

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 Public Law 106–113 and section 307(b)(1) of Public Law 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 June 6, 2003 LTCH PPS final rule (68 FR 34122)). 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 Public Law 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 (referred to as inpatient psychiatric facilities (IPFs)).

#### 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. Summary of the Provisions of the May 19, 2003 Proposed Rule*

On May 19, 2003, we published a proposed rule in the **Federal Register** (68 FR 27154) that set forth proposed changes to the Medicare IPPS for operating costs and for capital-related costs in FY 2004. We also set forth proposed 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. These changes were proposed to be effective for discharges occurring on or after October 1, 2003.

The following is a summary of the major changes that we proposed and the issues we addressed in the May 19, 2003 proposed rule:

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

As required by section 1886(d)(4)(C) of the Act, we proposed annual adjustments to the DRG classifications and relative weights. Based on analyses of Medicare claims data, we proposed to establish a number of new DRGs and make changes to the designation of

diagnosis and procedure codes under other existing DRGs.

Among the proposed changes discussed were:

- Expansion of the number of DRGs that are split on the basis of the presence or absence of complications or comorbidities (CCs). The DRGs we proposed to split were: DRG 4 (Spinal Procedures) into proposed new DRGs 531 and 532 (Spinal Procedures With and Without CC, respectively); DRG 5 (Extracranial Vascular Procedures) into proposed new DRGs 533 and 534 (Extracranial Vascular Procedures With and Without CC, respectively); DRG 231 (Local Excision and Removal of Internal Fixation Devices Except Hip and Femur) into proposed new DRGs 537 and 538 (Local Excision and Removal of Internal Fixation Devices Except Hip and Femur With and Without CC, respectively); and DRG 400 (Lymphoma and Leukemia With Major O.R. Procedure) into proposed new DRGs 539 and 540 (Lymphoma and Leukemia With Major O.R. Procedure With and Without CC, respectively).

- Creation of a new DRG for patients with an intracranial vascular procedure and an intracranial hemorrhage. The DRG we proposed to create was DRG 528 (Intracranial Vascular Procedure With a Principal Diagnosis of Hemorrhage).

- Creation of two new DRGs, differentiated on the basis of the presence or absence of a CC, for craniotomy patients with only a vascular shunt procedure. The DRGs we proposed to create were DRGs 529 and 530 (Ventricular Shunt Procedure With CC and Without CC, respectively).

- Creation of 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. The new DRGs we proposed were DRG 535 (Cardiac Defibrillator Implant With Cardiac Catheterization and With Acute Myocardial Infarction, Heart Failure, or Shock) and DRG 536 (Cardiac Defibrillator Implant With Cardiac Catheterization and Without Acute Myocardial Infarction, Heart Failure, or Shock).

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

- Modification of DRG 492 (Chemotherapy With Acute Leukemia as