

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 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 market basket increase percentage of 3.4 percent. This 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' 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 labor-related share	FY 2004 nonlabor-related share
Psychiatric	\$7,294	\$2,899

Effective for cost reporting periods beginning on or after October 1, 2002, this payment limitation is no longer applicable to new LTCHs since they will be paid 100 percent of the Federal rate.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.

We are in the process of developing a proposed rule that would establish a per diem PPS for inpatient psychiatric facilities (IPFs) (previously referred to as psychiatric hospitals and units) that is required under the provisions of section 124 of Pub. L. 106-113.

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)).

On a quarterly basis, CMS will furnish three SDP files to all fiscal intermediaries. Each fiscal intermediary must accept the SDP files and process claims for any drug identified on the files on the basis of the price shown on the applicable file. Previously, the fiscal intermediary performed annual update calculations based on the most recent AWP data available to the carrier. The fiscal intermediary should use the SDP to price the blood clotting factors.

VI. Tables

This section contains the tables referred to throughout the preamble to this final rule and in this Addendum. For purposes of this final rule, and to avoid confusion, we have retained the designations of Tables 1 through 5 that were first used in the September 1, 1983 initial prospective payment final rule (48 FR 39844). Tables 1A, 1C, 1D, 2, 3A, 3B, 4A, 4B, 4C, 4F, 4G, 4H, 5, 6A, 6B, 6C, 6D,

6E, 6F, 6G, 6H, 7A, 7B, 8A, 8B, 9, 10, and 11 are presented below. The tables presented below are as follows:

Table 1A.—National Adjusted Operating Standardized Amounts, Labor/Nonlabor
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Table 1D.—Capital Standard Federal Payment Rate
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Table 7A.—Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 2002 MedPAR Update March 2003 GROUPER V20.0
Table 7B.—Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 2002 MedPAR Update March 2003 GROUPER V21.0
Table 8A.—Statewide Average Operating Cost-to-Charge Ratios—July 2003
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Table 9.—Hospital Reclassifications and Redesignations—FY 2004
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