

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 405, 412, 413, 415, 419, 422, and 485

[CMS-1500-P]

RIN 0938-AN57

Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates

AGENCY: Centers for Medicare and Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: We are proposing to revise the Medicare hospital inpatient prospective payment systems (IPPS) for operating and capital-related costs to implement changes arising from our continuing experience with these systems. In addition, in the Addendum to this proposed rule, we describe the proposed changes to the amounts and factors used to determine the rates for Medicare hospital inpatient services for operating costs and capital-related costs. We also are setting forth proposed rate-of-increase limits as well as proposed policy changes for hospitals and hospital units excluded from the IPPS that are paid in full or in part on a reasonable cost basis subject to these limits. These proposed changes would be applicable to discharges occurring on or after October 1, 2005, with one exception: The proposed changes relating to submittal of hospital wage data by a campus or campuses of a multicampus hospital system (that is, the proposed changes to §412.230(d)(2) of the regulations) would be effective upon publication of the final rule.

Among the policy changes that we are proposing to make are changes relating to: the classification of cases to the diagnosis-related groups (DRGs); the long-term care (LTC)-DRGs and relative weights; the wage data, including the occupational mix data, used to compute the wage index; rebasing and revision of the hospital market basket; applications for new technologies and medical services add-on payments; policies governing postacute care transfers, payments to hospitals for the direct and indirect costs of graduate medical education, submission of hospital quality data, payment adjustment for low-volume hospitals, changes in the requirements for provider-based facilities; and changes in the requirements for critical access hospitals (CAHs).

DATES: Comments will be considered if received at the appropriate address, as provided in the "ADDRESSES" section, no later than 5 p.m. on June 24, 2005.

ADDRESSES: In commenting, please refer to file code CMS-1500-P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of three ways (no duplicates, please):

1. Electronically

You may submit electronic comments to

<http://www.cms.hhs.gov/regulations/ecomments> (Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word).

2. By Mail

You may mail written comments (one original and two copies) to the following address ONLY:

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1500-P,
P.O. Box 8011,

Baltimore, MD 21244-1850.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. By hand or courier

If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786-7195 in advance to schedule your arrival with one of our staff members.

Room 445-G, Hubert H. Humphrey Building,
200 Independence Avenue, S.W.

Washington, DC 20201, or

7500 Security Boulevard,
Baltimore, MD 21244-1850.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. After the close of the comment period, CMS posts all electronic comments received before the close of the comment period on its public website. Written comments received timely will be available for public inspection as they are received, generally beginning approximately 4 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, Monday through Friday of each week from 8:30 a.m. to 4:00 p.m. To schedule an appointment to view public comments, phone 1-800-743-3951.

For comments that relate to information collection requirements, mail a copy of comments to the following addresses:

Centers for Medicare & Medicaid Services,
Office of Strategic Operations and Regulatory Affairs,
Security and Standards Group,

Office of Regulations Development and Issuances,
Room C4-24-02

7500 Security Boulevard

Baltimore, Maryland 21244-1850.

Attn: James Wickliffe, CMS-1500-P; and

Office of Information and Regulatory Affairs,

Office of Management and Budget,

Room 3001, New Executive Office Building,

Washington, DC 20503,

Attn: Christopher Martin, CMS Desk Officer, **[insert filecode]**,

Christopher_Martin@omb.eop.gov. Fax (202) 395-6974.

FOR FURTHER INFORMATION CONTACT:

Marc Harstein, (410) 786-4539, Operating Prospective Payment, Diagnosis-Related Groups (DRGs), Wage Index, New Medical Services and Technology Add-On Payments, Hospital Geographic Reclassifications, Postacute Care Transfers, and Disproportionate Share Hospital Issues

Tzvi Hefter, (410) 786-4487, Capital Prospective Payment, Excluded Hospitals, Graduate Medical Education, Critical Access Hospitals, and Long-Term Care (LTC)-DRGs, and Provider-Based Facilities Issues

Steve Heffler, (410) 786-1211, Hospital Market Basket Revision and Rebasing

Siddhartha Mazumdar, (410) 786-6673, Rural Hospital Community Demonstration Project Issues

Mary Collins, (410) 786-3189, Critical Access Hospitals (CAHs) Issues

Dr. Mark Krushat, (410) 786-6809, Quality Data for Annual Payment Update Issues

Martha Kuespert, (410) 786-4605 Specialty Hospitals Definition Issues

VII. Proposed Changes for Hospitals and Hospital Units Excluded from the IPPS

A. Payments to Excluded Hospitals and Hospital Units

1. Payments to Existing Excluded Hospitals and Hospital Units
2. Updated Caps for New Excluded Hospitals and Units
3. Implementation of a PPS for IRFs
4. Implementation of a PPS for LTCHs
5. Implementation of a PPS for IPFs

B. Critical Access Hospitals (CAHs)

1. Background
2. Proposed Policy Change Relating to Continued Participation by CAHs in Lugar Counties
3. Proposed Policy Change Relating to Designation of CAHs as Necessary Providers
 - a. Determination of the Relocation Status of a CAH
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B. Critical Access Hospitals (CAHs)

[If you choose to comment on issues in this section, please include the caption "Critical Access Hospitals" at the beginning of your comment.]

1. Background

Section 1820 of the Act provides for the establishment of Medicare Rural Hospital Flexibility Programs (MRHFPS), under which individual States may designate certain facilities as critical access hospitals (CAHs). Facilities that are so designated and meet the CAH conditions of participation (CoPs) under 42 CFR Part 485, Subpart F, will be certified as CAHs by CMS. Regulations governing payments to CAHs for services to Medicare beneficiaries are located in 42 CFR Part 413.

2. Proposed Policy Change Relating to Continued Participation by CAHs in Lugar Counties

Criteria for the designation of a CAH under the MRHFPS at section

1820(c)(2)(b)(i) of the Act require that a hospital be located in a rural area as defined in section 1886(d)(2)(D) of the Act or be treated as being located in a rural area in accordance with section 1886(d)(8)(E) of the Act. The regulations at §485.610 further define "rural area" for purposes of being a CAH. Under §485.610(b), a CAH must meet any one of the following three location requirements. First, a CAH must not be located in an MSA as defined by the Office of Management and Budget, not be deemed to be located in an urban area under 42 CFR 412.63(b), and not be reclassified by CMS or the MGCRB as urban for purposes of the standardized payment amount, nor be a member of a group of hospitals reclassified to an urban area under 42 CFR 412.232. Second, if a CAH does not meet the first criterion, if located in an MSA, a CAH will be treated as rural if it has been reclassified under 42 CFR 412.103. Third, as we stated in the FY 2005 IPPS final rule, if the CAH cannot meet either of the first two requirements and is located in a revised labor market area (CBSA) under the standards announced by OMB on June 6, 2003 and adopted by CMS effective October 1, 2004, it has until September 30, 2006, to meet one of the other classification requirements without losing its CAH status. Under section 1886(d)(8)(B) of the Act, hospitals that are located in a rural county that is adjacent to one or more urban counties are considered to be located in the urban

MSA to which the greatest number of workers in the county commute, if certain conditions, specified in section 1886(d)(8)(B) of the Act, are met. Regulations implementing this provision are set forth in 42 CFR 412.62(f)(1) (for FY 1984), 42 CFR 412.63(b)(3) (for FYs 1985 through 2004), and at 42 CFR 412.64(b)(3) (for FY 2005 and subsequent fiscal years). The provision (section 1886(d)(8)(B) of the Act) is referred to as the “Lugar provision” and the counties described by it are referred to as the “Lugar counties.”

As explained more fully in the FY 2005 IPPS final rule (69 FR 48916), certain counties that previously were not considered Lugar counties were, effective October 1, 2004, redesignated as Lugar counties as a result of the most recent census data and the new labor market area definitions announced by OMB on June 6, 2003. Some CAHs located in these newly designated Lugar counties are now unable to meet the rural location requirements described above, even though they were in full compliance with the location requirements in effect at the time they converted from short-term acute care hospital to CAH status.

We have received comments that suggest that it would be inappropriate for a facility to be required to terminate participation as a CAH and resume participating as a short-term acute care hospital because of a change in county classification that did not result from any change in functioning by the CAH. After consideration of these comments, we are clarifying our policy with respect to facilities located in Lugar counties. As we noted in the FY 2005 IPPS final rule, we believe it is appropriate to allow facilities located in counties that began to be considered part of MSAs effective October 1, 2004, as a result of data from the 2000 census and implementation of the new labor market area definitions announced by OMB on June 6, 2003, an opportunity to obtain rural designations under applicable State law or regulations from their State legislatures or regulatory agencies. Similarly, we believe that when a CAH's status as being located in a Lugar county occurs as a result of changes that the CAH did not originate and that were beyond its control, such as a change in the OMB standards for labor market area definitions, it is appropriate for the CAH to be allowed a reasonable opportunity to reclassify to rural status. Thus, we are clarifying our policy to note that CAHs in counties that were designated as Lugar counties effective October 1, 2004, because of implementation of the new labor market area definitions announced by OMB on June 6, 2003, are to be given the same reclassification opportunity. Of course, the opportunity to reclassify would not be available to a CAH if the CAH itself were to initiate some change, such as a redesignation as urban rather than rural under State law or regulations, which would invalidate a prior §412.103 reclassification. As a result, we are proposing to make changes to §485.610(b) of the regulations that would permit CAHs located in a county that, in FY 2004, was not part of a Lugar county, but as of FY 2005 was included in such a county as a result of the new labor market area definitions, to maintain their CAH status until September 30, 2006. These changes, if adopted in final form, would permit CAHs in newly designated Lugar counties to continue participating in Medicare as CAHs until September 30, 2006. We expect that this will provide these CAHs with sufficient time to seek reclassification as rural facilities under the current regulations at §412.103. In other words, after October 1, 2006, these facilities must meet at least one of the criteria in §412.103(a)(1) through (a)(3) to be eligible to reclassify from urban to rural status. Once the §412.103 reclassification is approved, the facilities

would meet the CAH rural location requirements in §485.610(b)(2). In addition, consistent with the clarification of the policy, we are proposing to amend the regulations at §412.103(a)(4) to reflect the proposed change in the text of the CAH location regulations at §485.610(b)(3).

In addition, we are making a technical amendment to §485.610(b)(1)(ii) by replacing the reference to 42 CFR 412.63(b) with 42 CFR 412.64(b). This proposed technical amendment would conform the regulations to reflect the rules governing geographic reclassification (found at §412.64) that are already in place for fiscal years beginning on or after October 1, 2004 (69 FR 49242).

3. Proposed Policy Change Relating to Designation of CAHs as Necessary Providers

Section 405(h) of Pub. L. 108-173 amended section 1820(c)(2)(B)(i)(II) of the Act by adding language that terminated a State's authority to waive the location requirement for a CAH by designating the CAH as a necessary provider, effective January 1, 2006. Currently, a CAH is required to be located more than a 35-mile drive (or in the case of mountainous terrain or secondary roads, a 15-mile drive) from a hospital or another CAH, unless the CAH is certified by the State as a necessary provider of health care services to residents in the area. Under this provision, after January 1, 2006, States will no longer be able to designate a CAH based upon a determination that it is a necessary provider of health care. In addition, section 405(h) of Pub. L. 108-173 amended section 1820(h) of the Act to include a grandfathering provision for CAHs that are certified as necessary providers prior to January 1, 2006. In the FY 2005 IPPS final rule (69 FR 49220), we incorporated these amendments in our regulations at §485.610 (c). Under that regulation, any CAH that is designated as a necessary provider in its State rural health plan prior to January 1, 2006, will be permitted to maintain its necessary provider designation. However, the regulations are limited to CAHs that were necessary providers as of January 1, 2006, and does not address the situation where the CAH is no longer the same facility due to relocation, cessation of business, or a substitute facility. Currently, CMS Regional Offices make the decision for continued certification following relocation of a certified facility on a case-by-case basis. The criteria used to qualify a CAH as a necessary provider were established by each State in its MRHFP. The State's MRHFP defined those CAHs that provide necessary services to a particular patient community in the event that the facility did not meet the required 35-mile (or 15-mile with stated exceptions) distance requirement from the nearest hospital or CAH. Each State's criteria are different, but the criteria share certain similarities and all define a necessary provider related to the facility location. Therefore, it becomes crucial to define whether the necessary provider designation remains pertinent in the event the certified CAH builds in a different location. Accordingly, the first step of this process is to determine whether building a new CAH facility in a different location is a replacement of an existing facility in essentially the same location, a relocation of the facility in a new location, or a cessation of business at one location and establishment of new business at another location.

a. Determination of the Relocation Status of a CAH

(1) Replacement in the same location. Under this approach, we are proposing that, if the CAH is constructing renovation of the same building in the same location, the renovation is considered to be a replacement of the same provider and not relocation. We would consider a construction of the CAH to be a replacement if construction was

undertaken within 250 yards of the current building, as set by prior precedence in defining a hospital campus. In addition, if the replacement is constructed on land that is contiguous to the current CAH, and that land was owned by the CAH prior to enactment of Pub. L. 108-173, and the CAH is operating under a State-issued necessary provider waiver that is grandfathered by Pub. L. 108-173, we would consider that construction to be a replacement of the existing provider and the provisions of the grandfathered necessary provider designation would continue to apply regardless of when the construction or renovation work commenced and was completed.

(2) Relocation of a CAH. Under our proposed approach, if the CAH is constructing a new facility in a location that does not qualify the construction as replacement of an existing facility in the same location under the criteria in the preceding paragraph, we would need to determine if this building would be a relocation of the current provider or a cessation of business at one location and establishment of a new business at another location. In the event of relocation, the CAH must ensure that the provider is functioning as essentially the same provider in order to operate under the same provider agreement. A provider that is changing location is considered to have closed the old facility if the original community or service area can no longer be expected to be served at the new location. The distance of the moved CAH from its old location will be considered, but it will not be the sole determining factor in granting the relocation of a CAH under the same provider agreement. For example, a specialty hospital may move a considerable distance and still care for generally the same inpatient population, while the relocation of a CAH at a relatively short distance within a rural area may greatly affect the community served.

In the event that CMS determines the rebuilding of the CAH in a different location to be a relocation, the provider agreement would continue to apply to the CAH at the new location. In addition to the relocation being within the same service area, serving the same population, the CAH would need to be providing essentially the same services with the same staff; that is, at least 75 percent of the same staff and 75 percent of the range of services are maintained in the new location as the same provider of services. We are proposing the use of a 75-percent threshold because we believe it indicates that the CAH that is relocating demonstrates that it will maintain a high level of involvement, as opposed to just a majority involvement, in the current community. We note that CMS has also used a 75-percent threshold in other provider designation policies such as the provider-based policies at §413.65(e)(3)(ii).

In all cases of relocation, the CAH must continue to meet all of the CoPs found at 42 CFR Part 485, Subpart F, including location in a rural area as provided for at §485.610.

(3) Cessation of business at one location. Under existing CMS policy, if the CAH relocation results in the cessation of furnishing services to the same community, we would not consider this to be a relocation, but instead would consider such a scenario a cessation of business at one location and establishment of a new business at another location. Cessation of business is a basis for voluntary termination of the provider agreement under 42 CFR Part 489. If the proposed move constitutes a cessation of business, the CMS Regional Office may assist the provider in obtaining an agreement to participate under a new provider number. Furthermore, in such a situation, the regulations require the provider to give advanced notice to CMS and the public regarding its intent to stop providing medical services to the community. There is no appeals process for a voluntary termination. Under our current

policies, the cessation of business by a CAH automatically terminates the CAH designation, regardless of whether the designation was obtained through a necessary provider determination.

b. Relocation of a CAH Using a Necessary Provider Designation to Meet the CoP for Distance

Once it has been determined that constructing a new facility will cause the CAH to relocate, the second step is to determine if the CAH that has a necessary provider designation can maintain this designation after relocating.

We recognize that §485.610 (c) relating to location relative to other facilities or necessary provider certification states that, after January 1, 2006, the "necessary provider" designation will no longer be used to waive the mileage requirements. In addition, CMS policy regarding a change of size or location of a provider states that there may be situations where the facility relocation is so far removed from the originally approved site that we would conclude that this is a different provider or supplier, for example, it has different employees, services, and patients. Furthermore, the language of section 1820(c)(2)(i) of the Act allows a State to waive the mileage requirement and designate a facility as a necessary provider of health care services to residents in the area. We have interpreted "services to residents in the area" to mean that the necessary provider designation does not automatically follow the provider if the facility relocates to a different location because it is no longer furnishing "services to patients" in the area determined to need a necessary provider.

We do not intend to change this policy. Our proposal, noted below, is intended to establish a methodology to be used by all CMS Regional Offices in making such a decision consistent with the statutory provisions concerning necessary provider designation.

In this proposed rule, we are proposing to amend the regulations at §485.610 to set forth the criteria by which those relocated CAHs designated as necessary providers that embarked on a replacement facility project before the sunset provision was enacted on December 8, 2003, but find that they cannot be operational in the replacement facility by January 1, 2006, can retain their necessary provider status. As required by statute, no additional CAHs will be certified as a necessary provider on or after January 1, 2006. We recognize that the statute refers to a facility designated as a CAH while relocation of a facility may result in a different building. However, to provide flexibility for a facility designated as a CAH whose location may change, but is essentially the same facility in a different location, we are proposing to amend the regulations to account for this scenario. Essentially, we recognize that the necessary provider designation may need to be applied to certain relocated CAHs. To this end, we are proposing to use the specified relocation criteria as the initial step to determine continuing necessary provider status. Specifically, in this proposed rule, we are proposing that, when a CAH is determined to have relocated, it may nonetheless continue to operate under its necessary provider designation that exempts the distance from other providers only if the following conditions are met:

(1) The relocated CAH has submitted an application to the State agency for relocation prior to the January 1, 2006, sunset date. If the CAH is applying under a grandfathered status under section 1820(h)(3) of the Act, the following items would need to be included in the application:

- A demonstration that the CAH will meet the same State criteria for the necessary provider designation that were established when the waiver was originally issued. For

example, if the location waiver was granted because the CAH was located in a health professional shortage area (HPSA), the CAH must remain in that HPSA.

- Assurance that, after the relocation, the CAH will be servicing the same community and will be operating essentially the same services with essentially the same staff (that is, a demonstration that it is serving at least 75 percent of the same service area, with 75 percent of the same services offered, and staffed by 75 percent of the same staff, including medical staff, contracted staff, and employees). This is essentially the same criteria used in determining whether the CAH has relocated.

- Assurance that the CAH will remain in compliance with all of the CoPs at 42 CFR Part 485 in the new location. Compliance will be established with a full survey in the new location to include the Life Safety Code and would include any off-site locations and rehabilitation or psychiatric distinct part units.

- A demonstration that construction plans were “under development” prior to the effective date of Pub. L. 108-173 (December 8, 2003) in the application the CAH submits to continue using a necessary provider designation. Supporting documentation could include the drafting of architectural specifications, the letting of bids for construction, the purchase of land and building supplies, documented efforts to secure financing for construction, expenditure of funds for construction, and compliance with state requirements for construction such as zoning requirements, application for a certificate of need, and architectural review. However, we recognize that it may not have been feasible for a CAH to have completed all of these activities noted above as examples prior to December 8, 2003. Thus, we expect the CMS Regional Offices to consider all of the criteria and make case-by-case determinations of whether a relocated CAH continues to warrant necessary provider status. We note that we have also used the above documentation guidelines in Publication 100-20 for grandfathered specialty hospitals to determine if construction plans were “under development.”

In proposing these criteria, our intent in clarifying the sunset of the necessary provider designation provision is to allow CAHs to complete construction projects that were initiated prior to the enactment of Pub. L. 108-173, which we believe is consistent with the statutory language of section 405(h) of Pub. L. 108-173.

(2) In the application, the CAH demonstrates that the replacement will facilitate the access to care and improve the delivery of services to Medicare beneficiaries. We are soliciting comments on how a necessary provider CAH should demonstrate that the replacement will improve access to care.

These guidelines are meant to be applied to the relocated CAH that meets the CoP in the new location and wishes to maintain a necessary provider designation in order to meet the distance requirement at §485.610(c). They are not meant to preclude a CAH from relocating at any time if the CAH does not seek to maintain the necessary provider designation. Any CAH may relocate at any time if the CAH meets the definition of relocation and can meet all the CoPs at 42 CFR Part 485, Subpart F, as determined by the CMS Regional Offices on a case-by-case basis.

Accordingly, we are proposing to revise §485.610 of the regulations by adding a new paragraph (d) to incorporate this proposal. Specifically, the proposed new paragraph (d) would specify that a CAH may maintain its necessary provider certification provided for under §485.610(c) if the new facility meets the requirements for either a replacement facility that is constructed within 250 yards of the current building or contiguous to the current CAH on land owned by the CAH prior to December 8, 2003; or as a relocated CAH if, at the

relocated site, the CAH provides essentially (75 percent) the same services to the same service area with essentially the same staff. The CAH that plans to relocate must provide documentation demonstrating that its plans to rebuild in the relocated area were undertaken prior to December 8, 2003. We are also proposing that if a CAH that has a necessary provider certification from the State places a new facility in service on or after January 1, 2006, and does not meet either the requirements for a replacement facility or a relocated facility, as specified in the regulations, the action will be considered a cessation of business.

§485.610 Condition of participation: Status and location.

In order to be considered a relocation, we are proposing under §485.610(d)(2)(ii) to require a CAH to provide documentation demonstrating that its plans to rebuild in a relocated area were undertaken prior to December 8, 2003. This requirement does impose an information collection requirement. However, because this burden would be imposed on less than 10 CAHs, under 5 CFR 1320.2(c), these requirements are exempt from the PRA.

§412.103 Special treatment: Hospitals located in urban areas and that apply for reclassification as rural.

(a) * * *

(1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification, the Rural-Urban Commuting Area codes, as determined by the Office of Rural Health Policy (ORHP) of the Health Resources and Services Administration, which is available via the ORHP website at: <http://www.ruralhealth.hrsa.gov> or from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, 5600 Fishers Lane, Room 9A-55, Rockville, MD 20857.

* * * * *

(4) For any period after September 30, 2004 and before October 1, 2006, a CAH in a county that, in FY 2004, was not part of an MSA as defined by the Office of Management and Budget and was not considered to be urban under §412.64(b)(3) of this chapter, but as of FY 2005 was included as part of an MSA or was considered to be urban under §412.64(b)(3) of this chapter as a result of the most recent census data and implementation of the new MSA definitions announced by OMB on June 6, 2003, may be reclassified as being located in a rural area for purposes of meeting the rural location requirement under §485.610(b) of this chapter if it meets any of the requirements in paragraphs (a)(1), (a)(2), or (a)(3) of this section.

§485.610 Condition of participation: Status and location.

* * * * *

(b) * * *

(3) Effective only for October 1, 2004 through September 30, 2006, the CAH does not meet the location requirements in either paragraph (b)(1) or paragraph (b)(2) of this section and is located in a county that, in FY 2004, was not part of a Metropolitan Statistical Area as defined by the Office of Budget Management and was not considered to be urban under §412.63(b)(3) of this chapter, but as of FY 2005 was included as part

of such an MSA or was considered to be urban under §412.64(b)(3) of this chapter, as a result of the most recent census data and implementation of the new MSA definitions announced by OMB on June 6, 2003.

* * * * *

(d) Standard: Relocation of CAHs with a necessary provider designation. A CAH that has a necessary provider certification from the State and places a new facility in service after January 1, 2006, can continue to meet the location requirement of paragraph (c) of this section based on the necessary provider certification only if the new facility meets either the requirement for replacement in the same location in paragraph (d)(1) of this section or the requirement for a relocation of a CAH in paragraph (d)(2) of this section.

(1) A new construction of a CAH will be considered as a replacement facility if the construction is undertaken within 250 yards of the current building or contiguous to the current CAH on land owned by the CAH prior to December 8, 2003.

(2) A new facility CAH will be considered as a relocation of a CAH if, at the relocated site--

(i) The CAH serves at least 75 percent of the same service area that it served prior to its relocation, provides at least 75 percent of the same services that it provided prior to the relocation, and is staffed by 75 percent of the same staff (including medical staff, contracted staff, and employees); and

(ii) The CAH provides documentation demonstrating that its plans to rebuild in the relocated area were undertaken prior to December 8, 2003.

(3) If a CAH that has a necessary provider certification from the State places a new facility in service on or after January 1, 2006, and does not meet either the requirements in paragraph (d)(1) or paragraph (d)(2) of this section, the action will be considered a cessation of business as described in §489.52(b)(3).

I. Impact of Proposed Policy on CAH Relocation Provisions

In section VII.B.3. of the preamble to this proposed rule, we discuss the proposed change to the necessary provider provision as it applies to CAHs. As required by statute, no additional CAHs will be certified as a necessary provider on or after January 1, 2006. We are proposing to revise the regulations to allow some flexibility for those CAHs previously designated as necessary providers that embarked on a replacement facility project before the sunset provision was enacted on December 8, 2003, but find that they cannot be operational in the replacement facility by January 1, 2006. We are proposing that, when a CAH is determined to have relocated, it may continue to operate under its existing necessary provider designation that exempts CAHs from the distance from another provider requirement only if certain conditions are met. The proposed clarification to the sunset of the necessary provider provision is intended to allow CAHs to complete construction projects that were initiated prior to the enactment of Pub. L. 108-173. The Health Resources Services Administration (HRSA) estimates that this proposal will apply to fewer than six CAHs nationwide. The average cost of construction of a new 25 bed CAH is approximately \$25 million. Given a depreciation schedule based on a 25 useful life and Medicare utilization of approximately 50 percent, the additional capital costs for six CAHs would be \$3 million. However, the actual cost to the program would be further reduced since those 6 CAH are currently being reimbursed for their existing capital costs and also the increased operating costs

that are associated with operating an aged facility. Accordingly, the budgetary impact for the proposed change on the affected CAHs is estimated at between \$1 million and \$2 million. Expressed on a per-facility basis, the budgetary impact of this proposed change is estimated at between \$167,000 and \$333,000 per CAH.