

Medicaid fraction, even if the patient's Medicare Part A coverage has been exhausted. We believe this interpretation is consistent with the statutory intent of section 1886(d)(5)(F)(vi)(II) of the Act. However, we recognize there are other plausible interpretations. In addition, on a more practical level, we recognize it is often difficult for fiscal intermediaries to differentiate the days for dual-eligible patients whose Part A coverage has been exhausted. The degree of difficulty depends on the data provided by the States, which may vary from one State to the next. Some States identify all dual-eligible beneficiaries in their lists of Medicaid patient days provided to the hospitals, while in other States the fiscal intermediary must identify patient days attributable to dual-eligible beneficiaries by matching Medicare Part A bills with the list of Medicaid patients provided by the State. The latter case is problematic when Medicare Part A coverage is exhausted because no Medicare Part A bill may be submitted for these patients. Thus, the fiscal intermediary has no data by which to readily verify any adjustment for these cases in the Medicaid data provided by the hospital. Currently, the fiscal intermediaries are reliant on the hospitals to identify the days attributable to dual-eligible beneficiaries so these days can be excluded from the Medicaid patient days count.

Therefore, in order to facilitate consistent handling of these days across all hospitals, we are proposing that the days of patients who have exhausted their Medicare Part A coverage will no longer be included in the Medicare fraction. Instead, we are proposing these days should be included in the Medicaid fraction of the DSH calculation. (We note that not all SSI recipients are Medicaid eligible. Therefore, it will not be automatic that the patient days of SSI recipients will be counted in the Medicaid fraction when their Part A coverage expires.)

Under this proposed change, before a hospital could count patient days attributable to dual-eligible beneficiaries in the Medicaid fraction, the hospital must submit documentation to the fiscal intermediary that justifies including the days in the Medicaid fraction after the Medicare Part A benefits have been exhausted. That is, if the State provides data on all the days associated with all dual-eligible patients treated at a hospital, regardless of whether the beneficiary had Medicare Part A coverage, the hospital is responsible for providing documentation showing which days should be included in the

Medicaid fraction because Medicare Part A coverage was exhausted.

8. Medicare+Choice (M+C) Days

Under § 422.1, an M+C plan "means health benefits coverage offered under a policy or contract by an M+C organization that includes a specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area of the M+C plan." Generally, each M+C plan must provide coverage of all services that are covered by Medicare Part A and Part B (or just Part B if the M+C plan enrollee is only entitled to Part B).

We have received questions whether patients enrolled in an M+C Plan should be counted in the Medicare fraction or the Medicaid fraction of the DSH patient percentage calculation. The question stems from whether M+C plan enrollees are entitled to benefits under Medicare Part A since M+C plans are administered through Medicare Part C.

We note that, under § 422.50, an individual is eligible to elect an M+C plan if he or she is entitled to Medicare Part A and enrolled in Part B. However, once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A.

Therefore, we are proposing to clarify that once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction.

D. Medicare Geographic Classification Review Board (MGCRB) Reclassification Process (§ 412.230)

With the creation of the MGCRB, beginning in FY 1991, under section 1886(d)(10) of the Act, hospitals could request reclassification from one geographic location to another for the purpose of using the other area's standardized amount for inpatient operating costs or the wage index value, or both (September 6, 1990 interim final rule with comment period (55 FR 36754), June 4, 1991 final rule with comment period (56 FR 25458), and June 4, 1992 proposed rule (57 FR 23631)). Implementing regulations in subpart L of part 412 (§§ 412.230 *et seq.*) set forth criteria and conditions for redesignations for purposes of the wage index or the average standardized amount, or both, from rural to urban,

rural to rural, or from an urban area to another urban area, with special rules for SCHs and rural referral centers.

Effective with reclassifications for FY 2003, section 1886(d)(10)(D)(vi)(II) of the Act provides that the MGCRB must use the average of the 3 years of hourly wage data from the most recently published data for the hospital when evaluating a hospital's request for reclassification. The regulations at § 412.230(e)(2)(ii) stipulate that the wage data are taken from the CMS hospital wage survey used to construct the wage index in effect for prospective payment purposes. To evaluate applications for wage index reclassifications for FY 2004, the MGCRB used the 3-year average hourly wages published in Table 2 of the August 1, 2002 IPPS final rule (67 FR 50135). These average hourly wages are taken from data used to calculate the wage indexes for FY 2001, FY 2002, and FY 2003, based on cost reporting periods beginning during FY 1997, FY 1998, and FY 1999, respectively.

Last year, we received a comment suggesting that we allow for the correction of inaccurate data from prior years as part of a hospital's bid for geographic reclassification (67 FR 50027). The commenter suggested that not to allow corrections to the data results in inequities in the calculation in the average hourly wage for purposes of reclassification. In the August 1, 2002 IPPS final rule, we responded:

"Hospitals have ample opportunity to verify the accuracy of the wage data used to calculate their wage index and to request revisions, but must do so within the prescribed timelines. We consistently instruct hospitals that they are responsible for reviewing their data and availing themselves to the opportunity to correct their wage data within the prescribed timeframes. Once the data are finalized and the wage indexes published in the final rule, they may not be revised, except through the mid-year correction process set forth in the regulations at § 412.63(x)(2). Accordingly, it has been our consistent policy that if a hospital does not request corrections within the prescribed timeframes for the development of the wage index, the hospital may not later seek to revise its data in an attempt to qualify for MGCRB reclassification."

"Allowing hospitals the opportunity to revise their data beyond the timelines required to finalize the data used to calculate the wage index each year would lessen the importance of complying with those deadlines. The likely result would be that the data used to compute the wage index would not be as carefully scrutinized because