' cost reporting periods ending during FY 1998 (October 1, 1997 through September 30, 1998), as provided by section 541 of Public Law 106–113. (Section VIII.B. of this preamble provides a more detailed explanation of how this amount was derived.) We note that, if a hospital did not have a cost reporting period ending in FY 1998, such as a hospital with a long cost reporting period beginning in FY 1997 and ending in FY 1999, the hospital was excluded from our calendar year 2000 calculations (but will be included in our calendar year 2001 calculations). We are including data for 1,257 hospitals in the calendar year 2000 calculations. Ten of these hospitals had more than one cost reporting period.

According to the methodology outlined in section VIII.C. of this preamble, we have estimated the Medicare+Choice nursing and allied health education payment ''pool'' for calendar year 2000 to be $26,272,140. The ratio of each hospital's nursing and allied health education payments from its cost reporting period ending in FY 1998 to total nursing and allied health education payments made from all cost reporting periods ending in FY 1998 is then multiplied by $26,272,140 to determine each hospital's additional

payment amount (as described in section VIII.B. of this preamble).

For calendar year 2000, the projected total Medicare+Choice direct GME payments made to all hospitals is $250 million. Therefore, consistent with the methodology described in section VIII.D. of this preamble, the ratio for calendar year 2000 is $26,272,140 to $250 million, which equals a 10.5 percent reduction to each hospital's Medicare+Choice direct GME payment during calendar year 2000.

Accordingly, for portions of cost reporting periods occurring in calendar year 2000, hospitals that receive Medicare+Choice direct GME payments will have these payments reduced by 10.5 percent. Specifically, each hospital with a calendar year cost reporting period that is receiving Medicare+Choice direct GME payments will have those payments reduced by 10.5 percent for the period of January through December 2000. If a hospital does not have a calendar year cost reporting period, then the reductions to its Medicare+Choice direct GME payments will depend upon the portion of its cost reporting period that falls within the current calendar year. For example, if a hospital has an October through September fiscal year, its Medicare+Choice direct GME payments from October through December 1999 will not be affected. However, the hospital's Medicare+Choice direct GME payments from January through September 2000 (from its FY 2000 cost reporting period), and its Medicare+Choice direct GME payments from October through December 2000 (from its FY 2001 cost reporting period), will be reduced by 10.5 percent. Its Medicare+Choice direct GME payments for the remainder of its FY 2001 cost reporting period, which extends from January through September 2001, will be reduced by the applicable percentage for calendar year 2001. Similarly, if a hospital has a July through June cost reporting period, its Medicare+Choice direct GME payments from July through December 1999 will not be affected. However, its Medicare+Choice direct GME payments from January through June 2000, and its Medicare+Choice direct GME payments from July through December 2000, will be reduced by 10.5 percent. Its Medicare+Choice direct GME payments for the remainder of its cost reporting period, which extends from January through June 2001, will be reduced by the applicable percentage for calendar year 2001.

In general, we note that hospitals that operate both GME and nursing or allied health education programs should experience either a net gain or loss as a result of this provision, because although their Medicare+Choice direct GME payments will be reduced by a certain percentage, their Medicare+Choice nursing and allied health payments will be increased. However, hospitals that operate only GME programs will see their Medicare reimbursement reduced, and hospitals that operate only nursing or allied health education programs will see their Medicare reimbursement increased.

F. Regulation Changes

We are adding a new § 413.87 to incorporate the provisions of section 541 of Public Law 106–113. In addition, we are making a conforming change to §§ 413.86(d)(4) through (d)(6) to account for the revised methodology in determining a hospital's Medicare+Choice direct GME payments.

IX. Hospitals and Units Excluded From the Prospective Payment System (Section 121 of Public Law 106–113 and 42 CFR 413.40(c)(4)(iii)(B) and 413.40(c)(4)(v))

A. Limitation on the Target Amounts

In the August 29, 1997 final rule (62 FR 46018), in accordance with section 4414 of Public Law 105–33, we implemented section 1886(b)(3)(H) of the Act, which provides for caps on the target amounts for excluded hospitals and units for cost reporting periods beginning on or after October 1, 1997, through September 30, 2002. The caps on the target amounts apply to the following three classes of excluded hospitals: psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals. In establishing the caps on the target amounts within each class of hospital for new hospitals, section 1886(b)(7)(C) of the Act, as amended by section 4416 of Public Law 105–33, instructed the Secretary to provide an appropriate adjustment to take into account area differences in average wage-related costs. However, since the statutory language under section 4414 of Public Law 105–33 did not provide for the Secretary to account for area differences in wage-related costs in establishing the caps on the target amounts within each class of hospital for existing hospitals, HCFA did not account for wage-related differences in establishing the caps on the target amounts for existing facilities in FY 1998.

Section 121 of Public Law 106–113, which amended section 1886(b)(3)(H) of the Act, directed the Secretary to provide for an appropriate wage adjustment to the caps on the target amounts for psychiatric hospitals and units, rehabilitation hospitals and units and long-term care hospitals, effective for cost reporting periods beginning on or after October 1, 1999, through September 30, 2002. For purposes of calculating the caps, section 1886(b)(3)(H)(ii) of the Act requires the Secretary to first ''estimate the 75th percentile of the target amounts for such hospitals within such class for cost reporting periods ending during fiscal year 1996.'' Section 1886(b)(3)(H)(iii) of the Act, as added by Public Law 106–113, requires the Secretary to provide for ''an appropriate adjustment to the labor-related portion of the amount determined under such subparagraph to take into account differences between average wage-related costs in the area of the hospital and the national average of such costs within the same class of hospital.''

For cost reporting periods beginning in FY 2000, we update the FY 1996 wage-neutralized national 75th percentile target amount for each class of hospital by the market basket percentage increase up through FY 2000. For cost reporting periods beginning during FY 2001 through 2002, we update the previous fiscal year's wage-neutralized national 75th percentile target amount for each class of hospital by the applicable market basket percentage increase. In determining the national 75th percentile target amount for each class of hospital and consistent with the broad authority conferred on the Secretary by section 1886(b)(3)(H)(iii) of the Act (as added by Public Law 106–113) to determine the appropriate wage adjustment, we have accounted for differences in wage-related costs by adjusting the caps on the target amounts for each class of hospital (psychiatric, rehabilitation, and long-term care) using the methodology described in the following section.

B. Wage-Neutralized National 75th Percentile Target Amounts

In determining the wage-neutralized national 75th percentile target amount for each class of hospital, we used FY 1996 hospital cost report data and determined the labor-related portion of each hospital's FY 1996 target amount by multiplying its target amount by the most recent actuarial estimate of the labor-related portion of excluded hospital costs (or 0.71553). This actuarial estimate of the labor-related share of excluded hospital costs reflects revisions made in connection with other revisions to the excluded hospital market basket published in the August 29, 1997 final rule (62 FR 45996). Based on the most recent estimate of the relative weights of the labor cost

categories (wages and salaries, employee benefits, professional fees, postal services, and all other labor intensive services), the labor-related portion is 71.553 percent. The remaining 28.447 percent is the most recent estimate of the nonlabor-related portion. Similarly, we determined the nonlabor-related portion of each hospital's FY 1996 target amount by multiplying its target amount by the actuarial estimate of the nonlabor-related portion of costs (or 0.28447).

Next, we wage-neutralized each hospital's FY 1996 target amount by dividing the labor-related portion of each hospital's FY 1996 target amount by the hospital's FY 2000 hospital wage index under the hospital inpatient prospective payment system (see § 412.63), as shown in Tables 4A and 4B of the July 30, 1999 final rule (64 FR 41585). The FY 2000 wage index is the most current wage index available. Moreover, the FY 2000 hospital inpatient prospective payment system wage index was calculated using FY 1996 data. Within the specified class of hospital, each hospital's FY 1996 target amount was wage-neutralized using the published FY 2000 wage index. Each hospital's wage-neutralized FY 1996 target amount was calculated by adding the nonlabor-related portion of its target amount and the wage-neutralized labor-related portion of its target amount.

This methodology for wage-neutralizing each hospital's target amount to determine the national 75th percentile of the target amounts for each class of hospital is identical to the methodology we utilized for the wage index adjustment described in the August 29, 1997 final rule (62 FR 46020) to calculate the wage-adjusted 110 percent of the national median target amounts for new excluded hospitals and units. Again, we recognize that wages may differ for prospective payment hospitals and excluded hospitals and units, but we believe that the wage data reflect area differences in wage-related costs.

In light of the short timeframe we have for implementing section 121 of Public Law 106–113 for cost reporting provisions beginning in FY 2000, the FY 2000 wage data for acute care hospitals was the most feasible data source to determine the wage-neutralized national 75th percentile target amounts since reliable wage data for hospitals and hospital units excluded from the prospective payment system is not available.

Within each class of hospital, the wage-neutralized national 75th percentile target amounts were determined by arraying the hospitals' wage-neutralized FY 1996 target amounts. The wage-neutralized national 75th percentile target amount for each class of hospital is then separated into a labor-related share and a nonlabor-related share based on actuarial estimates of 71.553 percent labor-related share and 28.447 percent nonlabor-related share.

In the July 30, 1999 final rule (64 FR 41557), based on the national 75th percentile of the target amounts for cost reporting periods ending during FY 1996 (which did not account for area wage-related differences), updated by the market basket percentage increase to FY 2000, we had established the caps on the target amounts for existing excluded hospitals and units as follows:

- Psychiatric hospitals and units: $11,100
- Rehabilitation hospitals and units: $20,129
- Long-term care hospitals: $39,712

Using the wage-neutralized national 75th percentile of the target amounts for cost reporting periods ending during FY 1996, updated by the applicable market basket percentage increase to FY 2000, and the wage adjustment provided for under the amendments made by Public Law 106–113, we are establishing the labor-related share and nonlabor-related share of the FY 2000 wage-neutralized national 75th percentile target amounts for each class of hospital to determine a hospital's FY 2000 cap on the target amount as follows:

Class of excluded hospital or unit	Labor-related share	Nonlabor-related share
Psychiatric	$7,863	$3,126
Rehabilitation	14,666	5,831
Long-Term Care	28,321	11,259

We note that the March 2000 Program Memorandum (Transmittal Number A–00–16) issued to all Medicare fiscal intermediaries listed incorrect amounts for the labor-related portion and nonlabor-related portion of the wage-neutralized caps on the target amounts for FY 2000. The FY 2001 proposed rule (65 FR 26314) also listed incorrect amounts for the labor-related portion and nonlabor-related portion of the proposed FY 2001 wage-neutralized national 75th percentile caps on the target amounts. The correct labor-related and nonlabor-related portions of the wage-neutralized national 75th percentile cap on the target amount for FY 2000 for each class of hospital are listed above. The correct labor-related and nonlabor-related portions of the FY 2001 wage-neutralized national 75th percentile caps on the target amounts for each class of hospital will be included in the FY 2001 hospital inpatient prospective payment system final rule to be published by August 1, 2000.

The estimates of the national 75th percentile of the target amounts were developed from the best available data on the hospital-specific target amounts for cost reporting periods ending during fiscal year 1996 and then updated by the market basket percentage increase for FY 2000. We used the data that have been reported to HCFA for over 3,000 hospitals and units within the three classes of hospitals specified by the statute. We note that, with respect to long-term care hospitals, we used the same data (provider universe and target amount figures for hospitals within that class) as were used to establish the caps on the target amounts for long-term care hospitals published in the May 12, 1998 final rule (63 FR 26347). The data for psychiatric hospitals and units and rehabilitation hospitals and units used to establish the caps on the target amounts for these classes of hospitals included updates to the hospital's FY 1996 target amounts resulting from settling cost reports that previously had not been settled prior to August 1997 when the final rule establishing the caps on the target amounts for existing excluded hospitals was published.

C. Wage-Adjusted Target Amounts

We are specifying that, within each class of hospital, a hospital's wage-adjusted cap on the target amount per discharge for FY 2000 is determined by adding the hospital's nonlabor-related portion of the wage-neutralized national 75th percentile cap to its wage-adjusted labor-related portion of the national 75th percentile cap. A hospital's wage-adjusted labor-related portion of the target amount is calculated by multiplying the labor-related portion of the wage-neutralized national 75th

percentile cap for the hospital's class by the hospital's applicable wage index. For FY 2000, a hospital's applicable wage index is the wage index under the hospital inpatient prospective payment system (see § 412.63) for cost reporting periods beginning on or after October 1, 1999, and ending on or before September 30, 2000 as shown in Tables 4A and 4B of the July 30, 1999 final rule (64 FR 41585). The FY 1996 wage-neutralized national 75th percentile target amount for each class of hospital updated through FY 2000 by the applicable market basket percentage increase for excluded hospitals and hospital units used to determine a hospital's limitation on its FY 2000 target amount. For FY 2000, a hospital's FY 2000 limitation on its target amount is used to determine payments for excluded hospitals and units under § 413.40(d). The FY 2000 acute care hospital wage index is used to wage-adjust the labor-related portion of the FY 2000 wage-neutralized national 75th percentile target amount within the specified class of hospital since it is used to provide for an appropriate wage adjustment by accounting for differences in area wage-related costs in FY 2000 hospital inpatient prospective payment system payments. As we stated previously in this section, we recognize that wages may differ for prospective payment hospitals and excluded hospitals and units, but we believe that these wage data reflect area differences in wage-related costs. A hospital's applicable wage index is the wage index value for the area in which the hospital or unit is physically located (MSA or rural area) without taking into account prospective payment system hospital reclassification under section 1886(d)(10) of the Act, and section 1886(d)(8) of the Act as amended by section 401 of Public Law 106–113.

D. Changes in the Regulations

We are revising §§ 413.40(c)(4)(iii)(B) and (c)(4)(v) to incorporate the changes in the methodology used to determine the limitation on the target amounts for psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals, as provided for under the amendments made by section 121 of Public Law 106–113.

X. Critical Access Hospitals (CAHs)

A. Background: The Medicare Rural Hospital Flexibility Program and CAHs

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

Sections 401(b) and 403 of Public Law 106–113 modified the CAH program set forth in section 1820 of the Act.

B. Permitting Certain Facilities To Be Designated as CAHs (Section 401(b) of Public Law 106–113 and 42 CFR 485.610)

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

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

The application procedures and effective dates for an urban hospital seeking to reclassify as rural and thus eligible for CAH designation are set forth in the new regulation at § 412.103 that implements section 401(a), and discussed in section IV.C. of this interim final rule with comment period. We also are revising the regulation concerning CAH location at § 485.610(b) to reflect this amendment.

C. Other Legislative Changes Affecting CAHs

1. 96-hour Average Length of Stay Standard (Section 403(a) of Public Law 106–113 and 42 CFR 485.620(b))

Prior to the enactment of Public Law 106–113, section 1820(c)(2)(B)(iii) of the Act limited CAH designation only to facilities that provided inpatient care to each patient for a period of time not to exceed 96 hours, unless a longer period was required because of inclement weather or other emergency conditions, or a peer review organization (PRO) or equivalent entity, on request, waived the 96-hour restriction. Section 403(a) of Public Law 106–113 amended section 1820(c)(2)(B)(iii) of the Act to require that the 96-hour limit on stays be applied on an annual average basis, and to delete the provisions regarding waiver of longer stays. Therefore, CAHs will be permitted to keep some individual patients more than 96 hours without a waiver request, so long as the facility's average length of acute stays in any 12-month cost reporting period is not more than 96 hours.

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

We are revising the conditions of participation for length of stay for CAHs at § 485.620(b) to reflect this change.

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

Prior to enactment of Public Law 106–113, section 1820(c)(2)(B) of the Act allowed only nonprofit or public hospitals to be designated as CAHs. Section 403(b) of Public Law 106–113 revises section 1820(c)(2)(B) of the Act to remove the words ''nonprofit or public'' before ''hospitals,'' thus enabling for-profit hospitals to qualify for CAH status.

We are revising the conditions of participation related to the status and location for CAHs at § 485.610(a) to reflect this change.

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

Under section 1820(c)(2) of the Act, CAH designation was available only to facilities currently operating as hospitals. Section 403(c) of Public Law 106–113 amended the statute to permit

a State to designate as a CAH a facility that previously was a hospital but ceased operations on or after November 29, 1989 (10 years prior to the enactment of Public Law 106–113), if that facility fulfills the criteria under section 1820(c)(2)(B) of the Act for CAH designation as of the effective date of its designation. The amendment also allows State CAH designation for facilities that previously had been hospitals, but are currently State-licensed health clinics or health centers if they meet the revised criteria for CAH designation under section 1820(c)(2)(B) of the Act as of the effective date of designation.

We are revising the CAH criteria for State certification at § 485.610(a)(1) to reflect this change.

4. Elimination of Coinsurance for Clinical Diagnostic Laboratory Tests Furnished by a CAH (Section 403(e) of Public Law 106–113 and 42 CFR 410.152 and 413.70))

Under the law in effect before the enactment of Public Law 106–113, clinical diagnostic laboratory services furnished by a CAH to its outpatients were, like other outpatient CAH services, paid for on a reasonable cost basis, subject to the Part B deductible and coinsurance provisions. With respect to coinsurance, this means that the beneficiary was responsible for payment of 20 percent of the CAH's customary charges for the services and the CAH received payment from the Medicare program equal to 80 percent of its reasonable costs of furnishing the services.

Section 403(e) of Public Law 106–113 eliminated the Part B coinsurance and deductible for laboratory tests furnished by a CAH on an outpatient basis by providing for Medicare payment to the full amount of the lesser of the fee schedule or billed charges. Thus, CAHs are not permitted to impose a deductible or coinsurance charge on the beneficiary for these services, and Medicare Part B is to pay 100 percent of the lesser of the amount determined under the local laboratory fee schedule, the national limitation amount for that test, or the amount of the charges billed for the tests. In the case of services paid for on the basis of a negotiated rate under section 1833(h)(6) of the Act, the amount to be paid is equal to 100 percent of the negotiated rate. The effect of this change is that clinical diagnostic laboratory tests furnished by a CAH to its outpatients will be paid for on the same basis as is paid for these services furnished by all hospitals to outpatients.

Section 403(e)(2) of Public Law 106–113 provides that this provision is effective with respect to services furnished on or after November 29, 1999.

We are clarifying our policy and incorporating the provisions of section 403(e) of Public Law 106–113 in §§ 410.152 and 413.70 of the regulations.

Since enactment of Public Law 106–113, we have received many inquiries from the provider community about implementation of section 403(e). In response, we wish to note that revised payment instructions were issued in June 2000 as Medicare Intermediary Manual Transmittal No. 1799 and as Medicare Hospital Manual Transmittal No. 757, and that needed Part B electronic bill processing system changes will be made as soon as possible. The payment instructions explain that CAHs are to no longer collect deductible or coinsurance for these services and that any amounts collected from beneficiaries for these services provided on or after November 29, 1999, are to be returned to the beneficiaries in an appropriate and timely manner. The instructions also explain that payments to CAHs for the services will be adjusted, at cost report settlement, to reflect the payment method required by section 403(e).

5. Participation in Swing-Bed Program (Section 403(f) of Public Law 106–113)

Section 403(f) of Public Law 106–113, entitled ''Improvements in the Critical Access Hospital Program,'' includes a provision on swing-bed agreements. Since our existing regulations at § 485.645 already provide for swing beds in CAHs, we are not making any changes to our regulations based on this provision.

XI. Hospital Swing-Bed Program

Section 408(a) of Public Law 106–113 amended section 1883(b) of the Act to remove the provision that in order for a hospital to enter into an agreement to provide Medicare post-hospital extended care services, the hospital had to be granted a certificate of need for the provision of long-term care services from the State health planning and development agency (designated under section 1521 of the Public Health Service Act) for the State in which the hospital is located. Section 408(b) of Public Law 106–113 amended section 1883(d) of the Act to remove the provisions under paragraphs (d)(2) and (d)(3) that placed restrictions on lengths of stays in hospitals with more than 49 beds for post-hospital extended care services. These provisions are effective on the first day after the expiration of the transition period under section 1888(e)(2)(E) of the Act for payment for covered skilled nursing facility (SNF) services under the Medicare program; that is, at the end of the transition period for the SNF prospective payments system that began with the facility's first cost reporting period beginning on or after July 1, 1998 and extend through the end of the facility's third cost reporting period after this date.

The Medicare regulations that implemented the provision of section 1883(b) of the Act are located at § 482.66(a)(3). The regulations that implemented the provisions of sections 1883(d)(2) and (d)(3) of the Act are located at §§ 482.66(a)(6) and (a)(7). As a result of the changes made by section 408(a) and (b) of Public Law 106–113, we are removing §§ 482.66(a)(3), (a)(6), and (a)(7). (Existing paragraphs (a)(4) and (a)(5) are being redesignated as (a)(3) and (a)(4) respectively as a result of the removal of existing paragraph (a)(3).)

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

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

On July 30, 1999, we published a final rule addressing FY 2000 payment rates and policies for prospective payment system hospitals and excluded hospitals (64 FR 41490). Subsequently, on November 29, 1999, Public Law 106–113 was enacted. Public Law 106–113 contained a number of provisions relating to issues addressed in the final rule that have effective dates of October 1, 1999, November 29, 1999, or dates prior to the beginning of FY 2001 (that is, October 1, 2000).

In accordance with section 1871(b) of the Act, publication of a notice of proposed rulemaking is not required before implementing the statutory provisions of Public Law 106–113 that take effect on October 1, 1999, November 29, 1999, January 1, 2000, or

April 1, 2000. In addition, we find good cause to waive prior notice and comment procedures with respect to the provisions of this interim final rule with comment period that implement the specified provisions of Public Law 106–113 with these effective dates (except for sections 404 and 408), because the statutory provisions implemented by this document are clear and specific. Moreover, it would be impracticable to undertake such procedures before those provisions take effect, given the extremely short timeframe for implementing these statutory provisions.

Sections 404 and 408 are both provisions of Public Law 106–113 that contain changes to programs that have prospective effective dates after October 1, 2000. However, these provisions are specific and leave no room for further interpretation. That is, section 404 extends the MCH program as it is currently operated from FY 2002 through 2006. Sections 408(a) and (b) remove two provisions relating to implementation of the hospital swing-bed provision under sections 1883(b) and (d) that are effective on the first day after the expiration of the transition period under section 1888(e)(2)(E) of the Act for payment for covered SNF services; that is at the end of the transition period for the SNF prospective payments system that began with the facility's first cost reporting period beginning on or after July 1, 1998, and extend through the end of the facility's third cost reporting period after that date. These provisions of Public Law 106–113 require no exercise of discretion and we are merely conforming the Medicare regulations to the statute.

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

This rule has been determined to be a major rule as defined in Title 5, United States Code, section 804(2). Ordinarily, under 5 U.S.C. 801, as added by section 251 of Public Law 104–121, major rule shall take effect 60 days after the later of (1) the date a report on the rule is submitted to Congress or (2) the date the rule is published in the **Federal Register**. However, section 808(2) of Title 5, United States Code, provides that, notwithstanding 5 U.S.C. 801, a major rule shall take effect at such time as the Federal agency promulgating the rule determines, if, for good cause, the agency finds that notice and public procedure are impracticable, unnecessary, or contrary to the public interest. As indicated above, for good cause we find that it was impracticable to complete notice and comment procedures before publication of this rule and to delay the effective date of this rule . Accordingly, pursuant to 5 U.S.C. 808, these regulations are effective August 1, 2000.

XIII. Response to Comments

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

XIV. Regulatory Impact Analysis

A. Introduction

We have examined the impacts of this interim final rule with comment period as required by Executive Order 12866 and the Regulatory Flexibility Act (RFA) (Pub. L. 96–354). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more annually). The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $5 million or less annually. For purposes of the RFA, all hospitals are considered to be small entities. Individuals and States are not included in the definition of a small entity.

Also, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 50 beds.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in an expenditure in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of $100 million. This interim final rule with comment period does not mandate any requirements for State, local, or tribal governments.

It is clear that the changes being made in this document will affect both a substantial number of small rural hospitals as well as other classes of hospitals, and the effects on some may be significant. We are providing below, in combination with the rest of this interim final rule with comment period, a discussion of the regulatory impact on providers of the various provisions of Public Law 106–113 implemented in this interim final rule with comment period for which we are able to compute estimates of fiscal impact. Two sections of Public Law 106–113, sections 401 and 403, authorize certain hospitals to reclassify into different payment categories or apply for designation as a different class of provider. Since we have no way of anticipating how many hospitals will avail themselves of these options, we cannot predict the financial impact on the Medicare program of these provisions. The total anticipated impact of the provisions for which we can gather data is $400 million for FY 2000. These provisions, along with those for which data cannot be predicted, are discussed below.

B. Anticipated Effects

1. Impact of Changes Relating to the IME Adjustment Factor Schedule

As discussed in section VI. of this interim final rule with comment period, we are implementing the revised transition schedule for the IME adjustment for FY 2000. Section 111 of Public Law 106–113 provides for special payments to be made to each hospital to reflect the amount of IME payments if the payment factor for FY 2000 equaled 1.6 rather than 1.47.

For the purposes of this interim final rule, we have simulated the difference in IME payments due to the change described above based on the figures we used for computing the proposed FY 2001 prospective payment system rates. We have estimated that, for FY 2000, the total increase in IME payments to teaching hospitals is approximately $342.2 million, or 0.81 percent.

2. Impact on Excluded Hospitals and Units

We are implementing section 121(a) of Public Law 106–113, which amended section 1886(b)(3)(H) of the Act to direct the Secretary to make an appropriate wage adjustment to the 75th percentile cap on target amounts for psychiatric

hospitals and units, rehabilitation hospitals and units, and long-term care hospitals, established in FY 1998 by section 4414 of Public Law 105–33. The data sources for determining the wage-neutralized national 75th percentile target amounts were FY 1996 cost report data and the FY 2000 inpatient hospital prospective payment system wage index data.

Prior to the enactment of Public Law 106–113, target amounts for these hospitals were set, in accordance with the regulations at § 413.40(c)(4)(iii), at the lesser of the hospital-specific target amount or the national 75th percentile target amount, which was not adjusted to account for area differences in wage-related costs. Public Law 106–113 amended the regulations at § 413.40(c)(4)(iii) to specify that target amounts for FY 2000 for psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals are set at the lesser of the hospital-specific target amount or the wage-adjusted cap on the target amount, which is derived from the national 75th percentile wage-neutralized target amount for each class of hospital.

In order to estimate the impact of the wage-adjusted target amounts on hospitals within each class, we first calculated the target amount for each hospital as it was set under section 4414 of Public Law 105–33. Each hospital's target amount was set at the lesser of the hospital's hospital-specific target amount or the national 75th percentile target amount. In accordance the regulations at 42 CFR 413.40(d), we then compared the resulting target amount to the hospital's costs per discharge.

Taking into account the provisions of section 123(a) of Public Law 106–113, we then repeated the comparative calculations described above, replacing the national unadjusted 75th percentile target amount with each hospital's wage-adjusted target amount. The results were compared to show the estimated impact on these classes of hospitals and units as follows:

PERCENT OF TOTAL PROVIDERS BY TYPE

Class of hospital/unit	Percent of free-standing hospitals	Percent of hospital-based units
Psychiatric	30.7	69.3
Rehabilitation	16.4	83.6
Long-Term Care	100.0	([1])

[1] Not applicable.

PERCENT OF TOTAL PROVIDERS BY GEOGRAPHIC LOCATION

Class of hospital/unit	Percent of large urban	Percent of other urban	Percent of rural
Psychiatric	48.3	33.5	18.2
Rehabilitation	49.8	38.1	12.1
Long Term Care	68.6	23.1	8.3

NET CHANGE IN FY 2000 CAP PER DISCHARGE

Class of hospital/unit	Unadjusted FY 2000 target amount [1]	Wage-neutral FY 2000 target amount	Net percentage change
Psychiatric	$11,100	$10,990	−1.0
Rehabilitation	20,129	20,496	+1.8
Long-Term Care	39,712	39,580	−0.3

[1] As published in the July 30, 1999 Final Rule (64 FR 41557).

NET CHANGE BY CLASS OF HOSPITAL

Class of hospital/unit	Percent of Providers estimated to experience negative impact	Percent of providers estimated to experience no impact	Percent of providers estimated to experience positive impacts
Psychiatric	6.7	87.7	5.6
Rehabilitation	2.5	95.0	2.5
Long-Term Care	6.5	90.2	3.3

The impact of the wage-adjusted caps on target amounts on excluded hospitals and units (psychiatric, rehabilitation, and long-term care) was estimated based on FY 1996 data as this was the most complete data source available. The target amounts (hospital-specific targets, 75th percentile targets, and wage-adjusted targets) and costs compared in this estimated impact analysis were trended forward to account for inflation through FY 2000.

When comparing the costs to target amounts to determine the impact on hospitals, we did not attempt to determine the impact on incentive payments, continuous improvement bonus payments, or other payment adjustments for excluded hospitals outlined in the regulations at § 413.40(d). The actual impact on payments to each class of hospital depends on the cost experienced by each excluded hospital or unit since its

applicable base period. It is important to note that while the providers whose hospital-specific target amounts exceed the wage-adjusted cap on the target amounts will have their target amounts reduced to their wage-adjusted target amount, the real impact on each hospital and unit will depend on the level of its operating cost per discharge in relation to its target amount as outlined in at § 413.40(d).

As discussed in the preceding paragraphs, excluded hospital payments are calculated based on the lesser of costs per discharge or the target amount as set forth under § 413.40(c)(4)(iii). Consequently, the fact that the wage-neutralized national 75th percentile target amounts decreased slightly for both psychiatric hospitals and units and long-term care hospitals does not necessarily imply lower payments.

Approximately 75 percent of the hospitals and units in each of these classes have hospital-specific target amounts lower than both the unadjusted and wage-neutralized target amounts, and of those hospitals and units whose hospital-specific target amounts are higher than both the unadjusted and wage-neutralized target amounts, many have costs lower than their target amounts. Consequently, as shown in the table ''Net Change by Class of Hospital,'' most hospitals and hospital units do not appear to experience an impact from the wage-adjustment to the target amounts.

Among those hospitals that do appear to experience an impact from the wage-adjustment to the target amount, the wage-index associated with their location is an indicator in determining whether that impact is positive or negative. Since the wage-neutralized target amounts are wage-adjusted using the hospital inpatient prospective payment system wage index, hospital's located in areas with wage-index values greater than one will have higher wage-adjusted target amounts relative to hospitals located in areas with wage-index values less than one.

3. Impact of Provisions on Reclassification of Hospitals

We are implementing section 401(a) of Public Law 106–113, which added a new section 1886(d)(8)(E) to the Act that directs the Secretary to treat any hospital located in an urban area as being located in the rural area of a State if the hospital files an application and meets certain criteria specified in the statute.

The number of hospitals that will seek to reclassify from urban to rural is unknown at this time. However, generally, reclassification may affect payment rates under the prospective payment system, wage index calculations, and DSH, SCH, and IME adjustments.

4. Impact of Provisions on CAHs

We are implementing sections 401(b) and 403 of Public Law 106–113, which made a number of modifications to the CAH program under section 1820 of the Act. Specifically, it—

- Authorizes a State to designate a hospital as a CAH if, as set forth in the section 401(a) criteria for a hospital to be eligible to request reclassification from urban to rural, it would be considered as being located in the rural area of the State in which the hospital is located.
- Requires the 96-hour limit on stays in CAHs to be applied on an annual average basis and deletes the provisions regarding waiver for longer stays.
- Provides that for-profit hospitals may qualify for CAH status.
- Permits a State to designate as a CAH a facility that previously was a hospital but ceased operations on or after November 29, 1989 if that facility fulfills the criteria under section 1820(c)(2)(B) of the Act as of the effective date of its designation.
- Permits a State to designate as a CAH a facility that was once a hospital that downsized and now functions as a State licensed health clinic or health center, if the facility meets criteria under section 1820(c)(2)(B) of the Act as of the effective date of its designation.
- Eliminates the coinsurance and deductible for outpatient clinical diagnostic laboratory tests furnished by a CAH and requires that such tests be paid for on the same basis as would apply if the tests had been performed on an outpatient basis.
- Reaffirms the eligibility of CAHs that meet the applicable requirements to enter into ''swing-bed'' agreements, thus permitting inpatient CAH facilities to be used for furnishing of extended care services type (SNF) services.

The number of facilities that qualify as CAHs will increase as a consequence of the Public Law 106–113 amendments to the CAH program. CAHs are paid on a reasonable cost basis rather than under the prospective payment system. The budgetary impact of these amendments will correlate with the number of facilities that are designated as CAHs under the statutory amendment made by sections 401(b) and 403 of Public Law 106–113. However, we are unable at this time to predict the number of facilities that will be designated as CAHs under these provisions.

5. Impact of Provisions on MDHs

We are incorporating the provisions of section 404 of Public Law 106–113, which extended special payments under the prospective payment system to MDHs for 5 years, from FY 2002 through FY 2006. We estimate that the extension will amount to an increase in payment of 4.4 percent for each of the 5 years of the MDH extension. There is no increase in payment amounts for MDHs for FY 2000 as a result of PublicLaw 106–113.

6. Impact of Direct GME and IME Provisions

We are amending our regulations to incorporate changes mandated by sections 407(a) through (d) of Public Law 106-113, which amended sections 1886(d) and (h) of the Act to address specific GME FTE cap issues. These changes include increasing the cap for rural hospitals and urban hospitals that establish programs with training in rural areas, revising the FTE caps for hospitals with certain residents on leave during the base period, and temporarily increasing the cap for hospitals that train residents that transferred from certain VA hospitals. The regulations also reflect the provisions of section 312 of Public Law 106–113, which amended section 1886(h)(5) of the Act to change (for purposes of payment) the initial residency period for child neurology residents.

a. Approved Leave of Absences of Residents. Section VII.A. of this interim final rule implements section 407(a) of Public Law 106–113, which directs the Secretary to count an individual for purposes of determining a hospital's FTE cap, to the extent that the individual would have been counted as a primary care resident for purposes of the FTE cap but for the fact that the individual was on maternity or disability leave or a similar approved leave of absence. The provision allows a hospital to receive an adjustment to its individual FTE cap of up to three additional FTE residents. We are unable to predict at this time the number of residents affected by this provision. However, we believe the financial impact will be negligible, because few hospitals and FTEs are likely to be affected.

b. Adjustment to FTE Caps for Rural Hospitals. As explained in section VII.C. of this interim final rule, we are implementing section 407(b) of Public Law 106-113 which provides for a 30-percent expansion to a rural hospital's FTE resident cap. We have calculated an estimated impact on the Medicare program as a result of this provision. We used the best available cost report data

from 1995 HCRIS, which included the resident counts from which the rural hospitals' (and urban hospitals') caps were set. Seventy rural teaching hospitals were included in this impact analysis.

To determine the impact of this provision, we first estimated the average GME (direct GME and IME combined) payment amount made to rural hospitals in FY 1995. Then, we increased the average GME payment amount by 30-percent and multiplied this amount by 70 to reflect a potential 30-percent increase in the number of FTEs across all rural hospitals. Next, we updated this amount for inflation from FY 1995 to FY 2000, and from FY 2000 through FY 2004. Specifically, the estimated costs for each fiscal year are as follows:

FY 2000: $28.8 million
FY 2001: $29.5 million
FY 2002: $30.2 million
FY 2003: $31.1 million
FY 2004: $31.9 million

The total maximum estimated cost for FY 2000 through FY 2004 is $151.5 million. However, we do not anticipate that all rural hospitals will expand their counts by 30-percent in FY 2000. Therefore, we believe that the actual cost in FY 2000 will be somewhat less than $28.8 million.

c. Urban Hospitals with Rural Track Residency Programs. As discussed in section VII.C. of this interim final rule with comment period, we are implementing the provision that allows an urban hospital that establishes a new residency program or has an existing residency program with a rural track (or an integrated rural track) to include in its FTE count residents in those rural tracks, in addition to the residents already included in the hospital's FTE cap.

We estimated the costs to the Medicare program from FY 2000 through FY 2004 based on the number of currently existing (as of May 2000), separately accredited, ''1–2'' rural training track programs. Considering that there are currently 26 such programs, each averaging 4 residents, and making assumptions about the growth of new programs, we estimate that the cost from FY 2000 through FY 2004 will be $75 million. Specifically, the estimated cost per year is $5 million for FY 2000, $10 million for FY 2001, and $20 million for FYs 2002, 2003, and 2004.

d. Residents Training at VA Hospitals That Would Lose Accreditation. Section VII.D. of this interim final rule with comment period implements section 407(d) of Public Law 106–113 which addresses the situation where a non-VA hospital temporarily takes on residents training at a VA hospital because the program at the VA hospital would lose its ACGME accreditation if the residents continued to train at the VA hospital. We estimate that the number of residents affected by this provision will be small; we know of only one hospital that is affected by this provision. Therefore, the financial impact will be negligible.

e. Child Neurology Training. We are implementing the provisions of section 312 of Public Law 106–113 which amended section 1886(h)(5) of the Act to revise the initial residency period for child neurology residency programs. We believe this provision will have a minimal financial impact, because there are so few hospitals that will be affected by this provision.

7. Medicare+Choice Nursing and Allied Health Education Payments

As discussed in section VIII. of this interim final rule, we are implementing the methodology for determining the additional payments to be made to hospitals that receive reasonable cost payment for approved nursing or allied health education programs for their services associated with Medicare+Choice enrollees. The estimated total amount calculated for these payments, not to exceed $60,000,000 in a calendar year, is based on the proportion of projected total direct GME payments for Medicare+Choice enrollees to projected total direct GME payments, multiplied by projected total nursing and allied health education payments. Hospitals would receive these payments in proportion to the amount of Medicare nursing and allied health education payments received in the cost reporting period that ended in the fiscal year that is 2 years prior to the current calendar year, to the total amount of nursing and allied health education payments paid to all hospitals in that cost reporting period. Direct GME payments for Medicare+Choice utilization would be reduced to reflect the estimated amount of additional payments that would be made for nursing and allied health education programs under this provision. For a more detailed explanation of this policy, refer to section VIII. of this preamble.

By requiring that the Medicare+Choice direct GME payments be reduced in order to provide for the additional nursing and allied health education payments, this provision is designed to be budget neutral in the aggregate. However, on a hospital specific basis, hospitals that operate both GME and nursing or allied health education programs may experience either a net gain or loss as a result of this provision. This is because, although their Medicare+Choice direct GME payments will be reduced by a certain percentage, their nursing and allied health education payments will be increased. However, those hospitals that operate only GME programs will see their Medicare reimbursement reduced, and those hospitals that operate only nursing or allied health education programs will see their Medicare reimbursement increased.

As explained in section VIII.E. of this preamble, the percentage decrease to hospitals' Medicare+Choice direct GME payments is 10.5 percent. For purposes of this interim final rule with comment period, we have estimated a percentage increase to hospitals' nursing and allied health education payments for calendar year 2000. When the nursing and allied health education payment ''pool'' is added to the total projected nursing and allied health education payments for calendar year 2000, the estimated percentage increase in total nursing and allied health payments is 10.2 percent.

8. Hospital Swing Bed Program

The elimination of the requirements for State certification of need to use acute care beds as swing beds for long-term care patients and the elimination of the constraints on the length of stay in swing beds for rural hospitals with 50 to 100 beds will have a positive effect on providers, especially rural hospitals. However, we do not have the necessary data to determine at this time a budgetary impact of these provisions on Medicare payments.

C. Federalism

We have examined this interim final rule with comment period in accordance with Executive Order 13132, Federalism, and have determined that this interim final rule with comment period will not have any negative impact on the rights, rules, and responsibilities of State, local, or tribal governments.

D. Executive Order 12866

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

XV. Information Collection Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is

submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

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

We are soliciting public comment on each of these issues for § 412.103(b), which contains information collection and recordkeeping requirements.

Section 412.103(b) specifies that a facility seeking reclassification under section 401(a) or (b) of Public Law 106–113 must apply in writing to the HCFA Regional Office and include documentation of the criteria on which its request is based. The application must be mailed; facsimile or other electronic means are not acceptable.

The hospital's application must include a copy of the State law or regulation or other authoritative document verifying that the requesting hospital is situated in an area determined to be rural by the State or the hospital is considered to be a rural hospital.

We estimate that it will take each hospital approximately 30 minutes to complete the application process. We estimate that additional time would be needed to collect the required documentation. This recordkeeping should take no more than approximately 2 hours. Therefore, the paperwork burden associated with the reclassification process would add up to an additional 2½ hours per hospital that request reclassification under section 401 of Public Law 106–113.

These information collection and recordkeeping requirements are not effective until they are approved by OMB.

Comments on these information collection and recordkeeping requirements should be mailed to the following addresses:

Health Care Financing Administration, Office of Information Services, Security and Standards Group, Division of HCFA Enterprise Standards, Room N2–14–26, 7500 Security Boulevard, Baltimore, Maryland 21244–1850, Attn: John Burke HCFA–1131-IFC; and

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 3001, New Executive Office Building, Washington, DC 20503, Attn: Allison Herron Eydt HCFA–1131–IFC, HCFA Desk Officer.

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 482

Grant programs-health, Hospitals, Medicaid, 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:

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

A. Part 410 is amended as follows:

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

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

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

§ 410.152 Amounts of payment.

* * * * *

(k) *Amount of payment: Outpatient CAH services.* (1) Payment for CAH outpatient services is the reasonable cost of the CAH in providing these services, as determined in accordance with section 1861(v)(1)(A) of the Act, with § 413.70(b) and (c) of this chapter, and with the applicable principles of cost reimbursement in part 413 and in part 415 of this chapter.

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

* * * * *

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

B. Part 412 is amended as follows:

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

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

2. Section 412.63 is amended by revising paragraph (b)(1) to read as follows:

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

* * * * *

1. *Geographic classifications.* (1) For purposes of this section, the definitions set forth in § 412.62(f) apply, except that, effective January 1, 2000, a hospital reclassified as rural may mean a reclassification that results from a geographic redesignation as set forth in § 412.62(f)(1)(iv) or a reclassification that results from an urban hospital applying for reclassification as rural as set forth in § 412.103.

* * * * *

3. Section 412.90 is amended by revising paragraphs (e) and (j) to read as follows:

§ 412.90 General rules.

* * * * *

(e) *Hospitals located in areas that are reclassified from urban to rural.* (1) HCFA adjusts the rural Federal payment amounts for inpatient operating costs for hospitals located in geographic areas that are reclassified from urban to rural as defined in § 412.62(f). This adjustment is set forth in § 412.102.

(2) HCFA establishes a procedure by which certain individual hospitals located in urban areas may apply for reclassification as rural. The criteria for reclassification are set forth in § 412.103.

* * * * *

(j) *Medicare-dependent, small rural hospitals.* For cost reporting periods beginning on or after April 1, 1990 and before October 1, 1994, or beginning on or after October 1, 1997 and before October 1, 2006, HCFA adjusts the prospective payment rates for inpatient operating costs determined under subparts D and E of this part if a hospital is classified as a Medicare-dependent, small rural hospital.

* * * * *

4. The section heading of § 412.102 is revised to read as follows:

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

5. A new § 412.103 is added to read as follows:

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

(a) *General criteria.* A prospective payment hospital that is located in an urban area (as defined in § 412.62(f)(1)(ii)) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:

(1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification as determined by the Office of Rural Health Policy (ORHP) of the Health Resources and Services Administration which is available via the ORHP website at *http://www.nal.usda.gov/orph* or from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, 5600 Fishers Lane, Room 9–05, Rockville, MD 20857.

(2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.

(3) The hospital would qualify as a rural referral center as set forth in § 412.96, or as a sole community hospital as set forth in § 412.92, if the hospital were located in a rural area.

(b) *Application requirements.* (1) *Written application.* A hospital seeking reclassification under this section must submit a complete application in writing to HCFA in accordance with paragraphs (b)(2) and (b)(3) of this section.

(2) *Contents of application.* An application is complete if it contains an explanation of how the hospital meets the condition that constitutes the basis of the request for reclassification set forth in paragraph (a) of this section, including data and documentation necessary to support the request.

(3) *Mailing of application.* An application must be mailed to the HCFA Regional Office by the requesting hospital and may not be submitted by facsimile or other electronic means.

(4) *Notification by HCFA.* Within 5 business days after receiving the hospital's application, the HCFA Regional Office will send the hospital a letter acknowledging receipt, with a copy to the HCFA Central Office.

(5) *Filing date.* The filing date of the application is the date HCFA receives the application.

(c) *HCFA review.* The HCFA Regional Office will review the application and notify the hospital of its approval or disapproval of the request within 60 days of the filing date.

(d) *Effective dates of reclassification.* (1) Except as specified in paragraph (d)(2) of this section, HCFA will consider a hospital that satisfies any of the criteria set forth in paragraph (a) of this section as being located in the rural area of the State in which the hospital is located as of that filing date.

(2) If a hospital's complete application is received in HCFA by September 1, 2000, and satisfies any of the criteria set forth in paragraph (a) of this section, HCFA will consider the filing date to be January 1, 2000.

(e) *Withdrawal of application.* A hospital may withdraw an application at any time prior to the date of HCFA's decision as set forth in paragraph (c) of this section.

(f) *Duration of classification.* An approved reclassification under this section remains in effect without need for reapproval unless there is a change in the circumstances under which the classification was approved.

(g) *Cancellation of classification.* (1) A hospital may cancel its rural reclassification by submitting a written request to the HCFA Regional Office not less than 120 days prior to the end of its current cost reporting period.

(2) The hospital's cancellation of the classification is effective beginning with the hospital's next full cost reporting period following the date of its request for cancellation.

6. Section 412.105 is amended by:

A. Revising paragraph (d)(3)(iv).

B. Revising paragraph (f)(1)(iv).

C. Adding and reserving paragraphs (f)(1)(viii) and (ix).

D. Adding new paragraphs (f)(1)(x), (f)(1)(xi), and (f)(1)(xii).

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

* * * * *

(d) *Determination of education adjustment factor.* * * *

(3) *Step three.* * * *

(iv) For discharges occurring during fiscal year 2000, 1.47.

(A) Each hospital receives an amount that is equal in the aggregate to the difference between the amount of payments made to the hospital if 'c' equaled 1.6, rather than 1.47.

(B) The payment of this amount will not affect any other payments, determinations, or budget neutrality adjustments.

* * * * *

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

(iv) Effective for discharges occurring on or after October 1, 1997, the total number of FTE residents in the fields of allopathic and osteopathic medicine in either a hospital or a nonhospital setting that meets the criteria listed in paragraph (f)(1)(ii) of this section may not exceed the number of such FTE residents in the hospital (or, in the case of a hospital located in a rural area, effective for discharges occurring on or after April 1, 2000, 130 percent of that number) with respect to the hospital's most recent cost reporting period ending on or before December 31, 1996.

* * * * *

(x) Effective for discharges occurring on or after April 1, 2000, an urban hospital that establishes a new residency program (as defined in § 413.86(g)(12) of this subchapter), or has an existing residency program, with a rural track (or an integrated rural track) may include in its FTE count residents in those rural tracks in accordance with the provisions of §§ 413.86(g)(11) of this subchapter.

(xi) Effective for discharges occurring in cost reporting periods beginning on or after November 29, 1999, a hospital may receive an adjustment to its FTE cap of up to three additional FTEs to the extent that the additional residents would have been counted as primary care residents for purposes of the hospital's FTE cap but for the fact that the additional residents were on maternity or disability leave or a similar approved leave of absence, in accordance with the provisions of § 413.86(g)(9) of this subchapter.

(xii) For discharges occurring on or after October 1, 1997, a non-Veterans Affairs (VA) hospital may receive a temporary adjustment to its FTE cap to reflect residents who had been previously trained at a VA hospital and were subsequently transferred to the non-VA hospital, if the hospital meets the criteria and other provisions of § 413.86(g)(10) of this subchapter.

* * * * *

§ 412.108 [Amended]

6. Section 412.108 is amended as follows:

a. In paragraph (a)(1), the date ''October 1, 2001'', is removed and ''October 1, 2006'' is added in its place.

b. In paragraph (c)(2)(ii) the date ''October 1, 2001'', is removed and ''October 1, 2006'' is added in its place.

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

C. Part 413 is amended as follows:

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

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

2. Section 413.40 is amended by republishing the introductory text of paragraph (c)(4) and of paragraph (c)(4)(iii) and revising paragraphs (c)(4)(iii)(B) and (c)(4)(v), to read as follows:

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

* * * * *

(c) *Costs subject to the ceiling.* * * *

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

* * * * *

(iii) In the case of a psychiatric hospital or unit, rehabilitation hospital or unit, or long-term care hospital, the target amount is the lower of—

* * * * *

(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 year 1999, 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.

(*3*) For cost reporting periods beginning during fiscal year 2000—

(*i*) The labor-related portion and the nonlabor-related portion of the wage-neutralized 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, are increased by the applicable market basket percentage up to the first cost reporting period beginning on or after October 1, 1999.

(*ii*) The labor-related portion of the wage-neutralized 75th percentile target amounts under paragraph (c)(4)(iii)(B)(*4*)(*i*) of this section is wage adjusted by multiplying it by the hospital's FY 2000 hospital inpatient prospective payment system wage index.

(*iii*) The wage-adjusted 75th percentile target amounts for hospitals in the same class is determined by adding the nonlabor-related portion of the wage-neutralized 75th percentile target amounts under paragraph (c)(4)(iii)(B)(*3*)(*i*) of this section and the hospital's wage-adjusted labor-related portion of the wage-neutralized 75th percentile target amounts determined under paragraph (c)(4)(iii)(B)(*3*)(*ii*) of this section, subject to the provisions of paragraph (c)(4)(iv) of this section.

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

(*i*) The amounts determined under paragraph (c)(4)(iii)(B)(*3*)(*i*) of this section are increased by the market basket percentage up through the subject period.

(*ii*) The labor-related portion of the wage-neutralized 75th percentile target amounts under paragraph (c)(4)(iii)(B)(**4**)(*i*) of this section is wage-adjusted by multiplying by the hospital's FY 2001 hospital inpatient prospective payment system wage index, for cost reporting periods beginning during fiscal year 2001 and the hospital's FY 2002 hospital inpatient prospective payment system wage index for cost reporting periods beginning during fiscal year 2002.

(*iii*) The wage-adjusted 75th percentile target amounts for hospitals in the same class are determined by adding the nonlabor-related portion of the wage-neutralized 75th percentile target amounts under paragraph (c)(4)(iii)(B)(*4*)(*i*) of this section and the hospital's wage-adjusted labor-related portion of the wage-neutralized 75th percentile target amounts determined under paragraph (c)(4)(iii)(B)(*4*)(*ii*) of this section, subject to the provisions of paragraph (c)(4)(iv) of this section.

* * * * *

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

* * * * *

3. Section 413.70 is amended by:

A. Revising paragraphs (b)(2)(iii) and (b)(2)(iv).

B. Removing paragraph (b)(2)(v).

C. Adding a new paragraph (c).

§ 413.70 Payment for services of a CAH.

* * * * *

(b) * * *

(2) * * *

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

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

(c) The following payment principles are used when determining payment for outpatient clinical diagnostic laboratory tests:

(1) The amount paid is equal to 100 percent of the least of—

(i) Charges determined under the fee schedule as set forth in section 1833(h)(1) or section 1834(d)(1) of the Act;

(ii) The limitation amount for that test determined under section 1833(h)(4)(B) of the Act or the amount of the charges billed for the test; or

(iii) A negotiated rate established under section 1833(h)(6) of the Act.

(2) Payment for outpatient clinical diagnostic laboratory tests is not subject to the Medicare Part B deductible and coinsurance amounts, as specified in § 410.152(k) of this chapter.

4. Section 413.86 is amended by:

A. Adding definitions of ''rural track FTE limitation'' and ''rural track or integrated rural track'' in alphabetical order under paragraph (b).

B. Revising paragraphs (d)(4) and (d)(5).

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

D. Revising paragraph (g)(1).

E. Revising the first sentence of paragraph (g)(4).

F. Redesignating paragraph (g)(9) as paragraph (g)(12).

G. Add new paragraphs (g)(9), (g)(10), and (g)(11).

§ 413.86 Direct graduate medical education payments.

* * * * *

(b) *Definitions.* * * *

Rural track FTE limitation means the maximum number of residents (as

specified in paragraph (g)(11) of this section) training in a rural track residency program that an urban hospital may include in its FTE count and that is in addition to the number of FTE residents already included in the hospital's FTE cap.

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

* * * * *

(d) *Calculating payment for graduate medical education costs.* * * *

(4) *Step four.* Effective for cost reporting periods beginning on or after January 1, 2000, the product derived from step three is reduced in accordance with the provisions of § 413.87(f).

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

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

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

* * * * *

(g) *Determining the weighted number of FTE residents.* (1) Generally, for purposes of this section, effective July 1, 1995, an initial residency period is defined as the minimum number of years required for board eligibility. Prior to July 1, 1995, the initial residency period equals the minimum number of years required for board eligibility in a specialty or subspecialty plus 1 year. An initial residency period may not exceed 5 years in order to be counted toward determining FTE status except in the case of fellows in an approved geriatric program whose initial residency period may last up to 2 additional years. Effective July 1, 2000, for residency programs that began before, on, or after November 29, 1999, the period of board eligibility and the initial residency period for a resident in an approved child neurology program is the period of board eligibility for pediatrics plus 2 years. Effective August 10, 1993, residents or fellows in an approved preventive medicine residency or fellowship program also may be counted as a full FTE resident for up to 2 additional years beyond the initial residency period limitations. For combined residency programs, an initial residency period is defined as the time required for individual certification in the longer of the programs. If the resident is enrolled in a combined medical residency training program in which all of the individual programs (that are combined) are for training primary care residents (as defined in paragraph (b) of this section) or obstetrics and gynecology residents, the initial residency period is the time required for individual certification in the longer of the programs plus 1 year.

* * * * *

(4) For purposes of determining direct graduate medical education payment, for cost reporting periods beginning on or after October 1, 1997, a hospital's unweighted FTE count for residents in allopathic and osteopathic medicine may not exceed the hospital's unweighted FTE count (or, effective for cost reporting periods beginning on or after April 1, 2000, 130 percent of the unweighted FTE count for a hospital located in a rural area) for these residents for the most recent cost reporting period ending on or before December 31, 1996. * * *

(9) Effective for cost reporting periods beginning on or after November 29, 1999, a hospital may receive an adjustment to its FTE cap of up to three additional resident FTEs, if the hospital meets the following criteria:

(i) The additional residents are residents of a primary care program that would have been counted by the hospital as residents for purposes of the hospital's FTE cap but for the fact that the additional residents were on maternity or disability leave or a similar approved leave of absence during the hospital's most recent cost reporting period ending on or before December 31, 1996;

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

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

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

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

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

(iii) The hospital submits a request to its fiscal intermediary for a temporary adjustment to its FTE cap, documents that it is eligible for this temporary adjustment by identifying the residents who have come from the VA hospital, and specifies the length of time those residents will be trained at the hospital.

(11) For cost reporting periods beginning on or after April 1, 2000, an urban hospital that establishes a new residency program, or has an existing residency program, with a rural track (or an integrated rural track) may include in its FTE count residents in those rural tracks, in addition to the residents subject to its FTE cap specified under paragraph (g)(4) of this section. An urban hospital with a rural track residency program may count residents in those rural tracks up to a rural track FTE limitation if the hospital complies with the conditions specified in paragraphs (g)(11)(i) through (g)(11)(vi) of this section.

(i) If an urban hospital rotates residents in the rural track program to a rural hospital(s) for at least two-thirds of the duration of the program, the urban hospital may include those residents in its FTE count for the time the rural track residents spend at the urban hospital. The urban hospital may include in its FTE count those residents in the rural track training at the urban hospital, not to exceed its rural track FTE limitation, determined as follows:

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

(B) Beginning with the fourth year of the rural track's existence, the rural track FTE limitation is equal to the product of the highest number of residents in any program year, who during the third year of the rural track's existence are training in the rural track at the urban hospital or the rural hospital(s) and are designated at the beginning of their training to be rotated to the rural hospital(s) for at least two-

thirds of the duration of the program, and the number of years those residents are training at the urban hospital.

(ii) If an urban hospital rotates residents in the rural track program to a rural nonhospital site(s) for at least two-thirds of the duration of the program, the urban hospital may include those residents in its FTE count, subject to the requirements under paragraph (f)(4) of this section. The urban hospital may include in its FTE count those residents in the rural track, not to exceed its rural track FTE limitation, determined as follows:

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

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

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

(*i*) The urban hospital and are designated at the beginning of their training to be rotated to a rural nonhospital site(s) for at least two-thirds of the duration of the program; and

(*ii*) The rural nonhospital site(s); and

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

(iii) If an urban hospital rotates residents in the rural track program to a rural hospital(s) for periods of time that are less than two-thirds of the duration of the program, the rural hospital may not include those residents in its FTE count (if the urban hospital's FTE count exceeds that hospital's FTE cap), nor may the urban hospital include those residents when calculating its rural track FTE limitation.

(iv) If an urban hospital rotates residents in the rural track program to a rural nonhospital site(s) for periods of time that are less than two-thirds of the duration of the program, the urban hospital may include those residents in its FTE count, subject to the requirements under paragraph (f)(4) of this section. The urban hospital may include in its FTE count those residents in the rural track, not to exceed its rural track FTE limitation, determined as follows:

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

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

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

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

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

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

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

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

(vi) If HCFA finds that residents who are included by the urban hospital as part of its FTE count did not actually complete the training in the rural area, HCFA will reopen the urban hospital's cost report within the 3-year reopening period as specified in § 405.1885 of this chapter and adjust the hospital's Medicare GME payments (and, where applicable, the hospital's rural track FTE limitation).

* * * * *

5. A new § 413.87 is added to read as follows:

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

(a) *Statutory basis.* This section implements section 1886(l) of the Act, which provides for additional payments to hospitals that operate and receive Medicare reasonable cost reimbursement for approved nursing and allied health education programs and the methodology for determining the additional payments.

(b) *Scope.* This section sets forth the rules for determining an additional payment amount to hospitals that receive payments for the costs of operating approved nursing or allied health education programs under § 413.85.

(c) *Qualifying conditions for payment.* For portions of cost reporting periods occurring on or after January 1, 2000, a hospital that operates and receives payment for a nursing or allied health education program under § 413.85 may receive an additional payment amount. The hospital may receive the additional payment amount, which is calculated in accordance with the provisions of paragraph (d) of this section, if both of the conditions specified in paragraph (c)(1) and (c)(2) of this section are met.

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

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

(d) *Calculating the additional payment amount.* Subject to the provisions of paragraph (f) of this section relating to calculating a proportional reduction in Medicare+Choice direct GME payments, the additional payment amount specified in paragraph (c) of this section is calculated according to the following steps:

(1) *Step one.* Each calendar year, determine the hospital's total nursing and allied health education program payments from its cost reporting period(s) ending in the fiscal year that is 2 years prior to the current calendar year.

(2) *Step two.* Determine the ratio of the hospital's payments from step one to the total of all nursing and allied health education program payments across all hospitals for all cost reporting periods ending in the fiscal year that is 2 years prior to the current calendar year.

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

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

(i) Determine the ratio of projected total Medicare+Choice direct GME payments made in accordance with the provisions of § 413.86(d)(3) across all hospitals in the current calendar year to projected total direct GME payments made across all hospitals in the current calendar year.

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

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

(3) The payment pool may not exceed $60 million in any calendar year.

PART 482—CONDITIONS OF PARTICIPATION FOR HOSPITALS

D. Part 482 is amended as follows:

1. The authority citation for Part 482 continues to read as follows:

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

§ 482.66 [Amended]

2. Section 482.66 is amended by:

A. Removing paragraph (a)(3).

B. Redesignating paragraphs (a)(4) and (a)(5) as (a)(3) and (a)(4), respectively.

C. Removing paragraphs (a)(6) and (a)(7).

PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

E. Part 485 is amended as follows:

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

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

2. Section 485.610 is amended by:

A. Revising paragraph (a).

B. Republishing the introductory text of paragraph (b).

C. Redesignating paragraph (b)(4) as paragraph (b)(5) and republishing newly designated paragraph (b)(5).

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

§ 485.610 Condition of participation: Status and location.

(a) *Standard:* Status. The facility is—

(1) A currently participating hospital that meets all conditions of participation set forth in this subpart;

(2) A recently closed facility, provided that the facility—

(i) Was a hospital that ceased operations on or after the date that is 10 years before November 29, 1999; and

(ii) Meets the criteria for designation under this subpart as of November 29, 1999; or

(3) A health clinic or a health center (as defined by the State) that—

(i) Is licensed by the State as a health clinic or a health center;

(ii) Was a hospital that was downsized to a health clinic or a health center; and

(iii) As of the effective date of its designation, meets the criteria for designation set forth in this subpart.

(b) *Standard: Location.* The CAH meets the following requirements:

* * * * *

(4) The CAH is being treated as being located in a rural area in accordance with § 412.103 of this chapter.

(5) The CAH is located more than a 35-mile drive (or, in the case of mountainous terrain or in areas with only secondary roads available, a 15-mile drive) from a hospital or another CAH, or the CAH is certified by the State as being a necessary provider of health care services to residents in the area.

3. Section 485.620 is amended by revising paragraph (b) to read as follows:

§ 485.620 Condition of participation: Number of beds and length of stay.

* * * * *

(b) *Standard: Length of stay.* The CAH provides acute inpatient care for a period that does not exceed, on an annual average basis, 96 hours per patient.

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

Dated: July 21, 2000.

Nancy Ann Min DeParle,

Administrator, Health Care Financing Administration.

Dated: July 24, 2000.

Donna E. Shalala,

Secretary.

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

APPENDIX A—URBAN COUNTIES AS OF JANUARY 1, 2000 WITH CENSUS TRACTS THAT MAY QUALIFY AS RURAL UNDER GOLDSMITH MODIFICATION

[Based on 1990 Census Data]

County	State
BALDWIN	ALABAMA.
MOBILE	ALABAMA.
TUSCALOOSA	ALABAMA.
ANCHORAGE	ALASKA.
COCONINO	ARIZONA.
MARICOPA	ARIZONA.
MOHAVE	ARIZONA.
PIMA	ARIZONA.
PINAL	ARIZONA.
YUMA	ARIZONA.
BUTTE	CALIFORNIA.
EL DORADO	CALIFORNIA.
FRESNO	CALIFORNIA.
KERN	CALIFORNIA.
LOS ANGELES	CALIFORNIA.
MADERA	CALIFORNIA.
MERCED	CALIFORNIA.
MONTEREY	CALIFORNIA.
PLACER	CALIFORNIA.
RIVERSIDE	CALIFORNIA.
SAN BERNARDINO	CALIFORNIA.
SAN DIEGO	CALIFORNIA.
SAN JOAQUIN	CALIFORNIA.
SAN LUIS OBISPO	CALIFORNIA.
SANTA BARBARA	CALIFORNIA.
SANTA CLARA	CALIFORNIA.
SHASTA	CALIFORNIA.
SONOMA	CALIFORNIA.
STANISLAUS	CALIFORNIA.
TULARE	CALIFORNIA.
VENTURA	CALIFORNIA.
ADAMS	COLORADO.
EL PASO	COLORADO.
LARIMER	COLORADO.
MESA	COLORADO.
PUEBLO	COLORADO.
WELD	COLORADO.
COLLIER	FLORIDA.
DADE	FLORIDA.
MARION	FLORIDA.
OSCEOLA	FLORIDA.
PALM BEACH	FLORIDA.
POLK	FLORIDA.
BUTLER	KANSAS.
RAPIDES	LOUISIANA.
TERREBONNE	LOUISIANA.
PENOBSCOT	MAINE.
WORCESTER	MASSACHUSETTS.
POLK	MINNESOTA.
ST. LOUIS	MINNESOTA.
STEARNS	MINNESOTA.
CASCADE	MONTANA.
MISSOULA	MONTANA.
YELLOWSTONE	MONTANA.
CLARK	NEVADA.
NYE	NEVADA.
WASHOE	NEVADA.
DONA ANA	NEW MEXICO.
SANDOVAL	NEW MEXICO.
SANTA FE	NEW MEXICO.
HERKIMER	NEW YORK.
BURLEIGH	NORTH DAKOTA.
CASS	NORTH DAKOTA.
GRAND FORKS	NORTH DAKOTA.
MORTON	NORTH DAKOTA.
OSAGE	OKLAHOMA.

APPENDIX A—URBAN COUNTIES AS OF JANUARY 1, 2000 WITH CENSUS TRACTS THAT MAY QUALIFY AS RURAL UNDER GOLDSMITH MODIFICATION—Continued

[Based on 1990 Census Data]

County	State
CLACKAMAS	OREGON.
JACKSON	OREGON.
LANE	OREGON.
LYCOMING	PENNSYLVANIA.
PENNINGTON	SOUTH DAKOTA.
BEXAR	TEXAS.
BRAZORIA	TEXAS.
HARRIS	TEXAS.
HIDALGO	TEXAS.

APPENDIX A—URBAN COUNTIES AS OF JANUARY 1, 2000 WITH CENSUS TRACTS THAT MAY QUALIFY AS RURAL UNDER GOLDSMITH MODIFICATION—Continued

[Based on 1990 Census Data]

County	State
TOM GREEN	TEXAS.
WEBB	TEXAS.
KANE	UTAH.
UTAH	UTAH.
BENTON	WASHINGTON.
FRANKLIN	WASHINGTON.
KING	WASHINGTON.
PIERCE	WASHINGTON.
SNOHOMISH	WASHINGTON.

APPENDIX A—URBAN COUNTIES AS OF JANUARY 1, 2000 WITH CENSUS TRACTS THAT MAY QUALIFY AS RURAL UNDER GOLDSMITH MODIFICATION—Continued

[Based on 1990 Census Data]

County	State
SPOKANE	WASHINGTON.
WHATCOM	WASHINGTON.
YAKIMA	WASHINGTON.
DOUGLAS	WISCONSIN.
MARATHON	WISCONSIN.
LARAMIE	WYOMING.
NATRONA	WYOMING.

APPENDIX B.—HOSPITALS AS OF JANUARY 1, 2000 THAT MAY QUALIFY AS RURAL WITHIN A GOLDSMITH MODIFICATION AREA

[Based on 1990 Census Data]

Hospital name	County	State
North Baldwin Hospital	BALDWIN	ALABAMA.
South Baldwin Hospital	BALDWIN	ALABAMA.
Thomas Hospital	BALDWIN	ALABAMA.
Flagstaff Medical Center	COCONINO	ARIZONA.
Page Hospital	COCONINO	ARIZONA.
Wickenburg Regional Hospital	MARICOPA	ARIZONA.
Bullhead Community Hospital	MOHAVE	ARIZONA.
Havasu Samaritan Regional Hospital	MOHAVE	ARIZONA.
Kingman Regional Medical Center	MOHAVE	ARIZONA.
Mohave Valley Hospital and Medical Center	MOHAVE	ARIZONA.
Central Arizona Medical Center	PINAL	ARIZONA.
Casa Grande Regional Medical Center	PINAL	ARIZONA.
Biggs-Gridley Memorial Hospital	BUTTE	CALIFORNIA.
Feather River Hospital	BUTTE	CALIFORNIA.
Barton Memorial Hospital	EL DORADO	CALIFORNIA.
Coalinga Regional Medical Center	FRESNO	CALIFORNIA.
Kingsburg Medical Center	FRESNO	CALIFORNIA.
Sanger General Hospital	FRESNO	CALIFORNIA.
Selma District Hospital	FRESNO	CALIFORNIA.
Sierra Kings Health Care District	FRESNO	CALIFORNIA.
Delano Regional Medical Center	KERN	CALIFORNIA.
Kern Valley Hospital	KERN	CALIFORNIA.
Ridgecrest Community Hospital	KERN	CALIFORNIA.
Tehachapi Valley Hospital	KERN	CALIFORNIA.
Westside District Hospital	KERN	CALIFORNIA.
Avalon Municipal Hospital and Clinic	LOS ANGELES	CALIFORNIA.
Chowchilla District Memorial Hospital	MADERA	CALIFORNIA.
Madera Community Hospital	MADERA	CALIFORNIA.
Bloss Memorial Hospital	MERCED	CALIFORNIA.
Dos Palos Memorial Hospital	MERCED	CALIFORNIA.
Los Banos Community Hospital	MERCED	CALIFORNIA.
Sutter Auburn Faith Hospital	PLACER	CALIFORNIA.
Palo Verde Hospital	RIVERSIDE	CALIFORNIA.
San Gorgonio Memorial Hospital	RIVERSIDE	CALIFORNIA.
Santa Ynez Valley Cottage Hospital	SANTA BARBARA	CALIFORNIA.
Barstow Community Hospital	SAN BERNARDINO	CALIFORNIA.
Needles Desert Community Hospital	SAN BERNARDINO	CALIFORNIA.
Hi-Desert Medical Center	SAN BERNARDINO	CALIFORNIA.
Doctors Hospital of Manteca	SAN JOAQUIN	CALIFORNIA.
''St Dominic's Hospital''	SAN JOAQUIN	CALIFORNIA.
Tracy Community Memorial Hospital	SAN JOAQUIN	CALIFORNIA.
Twin Cities Community Hospital	SAN LUIS OBISPO	CALIFORNIA.
South Valley Hospital	SANTA CLARA	CALIFORNIA.
Petaluma Valley Hospital	SONOMA	CALIFORNIA.
Sonoma Valley Health Care District	SONOMA	CALIFORNIA.
Del Puerto Hospital	STANISLAUS	CALIFORNIA.
Emanuel Medical Center	STANISLAUS	CALIFORNIA.
Oak Valley District Hospital	STANISLAUS	CALIFORNIA.
Alta District Hospital	TULARE	CALIFORNIA.

APPENDIX B.—HOSPITALS AS OF JANUARY 1, 2000 THAT MAY QUALIFY AS RURAL WITHIN A GOLDSMITH MODIFICATION AREA—Continued

[Based on 1990 Census Data]

Hospital name	County	State
Sierra View District Hospital	TULARE	CALIFORNIA.
Tulare District Hospital	TULARE	CALIFORNIA.
Lindsay District Hospital	TULARE	CALIFORNIA.
Exeter Memorial Hospital	TULARE	CALIFORNIA.
Estes Park Medical Center	LARIMER	COLORADO.
McKee Medical Center	LARIMER	COLORADO.
Glades General Hospital	PALM BEACH	FLORIDA.
Bartow Memorial Hospital	POLK	FLORIDA.
Heart of Florida Hospital	POLK	FLORIDA.
Polk General Hospital	POLK	FLORIDA.
Lake Wales Medical Center	POLK	FLORIDA.
Susan B. Allen Memorial Hospital	BUTLER	KANSAS.
Millinocket Regional Hospital	PENOBSCOT	MAINE.
Penobscot Valley Hospital	PENOBSCOT	MAINE.
Harrington Memorial Hospital	WORCESTER	MASSACHUSETTS.
Heywood Hospital	WORCESTER	MASSACHUSETTS.
Athol Memorial Hospital	WORCESTER	MASSACHUSETTS.
Clinton Hospital	WORCESTER	MASSACHUSETTS.
First Care Medical Services	POLK	MINNESOTA.
Riverview Healthcare Association	POLK	MINNESOTA.
Ely-Bloomenson Community Hospital	ST. LOUIS	MINNESOTA.
Eveleth Health Services Park	ST. LOUIS	MINNESOTA.
Cook Hospital & Convalescent Center	ST. LOUIS	MINNESOTA.
University Medical Center—Mesabi	ST. LOUIS	MINNESOTA.
Virginia Regional Medical Center	ST. LOUIS	MINNESOTA.
White Community Hospital	ST. LOUIS	MINNESOTA.
Albany Area Hospital & Medical Center	STEARNS	MINNESOTA.
''St Michael's Hospital''	STEARNS	MINNESOTA.
Melrose Hospital & Pine Villa	STEARNS	MINNESOTA.
Paynesville Area Health Care	STEARNS	MINNESOTA.
Nye Regional Medical Center	NYE	NEVADA.
Lake Tahoe Medical Center	WASHOE	NEVADA.
Little Falls Hospital	HERKIMER	NEW YORK.
Northwood Deaconess Healthcare	GRAND FORKS	NORTH DAKOTA.
Fairfax Memorial Hospital	OSAGE	OKLAHOMA.
Pawhuska Hospital	OSAGE	OKLAHOMA.
Ashland Community Hospital	JACKSON	OREGON.
Cottage Grove Hospital	LANE	OREGON.
Peace Harbor Hospital	LANE	OREGON.
Jersey Shore Hospital	LYCOMING	PENNSYLVANIA.
Muncy Valley Hospital	LYCOMING	PENNSYLVANIA.
Angleton-Danbury General Hospital	BRAZORIA	TEXAS.
Brazosport Memorial Hospital	BRAZORIA	TEXAS.
Sweeny Community Hospital	BRAZORIA	TEXAS.
Kane County Hospital	KANE	UTAH.
Prosser Memorial Hospital	BENTON	WASHINGTON.
Providence Toppenish Hospital	YAKIMA	WASHINGTON.
Sunnyside Community Hospital	YAKIMA	WASHINGTON.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 410, 412, 413, and 485

[HCFA–1118–F]

RIN 0938–AK09

Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2001 Rates

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

ACTION: Final rule.

SUMMARY: We are revising the Medicare hospital inpatient prospective payment system for operating costs to: implement applicable statutory requirements, including a number of provisions of the Medicare, Medicaid, and State Children's Health Insurance Program Balanced Budget Refinement Act of 1999 (Pub. L. 106–113); and implement changes arising from our continuing experience with the system. In addition, in the Addendum to this final rule, we describe changes to the amounts and factors used to determine the rates for Medicare hospital inpatient services for