

system established by the Secretary.” The basic methodology for determining capital prospective payments is set forth in our regulations at 42 CFR 412.308 and 412.312. Under the capital PPS, payments are adjusted by the same DRG for the case as they are under the operating IPPS. Similar adjustments are also made for IME and DSH as under the operating IPPS. In addition, hospitals may receive an outlier payment for those cases that have unusually high costs.

The existing regulations governing payments to hospitals under the IPPS are located in 42 CFR part 412, subparts A through M.

2. Hospitals and Hospital Units Excluded From the IPPS

Under section 1886(d)(1)(B) of the Act, as amended, certain specialty hospitals and hospital units are excluded from the IPPS. These hospitals and units are: Psychiatric hospitals and units, rehabilitation hospitals and units; long-term care hospitals (LTCHs); children’s hospitals; and cancer hospitals. Various sections of the Balanced Budget Act of 1997 (Pub. L. 105–33), the Medicare, Medicaid and SCHIP [State Children’s Health Insurance Program] Balanced Budget Refinement Act of 1999 (Pub. L. 106–113), and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Pub. L. 106–554) provide for the implementation of PPSs for rehabilitation hospitals and units (referred to as inpatient rehabilitation facilities (IRFs)), psychiatric hospitals and units, and LTCHs, as discussed below. Children’s hospitals and cancer hospitals continue to be paid under reasonable cost-based reimbursement.

The existing regulations governing payments to excluded hospitals and hospital units are located in 42 CFR parts 412 and 413.

a. *Inpatient Rehabilitation Facilities.* Under section 1886(j) of the Act, as amended, rehabilitation hospitals and units (IRFs) have been transitioned from payment based on a blend of reasonable cost reimbursement subject to a hospital-specific annual limit under section 1886(b) of the Act and prospective payments for cost reporting periods beginning January 1, 2002 through September 30, 2002, to payment on a full prospective payment system basis effective for cost reporting periods beginning on or after October 1, 2002 (66 FR 41316, August 7, 2001 and 67 FR 49982, August 1, 2002). The existing regulations governing payments under the IRF PPS are located in 42 CFR part 412, subpart P.

b. *LTCHs.* Under the authority of sections 123(a) and (c) of Pub. L. 106–113 and section 307(b)(1) of Pub. L. 106–554, LTCHs are being transitioned from being paid for inpatient hospital services based on a blend of reasonable cost-based reimbursement under section 1886(b) of the Act to fully Federal prospective rates during a 5-year period, beginning with cost reporting periods that start on or after October 1, 2002. For cost reporting periods beginning on or after October 1, 2006, LTCHs will be paid under the fully Federal prospective payment rate (the August 30, 2002 LTCH PPS final rule (67 FR 55954)). LTCHs may elect to be paid based on full PPS payments instead of a blended payment in any year during the 5-year transition period. The existing regulations governing payment under the LTCH PPS are located in 42 CFR part 412, subpart O.

c. *Psychiatric Hospitals and Units.* Sections 124(a) and (c) of Pub. L. 106–113 provide for the development of a per diem PPS for payment for inpatient hospital services furnished in psychiatric hospitals and units under the Medicare program, effective for cost reporting periods beginning on or after October 1, 2002. This system must include an adequate patient classification system that reflects the differences in patient resource use and costs among these hospitals and maintain budget neutrality. We are in the process of developing a proposed rule, to be followed by a final rule, to implement the PPS for psychiatric hospitals and units.

3. Critical Access Hospitals

Under sections 1814, 1820, and 1834(g) of the Act, payments are made to critical access hospitals (CAHs) (that is, rural 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)(1)(A) of the Act and existing regulations under 42 CFR parts 413 and 415.

4. Payments for Graduate Medical Education

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

resident in a base year. The existing regulations governing payments to the various types of hospitals are located in 42 CFR part 413.

B. Major Contents of This Proposed Rule

In this proposed rule, we are setting forth proposed changes to the Medicare IPPS for operating costs and for capital-related costs in FY 2004. We also are proposing changes relating to payments for GME costs, payments to CAHs, and payments to providers classified as psychiatric hospitals and units that continue to be excluded from the IPPS and paid on a reasonable cost basis. The proposed changes would be effective for discharges occurring on or after October 1, 2003.

The following is a summary of the major changes that we are proposing to make:

1. Proposed Changes to the DRG Reclassifications and Recalibrations of Relative Weights

As required by section 1886(d)(4)(C) of the Act, we adjust the DRG classifications and relative weights annually. Based on analyses of Medicare claims data, we are proposing to establish a number of new DRGs and make changes to the designation of diagnosis and procedure codes under other existing DRGs. Our proposed changes for FY 2004 are set forth in section II. of this preamble.

Among the proposed changes discussed are:

- Expanding the number of DRGs that are split on the basis of the presence or absence of complications or comorbidities (CCs). The DRGs we are proposing to split are: DRG 4 (Spinal Procedures), DRG 5 (Extracranial Vascular Procedures), DRG 231 (Local Excision and Removal of Internal Fixation Devices Except Hip and Femur) and DRG 400 (Lymphoma and Leukemia With Major O.R. Procedure).

- Creating two new DRGs to differentiate current DRG 514 (Cardiac Defibrillator Implant With Cardiac Catheterization) on the basis of whether the patient does or does not experience any of the following symptoms: acute myocardial infarction, heart failure, or shock.

- Changing the DRG assignments of certain congenital anomalies that currently result in patients being assigned to newborn DRGs even when the patient is actually an adult. We also are adding to the list of major problems in newborns that affect DRG assignment.

- Modifying DRG 492 (Chemotherapy With Acute Leukemia as Secondary Diagnosis) to include in this DRG cases receiving high-dose Interleukin-2 (IL-2)