

dealing with the issue of determining the impact of these changes. However, we did not receive any comments that would help resolve this issue. Thus, we remain unable to accurately determine the number of cases that would be determined not to be provider-based or to estimate the dollar impact of these determinations.

VIII. Impact of Policies Affecting Rural Hospitals

A. Raising the Threshold To Qualify for the CRNA Pass-Through Payments

In section V. of the preamble of this final rule, we are raising the maximum number of surgical procedures (including inpatient and outpatient procedures) requiring anesthesia services that a rural hospital may perform to qualify for pass-through payments for the costs of CRNAs to 800 from 500. We have identified 622 hospitals that currently qualify under this provision.

To measure the impact of this provision, we determined that approximately half of the hospitals that would appear to be eligible based on the current number of procedures will receive pass-through payments. That is, another approximately 600 rural hospitals have similar volumes to hospitals that currently receive the pass-through. However, because in order to be eligible to receive pass-through payments, the hospital must employ the CRNA and the CRNA must agree not to bill for services under Part B, we estimate that half the hospitals that would otherwise qualify based on volume of procedures are not eligible because they either do not employ the CRNA or the CRNA does not agree not to bill for services under Part B. We estimate approximately 90 rural hospitals would qualify under the increased maximum volume threshold. If one-half of these hospitals then met the other criteria (the CRNA is employed by the hospital and the CRNA does not bill for Part B), 45 additional hospitals would now be eligible for these pass-through payments under this change.

B. Removal of Requirement for CAHs To Use State Resident Assessment Instrument

In section VII. of the preamble of this final rule, we are eliminating the requirement that CAHs use the State resident assessment instrument (RAI) to conduct patient assessments. There are approximately 630 CAHs. The overwhelming majority of CAHs, 95 percent, or approximately 598 CAHs, provide SNF level care. The elimination

of the requirement to use the State RAI will greatly reduce the burden on CAHs because facilities will no longer be required to complete an RAI document for each SNF patient (which would involve approximately 12,000 admissions based on the most recent claims data). Facilities would have the flexibility to document the assessment data in the medical record in a manner appropriate for their facility. The elimination of the requirement for use of the State RAI will reduce the amount of time required to perform patient assessments and allow more time for direct patient care.

C. Exclusion of Limited-Service Specialty Hospitals From the Definition of Like Hospitals for Purposes of Granting SCH Status

Section 1886(d)(5)(D)(iii) of the Act provides that, to qualify as an SCH, a hospital must be more than 35 road miles from another hospital. In addition, there are several other conditions under which a hospital may qualify as an SCH, including if it is the “* * * sole source of inpatient hospital services reasonably available to individuals in a geographic area * * *” because of factors such as the “* * * absence of other like hospitals. * * *” We have defined a “like hospital” in regulations as a hospital furnishing short-term, acute care (§ 412.92(c)(2)). “Like hospital” refers to a hospital paid under the acute care hospital inpatient prospective payment system.

We have become aware that, in some cases, new specialty hospitals that offer a very limited range of services have opened within the service area of an SCH and may be threatening the special status of the SCH. For example, a hospital that offers only a select type of surgery on an inpatient basis would qualify under our existing rules as an SCH “like hospital” if it met the hospital conditions of participation and was otherwise eligible for payment under the acute care hospital inpatient prospective payment system. Under our existing regulations, an SCH could lose its special status due to the opening of such a specialty hospital, even though there is little, if any, overlap in the types of services offered by the SCH and the specialty hospital. To prevent a hospital from losing its SCH status in such a situation, we are establishing criteria whereby a limited-service specialty hospital may be excluded from the definition of “like hospital”. To determine whether a hospital qualifies as an SCH, the fiscal intermediary will make a determination whether a nearby hospital paid under the acute care hospital inpatient prospective payment

system is a like hospital by comparing the total acute inpatient days of the SCH applicant hospital with the total acute inpatient days of the nearby hospital. If the total acute inpatient days of the nearby hospital are greater than 8 percent of the total inpatient days reported by the SCH applicant hospital, the hospital is considered a like hospital for purposes of evaluating the application for SCH status. If the total acute inpatient days of the nearby hospital are 8 percent or less of the total acute inpatient days of the applicant hospital, the nearby hospital is not considered a like hospital for purposes of evaluating the application for SCH status under § 412.92.

The impact of this change would be: To allow some hospitals that are currently SCHs but whose status is jeopardized by the opening of a limited-service specialty hospital to retain their status; to allow hospitals that are applying for SCH status to exclude existing limited-service specialty hospitals from the list of like hospitals in their service area; or to allow some hospitals that previously lost their SCH status due to a specialty hospital opening in their service area to regain that status. We note that this change is effective for cost reporting periods beginning on or after October 1, 2002. Therefore, hospitals that lost their SCH status and are able to regain that status as a result of this change cannot have that status applied retroactively to prior periods.

We are unable to quantify precisely the impact of this policy change. However, we anticipate it will be minimal because we believe the criteria we have established will limit the application of this policy. We do not anticipate more than approximately 10 situations that will be affected by this change during FY 2003.

IX. Waiver of Proposed Rulemaking and Delay in 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 a notice take effect. However, we can waive this procedure, if we find good cause that notice and comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporate a statement of the finding and the reasons for it into the notice issued.

We find it unnecessary to undertake notice and comment rulemaking because this notice merely provides technical corrections to the preamble language of the final rule. In this notice, the technical corrections include