

to receive payment based on 100 percent of the Federal rate. Effective with the third year of operation, we pay the hospital based on 100 percent of the capital Federal rate (that is, the same methodology used to pay all other hospitals subject to the capital PPS).

C. Capital Input Price Index

1. Background

Like the operating input price index, the capital input price index (CIPI) is a fixed-weight price index that measures the price changes associated with costs during a given year. The CIPI differs from the operating input price index in one important aspect—the CIPI reflects the vintage nature of capital, which is the acquisition and use of capital over time. Capital expenses in any given year are determined by the stock of capital in that year (that is, capital that remains on hand from all current and prior capital acquisitions). An index measuring capital price changes needs to reflect this vintage nature of capital. Therefore, the CIPI was developed to capture the vintage nature of capital by using a weighted-average of past capital purchase prices up to and including the current year.

We periodically update the base year for the operating and capital input prices to reflect the changing composition of inputs for operating and capital expenses. The CIPI was last rebased to FY 1997 in the August 1, 2002 final rule (67 FR 50044).

2. Forecast of the CIPI for Federal Fiscal Year 2004

We are forecasting the proposed CIPI to increase 0.7 percent for FY 2004. This reflects a projected 1.2 percent increase in vintage-weighted depreciation prices (building and fixed equipment, and movable equipment) and a 3.4 percent increase in other capital expense prices in FY 2004, partially offset by a 2.0 percent decline in vintage-weighted interest rates in FY 2004. The weighted average of these three factors produces the 0.7 percent increase for the CIPI as a whole.

IV. Proposed Changes to Payment Rates for Excluded Hospitals and Hospital Units: Rate-of-Increase Percentages

As discussed in section VI. of the preamble of this proposed rule, in accordance with section 1886(b)(3)(H)(i) of the Act and effective for cost reporting periods beginning on or after October 1, 2002, payments to existing psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals excluded from the IPPS are no longer subject to limits on a hospital-specific target amount (expressed in terms of the inpatient operating cost per discharge) that are set for each hospital, based on the hospital's own historical cost experience trended forward by the applicable rate-of-increase percentages (update factors).

Effective for cost reporting periods beginning on or after October 1, 2002, rehabilitation hospitals and units are no longer paid on a reasonable cost basis but are paid under the IRF PPS. Effective for cost reporting periods beginning on or after October 1, 2002, LTCHs also are no longer paid on a reasonable cost basis but are paid

under a DRG-based PPS. As part of the payment process for LTCHs, we established a 5-year transition period from reasonable cost-based reimbursement to a fully Federal PPS. However, a LTCH, subject to the blend methodology, may elect to be paid based on a 100 percent of the Federal prospective rate.

In accordance with existing § 413.40(c)(4)(ii) and (d)(1)(i) and (ii), where applicable, excluded hospitals and units that continue to be paid on a reasonable cost basis will have payments based on their Medicare inpatient operating costs, not to exceed the ceiling (as defined in § 413.40(a)(3)).

Section 1886(b)(7) of the Act had established a payment limitation for new hospitals and units excluded from the IPPS. While both rehabilitation hospitals and units and LTCHs are now paid under a PPS, psychiatric hospitals and units continue to be subject to the payment limitation. A discussion of how the payment limitation was calculated can be found in the August 29, 1997 final rule with comment period (62 FR 46019); the May 12, 1998 final rule (63 FR 26344); the July 31, 1998 final rule (63 FR 41000); and the July 30, 1999 final rule (64 FR 41529).

The amount of payment for a “new” psychiatric hospital or unit would be determined as follows:

- Under existing § 413.40(f)(2)(ii), for cost reporting periods beginning on or after October 1, 1997, the amount of payment for a new hospital or unit that was not paid as an excluded hospital or unit before October 1, 1997, is the lower of: (1) The hospital's net inpatient operating costs per case; or (2) 110 percent of the national median of the target amounts for the same class of excluded hospitals and units, adjusted for differences in wage levels and updated to the first cost reporting period in which the hospital receives payment. The second cost reporting period is subject to the same target amount applied to the first cost reporting period.

- In the case of a hospital that received payments under § 413.40(f)(2)(ii) as a newly created hospital or unit, to determine the hospital's or unit's target amount for the hospital's or unit's third 12-month cost reporting period, the payment amount determined under § 413.40(f)(2)(ii)(A) for the preceding cost reporting period is updated to the third cost reporting period.

The proposed amounts included in the following table reflect the updated 110 percent of the national median target amounts of new excluded psychiatric hospitals and units for cost reporting periods beginning during FY 2004. These figures are updated with the most recent data available to reflect the projected market basket increase percentage of 3.5 percent. This projected percentage change in the market basket reflects the average change in the price of goods and services purchased by hospitals to furnish inpatient hospital services (as projected by CMS's Office of the Actuary based on its historical experience with the IPPS). For a new provider, the labor-related share of the target amount is multiplied by the appropriate geographic area wage index, without regard to IPPS reclassifications, and added to the nonlabor-related share in order to determine the per case limit on payment

under the statutory payment methodology for new providers.

Class of excluded hospital or unit	FY 2004 proposed labor-related share	FY 2004 proposed nonlabor-related share
Psychiatric	\$7,301	\$2,902

Effective for cost reporting periods beginning on or after October 1, 2002, this payment limitation is no longer applicable to new LTCHs since they will be paid 100 percent of the Federal rate. A new LTCH is a provider of inpatient hospital services that meets the qualifying criteria for LTCHs specified under § 412.23(e)(1) and (e)(2) and whose first cost reporting period as a LTCH begins on or after October 1, 2002 (§ 412.23(e)(4)). Under the LTCH PPS, new LTCHs are paid based on 100 percent of the fully Federal prospective rate (they may not participate in the 5-year transition from cost-based reimbursement to prospective payment). In contrast, those “new” LTCHs that meet the definition of “new” under § 413.40(f)(2)(ii) and that have their first cost reporting periods beginning on or after October 1, 1997, and before October 1, 2002, may be paid under the LTCH PPS transition methodology. Since those hospitals by definition would have been considered new before October 1, 2002, they would have been subject to the updated payment limitation on new hospitals that was published in the FY 2003 IPPS final rule (67 FR 50103). Under existing regulations at § 413.40(f)(2)(ii), the “new” hospital would be subject to the same cap in its second cost reporting period; this cap would not be updated for the new hospital's second cost reporting year. Thus, since the same cap is to be used for the “new” LTCH's first two cost reporting periods, it is no longer necessary to publish an updated cap.

V. Payment for Blood Clotting Factor Administered to Hemophilia Inpatients

In December 2002, the Department implemented a policy that established the Single Drug Pricer (SDP) to correct identified discrepancies, further the legislative goal of establishing a uniform payment allowance as a reflection of the average wholesale price (AWP), and otherwise apply the existing statute and regulation more accurately and efficiently (CMS Program Memorandum AB-02-174, December 3, 2002, which can be accessed at: <http://www.cms.hhs.gov/manuals>). Under the SDP, CMS will establish prices centrally, thereby resulting in greater consistency in drug pricing nationally. The SDP instruction applies to blood clotting factors furnished to hospital inpatients. The payment allowance for the single national drug price for each Medicare covered drug is based on 95 percent of the AWP, except for drugs billed to durable medical equipment regional carriers (DMERCs) and hospital outpatient drugs billed to fiscal intermediaries. We are publishing this notice here because we previously have addressed the add-on payment for the costs of administering blood clotting factor in the IPPS annual rule (see the August 1, 2000 IPPS final rule (65 FR 47116)).