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Health Care Financing Administration

42 CFR Parts 405, 412, and 413

Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 1999 Rates; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 405, 412, and 413

[HCFA–1003–P]

RIN 0938–AI22

Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 1999 Rates

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Proposed rule.

SUMMARY: We are proposing to revise the Medicare hospital inpatient prospective payment systems for operating costs and capital-related costs to implement applicable statutory requirements, including section 4407 of the Balanced Budget Act of 1997, as well as changes arising from our continuing experience with the systems. In addition, in the addendum to this proposed rule, we are describing proposed changes in the amounts and factors necessary to determine rates for Medicare hospital inpatient services for operating costs and capital-related costs. These changes would be applicable to discharges occurring on or after October 1, 1998. We are also setting forth proposed rate-of-increase limits as well as proposing changes for hospitals and hospital units excluded from the prospective payment systems.

DATES: Comments will be considered if received at the appropriate address, as provided below, no later than 5 p.m. on July 7, 1998.

ADDRESSES: Mail written comments (an original and three copies) to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA–1003–P, P.O. Box 7517, Baltimore, MD 21207–0517.

If you prefer, you may deliver your written comments (an original and three copies) to one of the following addresses:

Room 309–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW, ashington, DC 20201, or

Room C5–09–26, Central Building, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code HCFA–1003–P. Comments received timely will be available for public inspection as they are received, generally beginning approximately three weeks after publication of a document, in Room 309–G of the Department's offices at 200 Independence Avenue, SW, Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: (202) 690–7890).

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

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Allison Herron Eydt, HCFA Desk Officer; and

Office of Financial and Human Resources, Management Planning and Analysis Staff, Room C2–26–17, 7500 Security Boulevard, Baltimore, MD 21244–1850.

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FOR FURTHER INFORMATION CONTACT:

Nancy Edwards, (410) 786–4531, Operating Prospective Payment, DRG, and Wage Index Issues.

Tzvi Hefter, (410) 786–4487, Capital Prospective Payment, Excluded Hospitals, and Graduate Medical Education Issues.

SUPPLEMENTARY INFORMATION:

I. Background

A. Summary

Sections 1886(d) and (g) of the Social Security Act (the Act), set forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively-set rates. Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of hospital inpatient stays under a prospective payment system. Under these prospective payment systems, Medicare payment for hospital inpatient operating and capital-related costs is made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups (DRGs).

Certain specialty hospitals are excluded from the prospective payment systems. Under section 1886(d)(1)(B) of the Act, the following hospitals and units are excluded from PPS: psychiatric hospitals or units, rehabilitation hospitals or units, children's hospitals, long term care hospitals, and cancer hospitals. For these hospitals and units, Medicare payment for operating costs is based on reasonable costs subject to a hospital-specific annual limit.

Under section 1886(a)(4) of the Act, costs incurred in connection with approved graduate medical education (GME) programs are excluded from the operating costs of inpatient hospital services. Hospitals with approved 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 number of the hospital's residents in that period and the hospital's costs per resident in a base year.

The regulations governing the hospital inpatient prospective payment system are located in 42 CFR Part 412. The regulations governing excluded hospitals are located in both Parts 412 and 413, and the graduate medical education regulations are found in Part 413.

On August 29, 1997, we published a final rule with comment period in the **Federal Register** (62 FR 45966) setting forth both statutorily required changes and other changes to the Medicare hospital inpatient prospective payment systems for both operating costs and capital-related costs, which were effective for discharges occurring on or after October 1, 1997. This rule also

implemented changes addressing payments for excluded hospitals and payments for graduate medical education costs. This final rule with comment period followed a proposed rule published in the **Federal Register** on June 2, 1997 (62 FR 29902) that set forth proposed updates and changes.

B. Major Contents of This Proposed Rule

In this proposed rule, we are setting forth proposed changes to the Medicare hospital inpatient prospective payment systems for both operating costs and capital-related costs. This proposed rule would be effective for discharges occurring on or after October 1, 1998. Following is a summary of the major changes that we are proposing to make:

1. Changes to the DRG Classifications and Relative Weights

As required by section 1886(d)(4)(C) of the Act, we must adjust the DRG classifications and relative weights at least annually. Our proposed changes for FY 1999 are set forth in section II. of this preamble.

2. Changes to the Hospital Wage Index

In section III. of this preamble, we discuss proposed revisions to the wage index and the annual update of the wage data. Specific issues addressed in this section include the following:

- FY 1999 wage index update.
- Changes to the data categories included in the wage index.
- Revisions to the wage index based on hospital redesignations.

3. Other Decisions and Changes to the Prospective Payment System for Inpatient Operating and Graduate Medical Education Costs

In section IV. of this preamble, we discuss several provisions of the regulations in 42 CFR parts 412 and 413 and set forth certain proposed changes concerning the following:

- Definition of transfer cases.
- Rural referral centers.
- Disproportionate share adjustment.
- Bad debts.
- Direct graduate medical education programs.

4. Changes to the Prospective Payment System for Capital-Related Costs

In section V. of this preamble, we discuss several provisions of the regulations in 42 CFR part 412 and set forth certain proposed changes and clarifications concerning the following:

- Capital indirect medical education payments.
- Payments to new hospitals.

5. Changes for Hospitals and Hospital Units Excluded from the Prospective Payment Systems

In section VI. of this preamble, we discuss the following criteria governing excluded hospital issues:

- Hospital-within-a-hospital.
- Adjustments to the target amounts for FY 1999.

6. Determining Prospective Payment Operating and Capital Rates and Rate-of-Increase Limits

In the addendum to this proposed rule, we set forth proposed changes to the amounts and factors for determining the FY 1999 prospective payment rates for operating costs and capital-related costs. We are also proposing update factors for determining the rate-of-increase limits for cost reporting periods beginning in FY 1999 for hospitals and hospital units excluded from the prospective payment system.

7. Impact Analysis

In Appendix A, we set forth an analysis of the impact that the proposed changes described in this proposed rule would have on affected entities.

8. Capital Acquisition Model

Appendix B contains the technical appendix on the proposed FY 1999 capital cost model.

9. Report to Congress on the Update Factor for Prospective Payment Hospitals and Hospitals Excluded from the Prospective Payment System

Section 1886(e)(3)(B) of the Act requires that the Secretary report to Congress on our initial estimate of a recommended update factor for FY 1999 for both hospitals included in and hospitals excluded from the prospective payment systems. This report is included as Appendix C to this proposed rule.

10. Proposed Recommendation of Update Factor for Hospital Inpatient Operating Costs

As required by sections 1886(e)(4) and (e)(5) of the Act, Appendix D provides our recommendation of the appropriate percentage change for FY 1999 for the following:

- Large urban area and other area average standardized amounts (and hospital-specific rates applicable to sole community and Medicare-dependent, small rural hospitals) for hospital inpatient services paid for under the prospective payment system for operating costs.
- Target rate-of-increase limits to the allowable operating costs of hospital inpatient services furnished by hospitals and hospital units excluded from the prospective payment system.

11. Discussion of Medicare Payment Advisory Commission Recommendations

The Balanced Budget Act of 1997 abolished the Prospective Payment Assessment Commission (ProPAC) and created the Medicare Payment Advisory Commission (MedPAC). Under section 1805(b) of the Act, MedPAC is required to submit a report to Congress, not later than March 1 of each year, that reviews and makes recommendations on Medicare payment policies. The March 1, 1998 report made several recommendations concerning hospital inpatient payment policies. We reviewed those recommendations and this document sets forth our responses to those recommendations.

Although it has been our practice to include a reprint of ProPAC's March 1 report as an appendix to the proposed rule, we are not following that practice with MedPAC reports. For further information relating specifically to that report or to obtain a copy of the report, contact MedPAC at (202) 653–7220.

II. Proposed Changes to DRG Classifications and Relative Weights

A. Background

Under the prospective payment system, we pay for inpatient hospital services on the basis of a rate per discharge that varies by the DRG to which a beneficiary's stay is assigned. The formula used to calculate payment for a specific case takes an individual hospital's payment rate per case and multiplies it by the weight of the DRG to which the case is assigned. Each DRG weight represents the average resources required to care for cases in that particular DRG relative to the average resources used to treat cases in all DRGs.

Congress recognized that it would be necessary to recalculate the DRG relative weights periodically to account for changes in resource consumption. Accordingly, section 1886(d)(4)(C) of the Act requires that the Secretary adjust the DRG classifications and relative weights annually. These adjustments are made to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources. The proposed changes to the DRG classification system and the proposed recalibration of the DRG weights for discharges occurring on or after October 1, 1998 are discussed below.

B. DRG Reclassification

1. General

Cases are classified into DRGs for payment under the prospective payment system based on the principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay, as well as age, sex, and discharge status of the patient. The diagnosis and procedure information is reported by the hospital using codes from the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD–9–CM). The Medicare fiscal intermediary enters the information into its claims system and subjects it to a series of automated screens called the Medicare Code Editor (MCE). These screens are designed to identify cases that require further review before classification into a DRG can be accomplished.

After screening through the MCE and any further development of the claims, cases are classified by the GROUPER software program into the appropriate DRG. The GROUPER program was developed as a means of classifying each case into a DRG on the basis of the diagnosis and procedure codes and demographic information (that is, sex, age, and discharge status). It is used both to classify past cases in order to measure relative hospital resource consumption to establish the DRG weights and to classify current cases for purposes of determining payment. The records for all Medicare hospital inpatient discharges are maintained in the Medicare Provider Analysis and Review (MedPAR) file. The data in this file are used to evaluate possible DRG classification changes and to recalibrate the DRG weights.

Currently, cases are assigned to one of 496 DRGs in 25 major diagnostic categories (MDCs). Most MDCs are based on a particular organ system of the body (for example, MDC 6, Diseases and Disorders of the Digestive System); however, some MDCs are not constructed on this basis since they involve multiple organ systems (for example, MDC 22, Burns).

In general, cases are assigned to an MDC based on the principal diagnosis, before assignment to a DRG. However, there are five DRGs to which cases are directly assigned on the basis of procedure codes. These are the DRGs for liver, bone marrow, and lung transplant (DRGs 480, 481, and 495, respectively) and the two DRGs for tracheostomies (DRGs 482 and 483). Cases are assigned to these DRGs before classification to an MDC.

Within most MDCs, cases are then divided into surgical DRGs (based on a surgical hierarchy that orders individual procedures or groups of procedures by resource intensity) and medical DRGs. Medical DRGs generally are differentiated on the basis of diagnosis and age. Some surgical and medical DRGs are further differentiated based on the presence or absence of complications or comorbidities (hereafter CC).

Generally, GROUPER does not consider other procedures; that is, nonsurgical procedures or minor surgical procedures generally not performed in an operating room are not listed as operating room (OR) procedures in the GROUPER decision tables. However, there are a few non-OR procedures that do affect DRG assignment for certain principal diagnoses, such as extracorporeal shock wave lithotripsy for patients with a principal diagnosis of urinary stones.

The changes we are proposing to make to the DRG classification system for FY 1999 and other decisions concerning DRGs are set forth below. Unless otherwise noted, our DRG analysis is based on the full (100 percent) FY 1997 MedPAR file based on bills received through September 1997.

2. MDC 5 (Diseases and Disorders of the Circulatory System)

In the August 29, 1997 hospital inpatient final rule with comment period (62 FR 45974), we noted that, because of the many recent changes in heart surgery, we were considering conducting a comprehensive review of the MDC 5 surgical DRGs. We have begun that review, and based upon our analysis thus far, we believe it is appropriate to propose some DRG changes immediately. These proposed changes are set forth below.

a. *Coronary Bypass.* There are two DRGs that capture coronary bypass procedures: DRG 106 (Coronary Bypass with Cardiac Catheterization) and DRG 107 (Coronary Bypass without Cardiac Catheterization). The procedures that allow a coronary bypass case to be assigned to DRG 106 include percutaneous valvuloplasty, percutaneous transluminal coronary angioplasty (PTCA), cardiac catheterization, coronary angiography, and arteriography.

In analyzing the FY 1997 MedPAR file, we noted that, of cases assigned to DRG 106, the average standardized charges for coronary bypass cases with PTCA were significantly higher than those cases without PTCA. There were approximately 4,400 cases in DRG 106 where PTCA is performed as a secondary procedure. These cases have an average standardized charge of approximately $69,000. The average charge of the approximately 95,000 cases in DRG 106 without PTCA is approximately $52,000.

Based on this analysis, we are proposing to create a new DRG for coronary bypass cases with PTCA. The cases currently in DRG 106 without PTCA would be assigned to another DRG and the cases currently assigned to DRG 107 would be unmodified. Because we would replace two DRGs with three new DRGs, we would revise the DRG numbers and titles accordingly. The new DRGs and their titles are set forth below:

DRG 106 Coronary Bypass with PTCA
DRG 107 Coronary Bypass with Cardiac Catheterization
DRG 109 Coronary Bypass without Cardiac Catheterization

We note that DRG 109 has been an empty DRG for the last several years.

b. Implantable Heart Assist System and Annuloplasty. In the August 29, 1997 final rule with comment period, we moved implant of an implantable, pulsatile heart assist system (procedure code 37.66) from DRGs 110 and 111 (Major Cardiovascular Procedures)[1] to DRG 108 (Other Cardiothoracic Procedures). Although this move improved payment for these procedures, they were still much more expensive than the other cases in DRG 108 ($96,000 for heart assist versus an average of $54,000 for all other cases in the FY 1996 MedPAR file). We stated that we would continue to review the MDC 5 surgical DRGs in an attempt to find a DRG placement for these cases that would be more similar in terms of resource use.

In reviewing the FY 1997 MedPAR file, we note that heart assist system implant continues to be the most expensive procedure in DRG 108. In fact, other than heart transplant, heart assist system implant is the most expensive procedure in MDC 5. The average FY 1997 charge for these cases, when assigned to DRG 108, is over $150,000 compared to about $53,000 for all cases in DRG 108. Obviously, the charges for heart assist implant are increasing at a much greater rate than the average charges for DRG 108. In addition, the length of stay for cases coded with 37.66 is approximately 32 days compared to about 11 days for all other DRG 108 cases.

[1] A single title combined with two DRG numbers is used to signify pairs. Generally, the first DRG is for cases with CC and the second DRG is for cases without CC. If a third number is included, it represents cases with patients who are age 0–17. Occasionally, a pair of DRGs is split between age >17 and age 0–17.

One possibility for improving payment for these cases is to move them to DRGs 104 and 105 (Cardiac Valve Procedures). Those DRGs, which split on the basis of the performance of cardiac catheterization, have average charges of approximately $66,000 and $51,000, respectively. While heart assist implant cases are still more expensive than the average case in these DRGs, payment would be improved. Clinically, placement of heart assist implant in DRGs 104 and 105 is not without precedent. Effective with FY 1988, we placed implant of a total automatic implantable cardioverter defibrillator (AICD) in these DRGs. In addition, the vast majority of procedures assigned to DRG 108 involve surgically splitting open the sternum to perform the procedure. However, implant of the heart assist device does not require this approach.

While reviewing the DRG 108 cases, we also noted that procedure code 35.33 (annuloplasty) is assigned to this DRG. Annuloplasty is a valve procedure and is clinically more similar to the cases assigned to DRGs 104 and 105 than it is to the cases assigned to DRG 108. In addition, the average standardized charge for annuloplasty cases assigned to DRG 108 is about $67,000, well above the overall average charge of approximately $53,000 for cases in DRG 108. Therefore, we are proposing to move annuloplasty from DRG 108 to DRGs 104 and 105.

In order to more accurately reflect the cases assigned to DRGs 104 and 105, we would retitle them as follows:

DRG 104 Cardiac Valve and Other Major Cardiothoracic Procedures with Cardiac Catheterization

DRG 105 Cardiac Valve and Other Major Cardiothoracic Procedures without Cardiac Catheterization.

3. MDC 22 (Burns)

Under the current DRG system, burn cases are assigned to one of six DRGs in MDC 22 (Burns), which have not been revised since 1986. In our FY 1998 hospital inpatient proposed rule (June 2, 1997; 62 FR 29912), in response to inquiries we had received, we indicated that we would conduct a comprehensive review of MDC 22 to determine whether changes in these DRGs could more appropriately capture the variation in resource use associated with different classes of burn patients. We solicited public comments on this issue, particularly asking for recommendations on ways to categorize related diagnosis and procedure codes to produce DRG groupings that would be more homogeneous in terms of resource use.

Among the comments we received was a proposal (endorsed by the American Burn Association (ABA)) for restructuring the DRGs based on several statistical and clinical criteria, including age, severity of the burn, and the presence of complications or comorbidities. Although this proposal was structured for a patient population encompassing all ages of patients, we believed that it showed great promise for Medicare patients as well. During the last several months, we have worked closely with representatives of the ABA and with the clinicians who developed the proposal in order to refine it for Medicare purposes.

Based on this work, we are proposing a new set of DRGs for burn cases. Under this proposal, we would replace the six existing DRGs in MDC 22 with eight new DRGs. For ease of reference and classification, the current DRGs in MDC 22, DRGs 456 through 460 and 472, would no longer be valid, and we would establish new DRGs 504 through 511 to contain all cases that currently group to MDC 22. (The complete titles of the new DRGs are set forth below.)

In reviewing the Medicare burn cases, we found that the most important distinguishing characteristic in terms of resource use was the amount of body surface affected by the burn and how much of that burn was a 3rd degree burn. The second most important factor was whether or not the patient received a skin graft. Thus, a patient with burns covering at least 20 percent of body area, with at least 10 percent of that a 3rd degree burn, consumed the most resources. However, if a patient met these criteria and did not receive a skin graft, then the case was much less expensive and the average length of stay fell from over 30 days to 8 days. The first two proposed burn DRGs would reflect these distinctions (DRGs 504 and 505).

After classifying the most extensive burn cases, we found that the patients with 3rd degree burns that did not meet the criteria to be assigned to DRGs 504 and 505 were the most expensive of the remaining cases (that is, those patients whose burns that did not meet the at least 20 percent body area or at least 10 percent 3rd degree criteria). These burns are referred to clinically as ''full-thickness burns.'' A subset of these full-thickness burn cases, those with skin graft or an inhalation injury, were much more expensive than the other cases. After dividing these patients into two groups, with or without skin graft or inhalation injury, we examined whether other factors had an influence on resource use. We found that patients who had a CC (complication or comorbidity) or a concomitant significant trauma consumed more resources whether or not they had a skin graft or inhalation injury. Thus, the next four DRGs were defined as full-thickness burns with skin graft or inhalation injury with or without CC or significant trauma, or full-thickness burns without skin graft or inhalation injury with or without CC or significant trauma (DRGs 506 through 509).

Finally, the last two proposed DRGs (510 and 511) are for cases with nonextensive burns. These cases are also split on the basis of CCs or concomitant significant trauma.

Consistent with the recommendations of several commenters on last year's proposed rule, the new burn DRGs would no longer include a separate DRG for cases in which burn patients were transferred to another acute care facility. Overall, we estimate that these proposed changes would increase by more than 25 percent the amount of variation in resource use explained by the DRGs in MDC 22. They would also improve the clinical coherence of the cases within each DRG. Thus, we believe that the proposed DRGs would provide for improved payment for cases assigned to MDC 22.

The specific diagnosis and procedure codes that would be included in each of the eight DRGs and their titles are as follows:

DRGs 504 and 505—Extensive 3rd Degree Burns with and without Skin Graft

DRGs 504 and 505 would include all cases with burns involving at least 20 percent of body surface area combined with a 3rd degree burn covering at least 10 percent of body surface area. Thus, these cases would have diagnosis codes of 948.xx, with a fourth digit of 2 or higher (indicating that burn extends over 20 percent or more of body surface) and a fifth digit of 1 or higher (indicating a 3rd degree burn extending over 10 percent or more of body surface). Cases with the appropriate diagnosis codes would be classified into DRG 504 if one of the following skin graft procedure codes is present:

85.82 Split-thickness graft to breast
85.83 Full-thickness graft to breast
85.84 Pedicle graft to breast
86.60 Free skin graft, NOS
86.61 Full-thickness skin graft to hand
86.62 Other skin graft to hand
86.63 Full-thickness skin graft to other sites
86.65 Heterograft to skin
86.66 Homograft to skin
86.67 Dermal regenerative graft (new code in FY 1999—see Table 6A in section V. of the Addendum)
86.69 Other skin graft to other sites
86.70 Pedicle of flap graft, NOS

86.71 Cutting and preparation of pedicle grafts or flaps
86.72 Advancement of pedicle graft
86.73 Attachment of pedicle or flap graft to hand
86.74 Attachment of pedicle or flap graft to other sites
86.75 Revision of pedicle or flap graft
86.93 Insertion of tissue expander

DRGs 506 and 507—Full Thickness Burn with Skin Graft or Inhalation Injury with or without CC or Significant Trauma

These DRGs would include all other cases of 3rd degree burns that also have either a skin graft or an inhalation injury. Thus, these cases would have diagnosis codes of 941.xx through 946.xx, and 949.xx, with a fourth digit of 3 or higher, as well as cases with codes of 948.xx that did not group into DRGs 504 or 505 (that is, 948.00, 948.01, and 948.1x through 948.9x with a fifth digit of 0). In addition, cases classified into DRGs 506 and 507 must have either one of the skin graft procedure codes listed above or one of the following diagnosis codes for inhalation injuries:

518.5 Pulmonary insufficiency following trauma and surgery
518.81 Respiratory failure
518.84 Acute and chronic respiratory failure (new code in FY 1999—see Table 6A in section V. of the Addendum)
947.1 Burn of larynx, trachea, or lung
987.9 Toxic effect of gas, fume, or vapor, NOS

Cases that meet both of these coding criteria would be assigned to DRG 506 if there is a diagnosis code indicating either a CC (based on the standard DRG CC list) or concomitant significant trauma (based on the significant trauma diagnosis codes, listed by body site, used for classification in MDC 24).

DRGs 508 and 509—Full Thickness Burn without Skin Graft or Inhalation Injury with or without CC or Significant Trauma

These DRGs would include all other cases of 3rd degree burns. Thus, these DRGs would include all cases without a skin graft or inhalation injury that have diagnosis codes of 941.xx through 946.xx, and 949.xx, with a fourth digit of 3 or higher, as well as cases with codes of 948.xx that did not group into DRGs 504 or 505. DRG 508 would also require a secondary diagnosis from the standard CC list or the trauma list based on the significant trauma diagnosis codes, listed by body site, used for classification in MDC 24.

DRGs 510 and 511—Nonextensive Burns with and without CC or Significant Trauma

The remaining burn cases would be classified into one of these two DRGs, depending on whether or not the claim included a diagnosis code reflecting the presence of a CC or a significant trauma, as explained above.

4. Legionnaires' Disease

Effective with discharges occurring on or after October 1, 1997, a new diagnosis code was created for pneumonia due to Legionnaires' disease (code 482.84). In the August 29, 1997 final rule with comment period, we assigned this code to DRGs 79, 80, and 81 (Respiratory Infections and Inflammations) (62 FR 46090). However, we did not include this code as a human immunodeficiency virus (HIV) major related condition in MDC 25 (HIV Infections). Because pneumonia due to Legionnaires' disease is a serious respiratory condition that has a deleterious effect on patients with HIV, we are proposing to assign diagnosis code 482.84 to DRG 489 (HIV with Major Related Condition) as a major related condition. In addition, we did not assign the code as a major problem in DRGs 387 (Prematurity with Major Problems) and 389 (Full Term Neonate with Major Problems). These DRGs are assigned to MDC 15 (Newborns and Other Neonates with Conditions Originating in the Perinatal Period). Again, as a part of this proposed rule, we would assign diagnosis code 482.84 as a major problem in DRGs 387 and 389 because of its effect on resource use in treating newborns.

5. Surgical Hierarchies

Some inpatient stays entail multiple surgical procedures, each one of which, occurring by itself, could result in assignment of the case to a different DRG within the MDC to which the principal diagnosis is assigned. It is, therefore, necessary to have a decision rule by which these cases are assigned to a single DRG. The surgical hierarchy, an ordering of surgical classes from most to least resource intensive, performs that function. Its application ensures that cases involving multiple surgical procedures are assigned to the DRG associated with the most resource-intensive surgical class.

Because the relative resource intensity of surgical classes can shift as a function of DRG reclassification and recalibration, we reviewed the surgical hierarchy of each MDC, as we have for previous reclassifications, to determine if the ordering of classes coincided with the intensity of resource utilization, as measured by the same billing data used to compute the DRG relative weights.

A surgical class can be composed of one or more DRGs. For example, in MDC 5, the surgical class ''heart transplant'' consists of a single DRG (DRG 103) and the class ''major cardiovascular procedures'' consists of two DRGs (DRGs 110 and 111). Consequently, in many cases, the surgical hierarchy has an impact on more than one DRG. The methodology for determining the most resource-intensive surgical class involves weighting each DRG for frequency to determine the average resources for each surgical class. For example, assume surgical class A includes DRGs 1 and 2 and surgical class B includes DRGs 3, 4, and 5. Assume also that the average charge of DRG 1 is higher than that of DRG 3, but the average charges of DRGs 4 and 5 are higher than the average charge of DRG 2. To determine whether surgical class A should be higher or lower than surgical class B in the surgical hierarchy, we would weight the average charge of each DRG by frequency (that is, by the number of cases in the DRG) to determine average resource consumption for the surgical class. The surgical classes would then be ordered from the class with the highest average resource utilization to that with the lowest, with the exception of ''other OR procedures'' as discussed below.

This methodology may occasionally result in a case involving multiple procedures being assigned to the lower-weighted DRG (in the highest, most resource-intensive surgical class) of the available alternatives. However, given that the logic underlying the surgical hierarchy provides that the GROUPER searches for the procedure in the most resource-intensive surgical class this result is unavoidable.

We note that, notwithstanding the foregoing discussion, there are a few instances when a surgical class with a lower average relative weight is ordered above a surgical class with a higher average relative weight. For example, the ''other OR procedures'' surgical class is uniformly ordered last in the surgical hierarchy of each MDC in which it occurs, regardless of the fact that the relative weight for the DRG or DRGs in that surgical class may be higher than that for other surgical classes in the MDC. The ''other OR procedures'' class is a group of procedures that are least likely to be related to the diagnoses in the MDC but are occasionally performed on patients with these diagnoses. Therefore, these procedures should only be considered if

no other procedure more closely related to the diagnoses in the MDC has been performed.

A second example occurs when the difference between the average weights for two surgical classes is very small. We have found that small differences generally do not warrant reordering of the hierarchy since, by virtue of the hierarchy change, the relative weights are likely to shift such that the higher-ordered surgical class has a lower average weight than the class ordered below it.

Based on the preliminary recalibration of the DRGs, we are proposing to modify the surgical hierarchy as set forth below. As we stated in the September 1, 1989 final rule (54 FR 36457), we are unable to test the effects of the proposed revisions to the surgical hierarchy and to reflect these changes in the proposed relative weights due to the unavailability of revised GROUPER software at the time this proposed rule is prepared. Rather, we simulate most major classification changes to approximate the placement of cases under the proposed reclassification and then determine the average charge for each DRG. These average charges then serve as our best estimate of relative resource use for each surgical class. We test the proposed surgical hierarchy changes after the revised GROUPER is received and reflect the final changes in the DRG relative weights in the final rule. Further, as discussed below in section II.C of this preamble, we anticipate that the final recalibrated weights will be somewhat different from those proposed, since they will be based on more complete data. Consequently, further revision of the hierarchy, using the above principles, may be necessary in the final rule.

At this time, we would revise the surgical hierarchy for MDC 3 (Diseases and Disorders of the Ear, Nose, Mouth and Throat) as follows:

- We would reorder Sinus and Mastoid Procedures (DRGs 53–54) above Myringotomy with Tube Insertion (DRGs 61–62).
- We would reorder Mouth Procedures (DRGs 168–169) above Tonsil and Adenoid Procedure Except Tonsillectomy and/or Adeniodectomy Only (DRGs 57–58).

6. Refinement of Complications and Comorbidities List

There is a standard list of diagnoses that are considered CCs. We developed this list using physician panels to include those diagnoses that, when present as a secondary condition, would be considered a substantial complication or comorbidity. In previous years, we have made changes to the standard list of CCs, either by adding new CCs or deleting CCs already on the list. At this time, we do not propose to delete any of the diagnosis codes on the CC list.

In the September 1, 1987 final notice concerning changes to the DRG classification system (52 FR 33143), we modified the GROUPER logic so that certain diagnoses included on the standard list of CCs would not be considered a valid CC in combination with a particular principal diagnosis. Thus, we created the CC Exclusions List. We made these changes to preclude coding of CCs for closely related conditions, to preclude duplicative coding or inconsistent coding from being treated as CCs, and to ensure that cases are appropriately classified between the complicated and uncomplicated DRGs in a pair.

In the May 19, 1987 proposed notice concerning changes to the DRG classification system (52 FR 18877), we explained that the excluded secondary diagnoses were established using the following five principles:

- Chronic and acute manifestations of the same condition should not be considered CCs for one another (as subsequently corrected in the September 1, 1987 final notice (52 FR 33154)).
- Specific and nonspecific (that is, not otherwise specified (NOS)) diagnosis codes for a condition should not be considered CCs for one another.
- Conditions that may not co-exist, such as partial/total, unilateral/bilateral, obstructed/unobstructed, and benign/malignant, should not be considered CCs for one another.
- The same condition in anatomically proximal sites should not be considered CCs for one another.
- Closely related conditions should not be considered CCs for one another.

The creation of the CC Exclusions List was a major project involving hundreds of codes. The FY 1988 revisions were intended to be only a first step toward refinement of the CC list in that the criteria used for eliminating certain diagnoses from consideration as CCs were intended to identify only the most obvious diagnoses that should not be considered complications or comorbidities of another diagnosis. For that reason, and in light of comments and questions on the CC list, we have continued to review the remaining CCs to identify additional exclusions and to remove diagnoses from the master list that have been shown not to meet the definition of a CC. (See the September 30, 1988 final rule for the revision made for the discharges occurring in FY 1989 (53 FR 38485); the September 1, 1989 final rule for the FY 1990 revision (54 FR 36552); the September 4, 1990 final rule for the FY 1991 revision (55 FR 36126); the August 30, 1991 final rule for the FY 1992 revision (56 FR 43209); the September 1, 1992 final rule for the FY 1993 revision (57 FR 39753); the September 1, 1993 final rule for the FY 1994 revisions (58 FR 46278); the September 1, 1994 final rule for the FY 1995 revisions (59 FR 45334); the September 1, 1995 final rule for the FY 1996 revisions (60 FR 45782); the August 30, 1996 final rule for the FY 1997 revisions (61 FR 46171); and the August 29, 1997 final rule for the FY 1998 revisions (62 FR 45966)).

We are proposing a limited revision of the CC Exclusions List to take into account the changes that will be made in the ICD–9–CM diagnosis coding system effective October 1, 1998. (See section II.B.8, below, for a discussion of ICD–9–CM changes.) These proposed changes are being made in accordance with the principles established when we created the CC Exclusions List in 1987.

Tables 6F and 6G in section V. of the Addendum to this proposed rule contain the proposed revisions to the CC Exclusions List that would be effective for discharges occurring on or after October 1, 1998. Each table shows the principal diagnoses with proposed changes to the excluded CCs. Each of these principal diagnoses is shown with an asterisk and the additions or deletions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.

CCs that are added to the list are in Table 6F—Additions to the CC Exclusions List. Beginning with discharges on or after October 1, 1998, the indented diagnoses will not be recognized by the GROUPER as valid CCs for the asterisked principal diagnosis.

CCs that are deleted from the list are in Table 6G—Deletions from the CC Exclusions List. Beginning with discharges on or after October 1, 1998 the indented diagnoses will be recognized by the GROUPER as valid CCs for the asterisked principal diagnosis.

Copies of the original CC Exclusions List applicable to FY 1988 can be obtained from the National Technical Information Service (NTIS) of the Department of Commerce. It is available in hard copy for $92.00 plus $6.00 shipping and handling and on microfiche for $20.50, plus $4.00 for shipping and handling. A request for the FY 1988 CC Exclusions List (which

should include the identification accession number (PB) 88–133970) should be made to the following address: National Technical Information Service; United States Department of Commerce; 5285 Port Royal Road; Springfield, Virginia 22161; or by calling (703) 487–4650.

Users should be aware of the fact that all revisions to the CC Exclusions List (FYs 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, and 1998) and those in Tables 6F and 6G of this document must be incorporated into the list purchased from NTIS in order to obtain the CC Exclusions List applicable for discharges occurring on or after October 1, 1998.

Alternatively, the complete documentation of the GROUPER logic, including the current CC Exclusions List, is available from 3M/Health Information Systems (HIS), which, under contract with HCFA, is responsible for updating and maintaining the GROUPER program. The current DRG Definitions Manual, Version 15.0, is available for $195.00, which includes $15.00 for shipping and handling. Version 16.0 of this manual, which will include the final FY 1999 DRG changes, will be available in October 1998 for $225.00. These manuals may be obtained by writing 3M/HIS at the following address: 100 Barnes Road; Wallingford, Connecticut 06492; or by calling (203) 949–0303. Please specify the revision or revisions requested.

7. Review of Procedure Codes in DRGs 468, 476, and 477

Each year, we review cases assigned to DRG 468 (Extensive OR Procedure Unrelated to Principal Diagnosis), DRG 476 (Prostatic OR Procedure Unrelated to Principal Diagnosis), and DRG 477 (Nonextensive OR Procedure Unrelated to Principal Diagnosis) in order to determine whether it would be appropriate to change the procedures assigned among these DRGs.

DRGs 468, 476, and 477 are reserved for those cases in which none of the OR procedures performed is related to the principal diagnosis. These DRGs are intended to capture atypical cases, that is, those cases not occurring with sufficient frequency to represent a distinct, recognizable clinical group. DRG 476 is assigned to those discharges in which one or more of the following prostatic procedures are performed and are unrelated to the principal diagnosis:

60.0 Incision of prostate
60.12 Open biopsy of prostate
60.15 Biopsy of periprostatic tissue
60.18 Other diagnostic procedures on prostate and periprostatic tissue
60.21 Transurethral prostatectomy
60.29 Other transurethral prostatectomy
60.61 Local excision of lesion of prostate
60.69 Prostatectomy NEC
60.81 Incision of periprostatic tissue
60.82 Excision of periprostatic tissue
60.93 Repair of prostate
60.94 Control of (postoperative) hemorrhage of prostate
60.95 Transurethral balloon dilation of the prostatic urethra
60.99 Other operations on prostate

All remaining OR procedures are assigned to DRGs 468 and 477, with DRG 477 assigned to those discharges in which the only procedures performed are nonextensive procedures that are unrelated to the principal diagnosis. The original list of the ICD–9–CM procedure codes for the procedures we consider nonextensive procedures, if performed with an unrelated principal diagnosis, was published in Table 6C in section IV. of the Addendum to the September 30, 1988 final rule (53 FR 38591). As part of the final rules published on September 4, 1990, August 30, 1991, September 1, 1992, September 1, 1993, September 1, 1994, September 1, 1995, August 30, 1996, and August 29, 1997, we moved several other procedures from DRG 468 to 477, as well as moving some procedures from DRG 477 to 468. (See 55 FR 36135, 56 FR 43212, 57 FR 23625, 58 FR 46279, 59 FR 45336, 60 FR 45783, 61 FR 46173, and 62 FR 45981, respectively.)

a. Adding Procedure Codes to MDCs. We annually conduct a review of procedures producing DRG 468 or 477 assignments on the basis of volume of cases in these DRGs with each procedure. Our medical consultants then identify those procedures occurring in conjunction with certain principal diagnoses with sufficient frequency to justify adding them to one of the surgical DRGs for the MDC in which the diagnosis falls. Based on this year's review, we did not identify any necessary changes; therefore, we are not proposing to move any procedures from DRGs 468 and 477 to one of the surgical DRGs.

b. Reassignment of Procedures Among DRGs 468, 476, and 477. We also reviewed the list of procedures that produce assignments to DRGs 468, 476, and 477 to ascertain if any of those procedures should be moved from one of these DRGs to another based on average charges and length of stay. Generally, we move only those procedures for which we have an adequate number of discharges to analyze the data. Based on our review this year, we are not proposing to move any procedures from DRG 468 to DRGs 476 or 477, from DRG 476 to DRGs 468 or 477, or from DRG 477 to DRGS 468 or 476.

8. Changes to the ICD–9–CM Coding System

As discussed above in section II.B.1 of this preamble, the ICD–9–CM is a coding system that is used for the reporting of diagnoses and procedures performed on a patient. In September 1985, the ICD–9–CM Coordination and Maintenance Committee was formed. This is a Federal interdepartmental committee charged with the mission of maintaining and updating the ICD–9–CM. That mission includes approving coding changes, and developing errata, addenda, and other modifications to the ICD–9–CM to reflect newly developed procedures and technologies and newly identified diseases. The Committee is also responsible for promoting the use of Federal and non-Federal educational programs and other communication techniques with a view toward standardizing coding applications and upgrading the quality of the classification system.

The Committee is co-chaired by the National Center for Health Statistics (NCHS) and HCFA. The NCHS has lead responsibility for the ICD–9–CM diagnosis codes included in the *Tabular List* and *Alphabetic Index for Diseases* while HCFA has lead responsibility for the ICD–9–CM procedure codes included in the *Tabular List* and *Alphabetic Index for Procedures.*

The Committee encourages participation in the above process by health-related organizations. In this regard, the Committee holds public meetings for discussion of educational issues and proposed coding changes. These meetings provide an opportunity for representatives of recognized organizations in the coding fields, such as the American Health Information Management Association (AHIMA) (formerly American Medical Record Association (AMRA)), the American Hospital Association (AHA), and various physician specialty groups as well as physicians, medical record administrators, health information management professionals, and other members of the public to contribute ideas on coding matters. After considering the opinions expressed at the public meetings and in writing, the Committee formulates recommendations, which then must be approved by the agencies.

The Committee presented proposals for coding changes at public meetings held on June 5 and December 4 and 5, 1997, and finalized the coding changes after consideration of comments received at the meetings and in writing

within 30 days following the December 1997 meeting. The initial meeting for consideration of coding issues for implementation in FY 2000 will be held on June 4, 1998. Copies of the minutes of the 1997 meetings can be obtained from the HCFA Home Page @ http://www.hcfa.gov/pubaffr.htm, under the ''What's New'' listing. Paper copies of these minutes are no longer available and the mailing list has been discontinued. We encourage commenters to address suggestions on coding issues involving diagnosis codes to: Donna Pickett, Co-Chairperson; ICD–9–CM Coordination and Maintenance Committee; NCHS; Room 1100; 6525 Belcrest Road; Hyattsville, Maryland 20782. Comments may be sent by E-mail to: dfp4@cdc.gov.

Questions and comments concerning the procedure codes should be addressed to: Patricia E. Brooks, Co-Chairperson; ICD–9–CM Coordination and Maintenance Committee; HCFA, Center for Health Plans and Providers, Plan and Provider Purchasing Policy Group, Division of Acute Care; C5–06–27; 7500 Security Boulevard; Baltimore, Maryland 21244–1850. Comments may be sent by E-mail to: pbrooks@hcfa.gov.

The ICD–9–CM code changes that have been approved will become effective October 1, 1998. The new ICD–9–CM codes are listed, along with their proposed DRG classifications, in Tables 6A and 6B (New Diagnosis Codes and New Procedure Codes, respectively) in section V. of the Addendum to this proposed rule. As we stated above, the code numbers and their titles were presented for public comment in the ICD–9–CM Coordination and Maintenance Committee meetings. Both oral and written comments were considered before the codes were approved. Therefore, we are soliciting comments only on the proposed DRG classifications.

Further, the Committee has approved the expansion of certain ICD–9–CM codes to require an additional digit for valid code assignment. Diagnosis codes that have been replaced by expanded codes, other codes, or have been deleted are in Table 6C (Invalid Diagnosis Codes). These invalid diagnosis codes will not be recognized by the GROUPER beginning with discharges occurring on or after October 1, 1998. The corresponding new or expanded diagnosis codes are included in Table 6A. Procedure codes that have been replaced by expanded codes, other codes, or have been deleted are in Table 6D (Invalid Procedure Codes). Revisions to diagnosis code titles are in Table 6E (Revised Diagnosis Code Titles), which also include the proposed DRG assignments for these revised codes. For FY 1999, there are no revisions to procedure code titles.

9. Other Issues—

a. Palliative Care. Effective October 1, 1996 (FY 1997), we introduced a diagnosis code to allow the identification of those cases in which palliative care was delivered to a hospital inpatient. This code, V66.7 (Encounter for palliative care), was unusual in that there had been no previous code assignment that included the concept of palliative care. Since this was a new concept, instructional materials were developed and distributed by the AHA as well as specialty groups on the use of this new code. With new codes, it sometimes takes several years for physician documentation to improve and for coders to become accustomed to looking for this type of information in order to assign a code. There is an inclusion note listed under V66.7 which indicates that this code should be used as a secondary diagnosis only; the patient's medical problem would always be listed first. Currently, use of diagnosis code V66.7 does not have an impact on DRG assignment. Consistent with prior practice, we have waited until the FY 1997 data became available for analysis before considering any possible modifications to the DRGs.

In analyzing the FY 1997 bills received through September 1997, we found that 4,769 discharges included V66.7 as a secondary diagnosis. These cases were widely distributed throughout 199 DRGs. The vast majority of these DRGs included five or fewer discharges with use of palliative care. Only 12 DRGs included more than 100 cases. These were the following:

DRG	Title	Number of cases
10	Nervous System Neoplasms with CC	144
14	Specific Cerebrovascular Disorders Except TIA	272
79	Respiratory Infections and Inflammations Age >17 with CC	139
82	Respiratory Neoplasms	526
89	Simple Pneumonia and Pleurisy Age >17 with CC	200
127	Heart Failure and Shock	184
172	Digestive Malignancy with CC	226
203	Malignancy of Hepatobiliary System or Pancreas	285
239	Pathological Fractures and Musculoskeletal and Connective Tissue Malignancy	218
296	Nutritional and Miscellaneous Metabolic Disorders Age >17 with CC	173
403	Lymphoma and Non-Acute Leukemia with CC	178
416	Septicemia Age >17	147

Six of these DRGs are cancer-related; however, the other DRGs are quite diverse. Upon further analysis, we found that, for the most part, discharges with code V66.7 do not significantly differ in length of stay from the discharges in the same DRG without code V66.7. Discharges with code V66.7 are sometimes longer and sometimes shorter and the comparative length of stay for a given DRG tends to vary by only one day. In general, the average charges for a palliative care case discharge with a secondary code of V66.7 were lower than the charges for other discharges within the DRG. However, these differences were relatively small and were well within the standard variation of charges for cases in the DRG.

One approach we could take to revise the DRGs would be to divide those DRGs with a large number of cases coded with V66.7 into two different DRGs, with and without palliative care. However, the relatively small proportion of cases in each DRG argues against this approach; no DRG has more than 1 percent of its cases coded with palliative care and, in most cases, the percentage is well under 1 percent. An alternative approach would be to group all palliative care cases, regardless of the underlying disease or condition, into one new DRG. However, the charges of these cases are so varied that this is not a logical choice. In addition, there is a lack of clinical coherence in such an approach. The underlying diagnoses of

these cases range from respiratory conditions to heart failure to septicemia. Because there are so few cases in the FY 1997 data and they are so widely dispersed among different DRGs, we are not proposing a DRG modification at this time. We will make a more detailed analysis of these cases over the next year based on a more complete FY 1997 data file as well as review of the FY 1998 cases that will be available later this year. As time goes by, hospital coders and physicians should become more aware of this code and we hope that more complete data will assist our decision making process.

b. PTCA. Effective with discharges occurring on or after October 1, 1997, we reassigned cases of PTCA with coronary artery stent implant from DRG 112 to DRG 116. In the August 29, 1997 final rule with comment period, we responded to several commenters who contended that PTCA cases treated with platelet inhibitors were as resource intensive as the PTCA with stent implant cases and that these cases should also be moved to DRG 116. However, there is currently no code that describes the infusion of platelet inhibitors. Therefore, we were unable to make any changes in the DRGs for FY 1998.

As set forth in Table 6B, New Procedure Codes in section V. of the addendum to this proposed rule, a new procedure code for injection or infusion of platelet inhibitors (code 99.20) will be effective with discharges occurring on or after October 1, 1998. Our usual policy on new codes is to assign them to the same DRG or DRGs as their predecessor code. Because infusion of platelet inhibitors is currently assigned to a non-OR procedure code, we followed our usual practice and designated code 99.20 as a non-OR code that does not affect DRG assignment.

We will not have any data on this new code until we receive bills for FY 1999. Thus, we would be unable to make any changes in DRG assignment until FY 2001. We note, however, that the Conference Report that accompanied the Balanced Budget Act of 1997 contained language stating that ''* * * in order to ensure that Medicare beneficiaries have access to innovative new drug therapies, the Conferees believe that HCFA should consider, to the extent feasible, reliable, validated data other than MedPAR data in annually recalibrating and reclassifying the DRGs.'' (H.R. Rep. No. 105–217.734). At this time, we have received no data that would allow us to make an appropriate modification of DRG 112 for PTCA cases with platelet infusion therapy. When we develop the final rule, we will review and analyze any data we receive about the use of platelet inhibitors for Medicare beneficiaries. If we believe that the data are adequate to allow identification of the percentage of cases in DRG 112 that receive this therapy and the charge and length of stay data convince us that these cases should be moved, we will consider such a move effective for discharges occurring on or after October 1, 1998.

C. Recalibration of DRG Weights

We are proposing to use the same basic methodology for the FY 1999 recalibration as we did for FY 1998. (See the August 29, 1997 final rule with comment (62 FR 45982).) That is, we would recalibrate the weights based on charge data for Medicare discharges. However, we would use the most current charge information available, the FY 1997 MedPAR file, rather than the FY 1996 MedPAR file. The MedPAR file is based on fully-coded diagnostic and surgical procedure data for all Medicare inpatient hospital bills.

The proposed recalibrated DRG relative weights are constructed from FY 1997 MedPAR data, based on bills received by HCFA through December 1997, from all hospitals subject to the prospective payment system and short-term acute care hospitals in waiver States. The FY 1997 MedPAR file includes data for approximately 11.2 million Medicare discharges.

The methodology used to calculate the proposed DRG relative weights from the FY 1997 MedPAR file is as follows:

- To the extent possible, all the claims were regrouped using the proposed DRG classification revisions discussed above in section II.B of this preamble. As noted in section II.B.5, due to the unavailability of revised GROUPER software, we simulate most major classification changes to approximate the placement of cases under the proposed reclassification. However, there are some changes that cannot be modeled.
- Charges were standardized to remove the effects of differences in area wage levels, indirect medical education costs, disproportionate share payments, and, for hospitals in Alaska and Hawaii, the applicable cost-of-living adjustment.
- The average standardized charge per DRG was calculated by summing the standardized charges for all cases in the DRG and dividing that amount by the number of cases classified in the DRG.
- We then eliminated statistical outliers, using the same criteria as was used in computing the current weights. That is, all cases that are outside of 3.0 standard deviations from the mean of the log distribution of both the charges per case and the charges per day for each DRG.
- The average charge for each DRG was then recomputed (excluding the statistical outliers) and divided by the national average standardized charge per case to determine the relative weight. A transfer case is counted as a fraction of a case based on the ratio of its length of stay to the geometric mean length of stay of the cases assigned to the DRG. That is, a 5-day length of stay transfer case assigned to a DRG with a geometric mean length of stay of 10 days is counted as 0.5 of a total case.
- We established the relative weight for heart and heart-lung, liver, and lung transplants (DRGs 103, 480, and 495) in a manner consistent with the methodology for all other DRGs except that the transplant cases that were used to establish the weights were limited to those Medicare-approved heart, heart-lung, liver, and lung transplant centers that have cases in the FY 1995 MedPAR file. (Medicare coverage for heart, heart-lung, liver, and lung transplants is limited to those facilities that have received approval from HCFA as transplant centers.)
- Acquisition costs for kidney, heart, heart-lung, liver, and lung transplants continue to be paid on a reasonable cost basis. Unlike other excluded costs, the acquisition costs are concentrated in specific DRGs (DRG 302 (Kidney Transplant); DRG 103 (Heart Transplant for heart and heart-lung transplants); DRG 480 (Liver Transplant); and DRG 495 (Lung Transplant)). Because these costs are paid separately from the prospective payment rate, it is necessary to make an adjustment to prevent the relative weights for these DRGs from including the effect of the acquisition costs. Therefore, we subtracted the acquisition charges from the total charges on each transplant bill that showed acquisition charges before computing the average charge for the DRG and before eliminating statistical outliers.

When we recalibrated the DRG weights for previous years, we set a threshold of 10 cases as the minimum number of cases required to compute a reasonable weight. We propose to use that same case threshold in recalibrating the DRG weights for FY 1999. Using the FY 1997 MedPAR data set, there are 38 DRGs that contain fewer than 10 cases. We computed the weights for the 38 low-volume DRGs by adjusting the FY 1998 weights of these DRGs by the percentage change in the average weight of the cases in the other DRGs.

The weights developed according to the methodology described above, using the proposed DRG classification

changes, result in an average case weight that is different from the average case weight before recalibration. Therefore, the new weights are normalized by an adjustment factor, so that the average case weight after recalibration is equal to the average case weight before recalibration. This adjustment is intended to ensure that recalibration by itself neither increases nor decreases total payments under the prospective payment system.

Section 1886(d)(4)(C)(iii) of the Act requires that beginning with FY 1991, reclassification and recalibration changes be made in a manner that assures that the aggregate payments are neither greater than nor less than the aggregate payments that would have been made without the changes. Although normalization is intended to achieve this effect, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payment to hospitals is affected by factors other than average case weight. Therefore, as we have done in past years and as discussed in section II.A.4.b of the Addendum to this proposed rule, we are proposing to make a budget neutrality adjustment to assure that the requirement of section 1886(d)(4)(C)(iii) of the Act is met.

III. Proposed Changes to the Hospital Wage Index

A. Background

Section 1886(d)(3)(E) of the Act requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts ''for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.'' In accordance with the broad discretion conferred under the Act, we currently define hospital labor market areas based on the definitions of Metropolitan Statistical Areas (MSAs), Primary MSAs (PMSAs), and New England County Metropolitan Areas (NECMAs) issued by the Office of Management and Budget (OMB). OMB also designates Consolidated MSAs (CMSAs). A CMSA is a metropolitan area with a population of one million or more, comprised of two or more PMSAs (identified by their separate economic and social character). For purposes of the hospital wage index, we use the PMSAs rather than CMSAs since they allow a more precise breakdown of labor costs. If a metropolitan area is not designated as part of a PMSA, we use the applicable MSA. Rural areas are areas outside a designated MSA, PMSA, or NECMA.

We note that effective April 1, 1990, the term Metropolitan Area (MA) replaced the term Metropolitan Statistical Area (MSA) (which had been used since June 30, 1983) to describe the set of metropolitan areas comprised of MSAs, PMSAs, and CMSAs. The terminology was changed by OMB in the March 30, 1990 **Federal Register** to distinguish between the individual metropolitan areas known as MSAs and the set of all metropolitan areas (MSAs, PMSAs, and CMSAs) (55 FR 12154). For purposes of the prospective payment system, we will continue to refer to these areas as MSAs.

Section 1886(d)(3)(E) of the Act also requires that the wage index be updated annually beginning October 1, 1993. Furthermore, this section provides that the Secretary base the update on a survey of wages and wage-related costs of short-term, acute care hospitals. The survey should measure, to the extent feasible, the earnings and paid hours of employment by occupational category, and must exclude the wages and wage-related costs incurred in furnishing skilled nursing services. We also adjust the wage index, as discussed below in section III.F, to take into account the geographic reclassification of hospitals in accordance with sections 1886(d)(8)(B) and 1886(d)(10) of the Act.

B. FY 1999 Wage Index Update

The proposed FY 1999 wage index in section V of the Addendum (effective for hospital discharges occurring on or after October 1, 1998 and before October 1, 1999) is based on the data collected from the Medicare cost reports submitted by hospitals for cost reporting periods beginning in FY 1995 (the FY 1998 wage index was based on FY 1994 wage data). The proposed FY 1999 wage index includes the following categories of data, which were also included in the FY 1998 wage index:

- Total salaries and hours from short-term, acute care hospitals.
- Home office costs and hours.
- Direct patient care contract labor costs and hours.

The proposed wage index also continues to exclude the direct salaries and hours for nonhospital services such as skilled nursing facility services, home health services, or other subprovider components that are not subject to the prospective payment system. Finally, as discussed in detail in the August 29, 1997 final rule with comment period, we would calculate a separate Puerto Rico-specific wage index and apply it to the Puerto Rico standardized amount. (See 62 FR 45984 and 46041) This wage index is based solely on Puerto Rico's data.

For FY 1999 we are proposing to include two changes to the categories: we will add contract labor costs and hours for top management positions and replace the fringe benefit category with the wage-related costs associated with hospital and home office salaries category. These two changes reflect changes to the Medicare cost report that were implemented in the FY 1995 hospital prospective payment system September 1, 1994 final rule with comment period (59 FR 45355). The changes were made to the cost report for cost reporting periods beginning during FY 1995. Because we are using wage data from the FY 1995 cost report for the proposed FY 1999 wage index, these two changes will be reflected in the wage index for the first time in FY 1999.

As discussed in detail in the September 1, 1994 final rule with comment period (59 FR 45355), we expanded the definition of contract services reported on the Worksheet S–3 to include the labor-related costs associated with contract personnel in a hospital's top four management positions: Chief Executive Officer (CEO)/Hospital Administrator, Chief Operating Officer (COO), Chief Financial Officer (CFO), and Nursing Administrator. We also revised the cost report to reflect a change in terminology from ''fringe benefits'' to ''wage-related costs,'' to promote the consistent reporting of these costs. (See September 1, 1994 final rule with comment period 59 FR 45356–45359.) We made this change in terminology because we believe that it will eliminate confusion regarding those wage-related costs that are incorporated in the wage index versus the broader definition of fringe benefits recognized under the Medicare cost reimbursement principles. Wage-related costs, which include core and other wage-related costs, are reported on the Form HCFA–339, the Provider Cost Report Reimbursement Questionnaire.

Finally, we have analyzed the wage data for the following costs, which were separately reported for the first time on the FY 1995 cost reports:

- Physician Part A costs.
- Resident and Certified Registered Nurse Anesthetist (CRNA) Part A costs.
- Overhead cost and hours by cost center.

Our analysis and proposals concerning these data are set forth below in section III.C.

C. Proposals Concerning the FY 1999 Wage Index

1. Physician Part A Costs.

Currently, if a hospital directly employs a physician, the Part A portion of the physician's salary and wage-related costs (that is, administrative and teaching service) is included in the calculation of the wage index. However, the costs for contract physician Part A services are not included. Our policy has been that, to be included in the wage index calculation, a contracted service must be related to direct patient care, or, beginning with the FY 1999 wage index, top level management (see discussion above). Because some States have laws that prohibit hospitals from directly hiring physicians, the hospitals in those States have claimed that they are disadvantaged by the wage index's exclusion of contract physician Part A costs. We began collecting separate wage data for both direct and contract physician Part A services on the FY 1995 cost report in order to analyze this issue. As we discussed in the September 1, 1994 final rule with comment period (59 FR 45354), our original purpose in collecting these data was to exclude all Part A physician costs from the wage index.

When we made the change to the cost report, there were five States in which hospitals were prohibited from directly employing physicians. We understand that only two States currently maintain this prohibition: Texas and California. Thus, the number of hospitals affected by our current policy has decreased. Nevertheless, the fact that hospitals in these two States are still prohibited from directly employing physicians for Part A services and, therefore, must enter into contractual agreements with physicians for these services, perpetuates the perceived inequity.

The main reasons we planned to exclude all Part A physician costs rather than include the contract costs was our concern that it would be difficult to accurately attribute the Part A costs and hours of these contract physicians and including these costs could inappropriately inflate the hospitals' average hourly wages. That is, we anticipated that average costs for contract physicians would be significantly higher than the costs for those physicians directly employed by the hospital. However, our analysis of the data shows that the average hourly wages for contract physician Part A costs are very similar to, and, in fact slightly lower than, the costs for salaried Part A physician services.

Based on this result, we believe that continuing to include the direct physician Part A costs and adding the costs for contract physicians would be the better policy. Thus, we are proposing to calculate the FY 1999 wage index including both direct and contract physician Part A costs.

Of the 5,115 hospitals included in the FY 1995 wage data file, approximately 23 percent reported contract physician Part A costs. Including these costs would raise the wage index values for one MSA (2 hospitals) by more than 5 percent and 5 MSAs (60 hospitals) by between 2 and 5 percent. One Statewide rural area (68 hospitals) would experience a decrease between 2 and 5 percent. The wage index values for the remaining 365 areas (5,055 hospitals) would be relatively unaffected, experiencing changes of between -2 and 2 percent. We understand that an unusually large number of hospitals have requested changes to these wage data; therefore, there may be relatively significant differences between the wage data file used to calculate the proposed wage index and the final corrected wage data in the file used to calculate the final wage index. Because of this, we will reevaluate our decision based on that final wage data, which will be submitted by April 6, 1998. If we find significant differences in the contract labor costs, we may reconsider our proposal.

2. Resident and CRNA Part A Costs

The wage index presently includes salaries and wage-related costs for residents in approved medical education programs and for CRNAs employed by hospitals under the rural pass-through provision. However, Medicare pays for these costs outside the prospective payment system. Removing these costs from the wage index calculation would be consistent with our general policy to exclude costs that are not paid through the prospective payment system, but, because they were not separately identifiable, we could not remove them.

In the September 1, 1994 final rule with comment period (59 FR 45355), we stated that we would begin collecting the resident and CRNA wage data separately and would evaluate the data before proposing a change in computing the wage index. However, there were data reporting problems associated with these costs on the FY 1995 cost report. The original instructions for reporting resident costs on Line 6 of Worksheet S–3, Part III, erroneously included teaching physician salaries and other teaching program costs from Worksheet A of the cost report. Although we issued revised instructions to correct this error, we now understand these revisions may not have been uniformly instituted. Another issue relating to residents' salaries stems from apparent underreporting of these costs by hospitals and inconsistent treatment of the associated wage-related costs.

In addition, the original Worksheet S–3 and reporting instructions did not provide for the separate reporting of CRNA wage-related costs. Another issue with the FY 1995 wage data is the inclusion of contract CRNA Part A costs in the contract labor costs reported on Worksheet S–3. We believe that much of the CRNA Part A costs are reported under contract labor, rather than under salaried employee costs, due to the heavy use of contract labor by rural hospitals. We do not believe that it would be feasible at this time to try to remove these CRNA Part A costs from the contract labor costs. We improved the reporting instructions for CRNA costs on the FY 1996 cost report.

Our analysis of the CRNA and resident wage data submitted on the FY 1995 cost report convinces us that these data are inaccurately and incompletely reported by hospitals. For example, although there are over 900 teaching hospitals receiving graduate medical education payments, only about 800 hospitals reported resident cost data. Because we do not want to make a relatively significant change in the wage index data calculation without complete and accurate data upon which to base our decision, we are proposing to delay any decision regarding excluding resident and CRNA costs from the wage index until at least next year. We will review the FY 1996 data when it becomes available later this year and present our analysis and any proposals in next year's proposed rule.

3. Overhead Allocation

Prior years' wage index calculations have excluded the direct wages and hours associated with certain subprovider components that are excluded from the prospective payment system; however, the overhead costs associated with excluded components have not been removed. We have previously attempted to remove the overhead costs associated with these excluded areas of the hospital on two separate occasions. Based on the quality of the data, as well as comments we received from the public, these proposals were never implemented.

In the September 1, 1995 final rule with comment period (60 FR 45797), we discussed the results of the second of these efforts. Our analysis was prompted by several suggestions from hospital representatives that the current methodology, which removes the higher

nursing costs in excluded areas from the hospital's direct salaries but leaves in the lower general services salaries, negatively distorts wages. However, the results of our analysis at that time dissuaded us from proposing to exclude these areas' overhead costs because the data were unreliable. We revised the FY 1995 cost report to allow for the reporting of the overhead salaries and hours. We stated that we would reexamine this issue when the FY 1995 cost report data became available.

To allocate overhead costs based on the data reported on Worksheet S–3, we first determined the ratio of the hours reported directly to excluded areas compared to the total hours. Total overhead hours and salaries were then multiplied by this ratio to allocate the proportion of overhead costs attributable to excluded areas. Next, the overhead hours and salaries attributable to excluded areas were subtracted from the hospital's total hours and salaries, and an average hourly wage reflecting this overhead allocation was computed.

Of the 5,115 hospitals in the FY 1995 wage data file, 3,661 reported overhead hours (hospitals were only required to separately report overhead hours if their number of directly assigned excluded hours exceeded 5 percent of their total hours). The overhead allocation would result in an increase in the wage index value of more than 5 percent for only one MSA (2 hospitals). A total of 12 labor areas (5 Statewide rural (206 hospitals) and 7 MSAs (25 hospitals)) would experience an increase of between 2 percent and 5 percent. Only one MSA (29 hospitals) would experience a decline of between 2 and 5 percent. The wage index value for the remaining 358 areas (4,921 hospitals) would be affected by less than 2 percent.

We are proposing to include this exclusion of overhead allocation in the calculation of the FY 1999 wage index. Although the overall impact on hospitals of this change is relatively small, we believe it is an appropriate step toward improving the overall consistency of the wage index. Additionally, we believe this change will significantly increase the accuracy of the wage data for individual hospitals, especially hospitals that have a relatively small portion of their facility devoted to acute inpatient care.

D. Verification of Wage Data From the Medicare Cost Report

The data for the proposed FY 1999 wage index were obtained from Worksheet S–3, Parts III and IV of the FY 1995 Medicare cost reports. The data file used to construct the proposed wage index includes FY 1995 data submitted to the Health Care Provider Cost Report Information System (HCRIS) as of early January 1998. As in past years, we performed an intensive review of the wage data, mostly through the use of edits designed to identify aberrant data.

Of the 5,123 hospitals originally in the data file, 851 hospitals had data elements that failed an edit. From mid-January to mid-February 1998, intermediaries contacted hospitals to revise or verify data elements that resulted in the edit failures.

As of February 17, 1998, 31 hospitals still had unresolved data elements. These unresolved data elements are included in the calculation of the proposed FY 1999 wage index pending their resolution before calculation of the final FY 1999 wage index. We have instructed the intermediaries to complete their verification of questionable data elements and to transmit any changes to the wage data (through HCRIS) no later than April 6, 1998. We expect that all unresolved data elements will be resolved by that date. The revised data will be reflected in the final rule.

Also, as part of our editing process, we deleted data for eight hospitals that failed edits. For two of these hospitals, we were unable to obtain sufficient documentation to verify or revise the data because the hospitals are no longer participating in the Medicare program or are in bankruptcy status. The data from the remaining six participating hospitals were removed because inclusion of their data would have significantly distorted the wage index values. The data for these six hospitals will be included in the final wage index if we receive corrected data that passes our edits. As a result, the proposed FY 1999 wage index is calculated based on FY 1995 wage data for 5,115 hospitals.

E. Computation of the Wage Index

The method used to compute the proposed wage index is as follows:

Step 1—As noted above, we are proposing to base the FY 1999 wage index on wage data reported on the FY 1995 Medicare cost reports. We gathered data from each of the non-Federal, short-term, acute care hospitals for which data were reported on the Worksheet S–3, Parts III and IV of the Medicare cost report for the hospital's cost reporting period beginning on or after October 1, 1994 and before October 1, 1995. In addition, we included data from a few hospitals that had cost reporting periods beginning in September 1994 and reported a cost reporting period exceeding 52 weeks. These data were included because no other data from these hospitals would be available for the cost reporting period described above, and particular labor market areas might be affected due to the omission of these hospitals. However, we generally describe these wage data as FY 1995 data.

Step 2—For each hospital, we subtracted the excluded salaries (that is, direct salaries attributable to skilled nursing facility services, home health services, and other subprovider components not subject to the prospective payment system) from gross hospital salaries to determine net hospital salaries. To determine total salaries plus wage-related costs, we added the costs of contract labor for direct patient care, certain top management, and physician Part A services; hospital wage-related costs, and any home office salaries and wage-related costs reported by the hospital, to the net hospital salaries. The actual calculation is the sum of lines 2, 4, 6, and 33 of Worksheet S–3, Part III. This calculation differs from the one computed on line 32 of Worksheet S–3, Part III. Therefore, a hospital's average hourly wage calculated under Step 2 will be different from the average hourly wage shown on line 32, column 5.

Step 3—For each hospital, we subtracted the reported excluded hours from the gross hospital hours to determine net hospital hours. To determine total hours, we increased the net hours by the addition of home office hours and hours for contract labor attributable to direct patient care, certain top management, and physician Part A salaries.

Step 4—For each hospital reporting both total overhead salaries and total overhead hours greater than zero, we then allocated overhead costs. First, we determined the ratio of excluded area hours (Line 24 of Worksheet S–3, Part III) to revised total hours (Line 9 of Worksheet S–3, Part III, adding back CRNA Part A, physician Part A, and resident hours). Second, we computed the amounts of overhead salaries and hours to be allocated to excluded areas by multiplying the above ratio by the total overhead salaries and hours reported on Line 16 of Worksheet S–3, Part IV. Finally, we subtracted the computed overhead salaries and hours associated with excluded areas from the total salaries and hours derived in Steps 2 and 3.

Step 5—For each hospital, we adjusted the total salaries plus wage-related costs to a common period to determine total adjusted salaries plus wage-related costs. To make the wage inflation adjustment, we estimated the percentage change in the employment

cost index (ECI) for compensation for each 30-day increment from October 14, 1994 through April 15, 1996, for private industry hospital workers from the Bureau of Labor Statistics *Compensation and Working Conditions.* For previous wage indexes, we used the percentage change in average hourly earnings for hospital industry workers to make the wage inflation adjustment. For FY 1999 we are proposing to use the ECI for compensation for private industry hospital workers because it reflects the price increase associated with total compensation (salaries plus fringes) rather than just the increase in salaries, which is what the average hourly earnings category reflected. In addition, the ECI includes managers as well as other hospital workers. We are also proposing to change the methodology used to compute the monthly update factors. This new methodology uses actual quarterly ECI data to determine the monthly update factors. The methodology assures that the update factors match the actual quarterly and annual percent changes. The inflation factors used to inflate the hospital's data were based on the midpoint of the cost reporting period as indicated below.

MIDPOINT OF COST REPORTING PERIOD

After	Before	Adjustment factor
10/14/94	11/15/94	1.032882
11/14/94	12/15/94	1.030771
12/14/94	01/15/95	1.028721
01/14/95	02/15/95	1.026731
02/14/95	03/15/95	1.024776
03/14/95	04/15/95	1.022827
04/14/95	05/15/95	1.020886
05/14/95	06/15/95	1.018901
06/14/95	07/15/95	1.016822
07/14/95	08/15/95	1.014649
08/14/95	09/15/95	1.012446
09/14/95	10/15/95	1.010279
10/14/95	11/15/95	1.008146
11/14/95	12/15/95	1.006047
12/14/95	01/15/96	1.003981
01/14/96	02/15/96	1.001950
02/14/96	03/15/96	1.000000
03/14/96	04/15/96	0.998181

For example, the midpoint of a cost reporting period beginning January 1, 1995 and ending December 31, 1995 is June 30, 1995. An inflation adjustment factor of 1.016822 would be applied to the wages of a hospital with such a cost reporting period. In addition, for the data for any cost reporting period that began in FY 1995 and covers a period of less than 360 days or greater than 370 days, we annualized the data to reflect a 1-year cost report. Annualization is accomplished by dividing the data by the number of days in the cost report and then multiplying the results by 365.

Step 6—Each hospital was assigned to its appropriate urban or rural labor market area prior to any reclassifications under sections 1886(d)(8)(B) or 1886(d)(10) of the Act. Within each urban or rural labor market area, we added the total adjusted salaries plus wage-related costs obtained in Step 5 for all hospitals in that area to determine the total adjusted salaries plus wage-related costs for the labor market area.

Step 7—We divided the total adjusted salaries plus wage-related costs obtained in Step 6 by the sum of the total hours (from Step 4) for all hospitals in each labor market area to determine an average hourly wage for the area.

Step 8—We added the total adjusted salaries plus wage-related costs obtained in Step 5 for all hospitals in the Nation and then divided the sum by the national sum of total hours from Step 4 to arrive at a national average hourly wage. Using the data as described above, the national average hourly wage is $20.6036.

Step 9—For each urban or rural labor market area, we calculated the hospital wage index value by dividing the area average hourly wage obtained in Step 7 by the national average hourly wage computed in Step 8.

Step 10—Following the process set forth above, we developed a separate Puerto Rico-specific wage index for purposes of adjusting the Puerto Rico standardized amounts. We added the total adjusted salaries plus wage-related costs (as calculated in Step 5) for all hospitals in Puerto Rico and divided the sum by the total hours for Puerto Rico (as calculated in Step 4) to arrive at an overall average hourly wage of $9.3339 for Puerto Rico. For each labor market area in Puerto Rico, we calculated the hospital wage index value by dividing the area average hourly wage (as calculated in Step 7) by the overall Puerto Rico average hourly wage.

Step 11—Section 4410 of Public Law 105–33 provides that, for discharges on or after October 1, 1997, the area wage index applicable to any hospital that is not located in a rural area may not be less than the area wage index applicable to hospitals located in rural areas in that State. Furthermore, this wage index floor is to be implemented in such a manner as to assure that aggregate prospective payment system payments are not greater or less than those which would have been made in the year if this section did not apply. For FY 1999, this change affects 229 hospitals in 34 MSAs. The MSAs affected by this provision are identified in Table 4A by a footnote.

F. Revisions to the Wage Index Based on Hospital Redesignation

Under section 1886(d)(8)(B) of the Act, hospitals in certain rural counties adjacent to one or more MSAs are considered to be located in one of the adjacent MSAs if certain standards are met. Under section 1886(d)(10) of the Act, the Medicare Geographic Classification Review Board (MGCRB) considers applications by hospitals for geographic reclassification for purposes of payment under the prospective payment system.

The methodology for determining the wage index values for redesignated hospitals is applied jointly to the hospitals located in those rural counties that were deemed urban under section 1886(d)(8)(B) of the Act and those hospitals that were reclassified as a result of the MGCRB decisions under section 1886(d)(10) of the Act. Section 1886(d)(8)(C) of the Act provides that the application of the wage index to redesignated hospitals is dependent on the hypothetical impact that the wage data from these hospitals would have on the wage index value for the area to which they have been redesignated. Therefore, as provided in section 1886(d)(8)(C) of the Act, the wage index values were determined by considering the following:

- If including the wage data for the redesignated hospitals would reduce the wage index value for the area to which the hospitals are redesignated by 1 percentage point or less, the area wage index value determined exclusive of the wage data for the redesignated hospitals applies to the redesignated hospitals.
- If including the wage data for the redesignated hospitals reduces the wage index value for the area to which the hospitals are redesignated by more than 1 percentage point, the hospitals that are redesignated are subject to that combined wage index value.
- If including the wage data for the redesignated hospitals increases the wage index value for the area to which the hospitals are redesignated, both the area and the redesignated hospitals receive the combined wage index value.
- The wage index value for a redesignated urban or rural hospital cannot be reduced below the wage index value for the rural areas of the State in which the hospital is located.
- Rural areas whose wage index values would be reduced by excluding the wage data for hospitals that have been redesignated to another area continue to have their wage index values calculated as if no redesignation had occurred.
- Rural areas whose wage index values increase as a result of excluding

the wage data for the hospitals that have been redesignated to another area have their wage index values calculated exclusive of the wage data of the redesignated hospitals.

• The wage index value for an urban area is calculated exclusive of the wage data for hospitals that have been reclassified to another area. However, geographic reclassification may not reduce the wage index value for an urban area below the statewide rural wage index value.

We note that, except for those rural areas where redesignation would reduce the rural wage index value, the wage index value for each area is computed exclusive of the wage data for hospitals that have been redesignated from the area for purposes of their wage index. As a result, several urban areas listed in Table 4a have no hospitals remaining in the area. This is because all the hospitals originally in these urban areas have been reclassified to another area by the MGCRB. These areas with no remaining hospitals receive the prereclassified wage index value. The prereclassified wage index value will apply as long as the area remains empty.

The proposed revised wage index values for FY 1999 are shown in Tables 4A, 4B, 4C, and 4F in the Addendum to this proposed rule. Hospitals that are redesignated should use the wage index values shown in Table 4C. Areas in Table 4C may have more than one wage index value because the wage index value for a redesignated urban or rural hospital cannot be reduced below the wage index value for the rural areas of the State in which the hospital is located. When the wage index value of the area to which a hospital is redesignated is lower than the wage index value for the rural areas of the State in which the hospital is located, the redesignated hospital receives the higher wage index value, that is, the wage index value for the rural areas of the State in which it is located, rather than the wage index value otherwise applicable to the redesignated hospitals.

Tables 4D and 4E list the average hourly wage for each labor market area, prior to the redesignation of hospitals, based on the FY 1995 wage data. In addition, Table 3C in the Addendum to this proposed rule includes the adjusted average hourly wage for each hospital based on the FY 1995 data (as calculated from Steps 4 and 5, above). The MGCRB will use the average hourly wage published in the final rule to evaluate a hospital's application for reclassification, unless that average hourly wage is later revised in accordance with the wage data correction policy described in § 412.63(w)(2). In such cases, the MGCRB will use the most recent revised data used for purposes of the hospital wage index. Hospitals that choose to apply before publication of the final rule may use the proposed wage data in applying to the MGCRB for wage index reclassifications that would be effective for FY 2000. We note that in adjudicating these wage index reclassification requests during FY 1999, the MGCRB will use the average hourly wages for each hospital and labor market area that are reflected in the final FY 1999 wage index.

At the time this proposed wage index was constructed, the MGCRB had completed its review. The proposed FY 1999 wage index values incorporate all 435 hospitals redesignated for purposes of the wage index (hospitals redesignated under section 1886(d)(8)(B) or 1886(d)(10) of the Act) for FY 1999. The final number of reclassifications may be different because some MGCRB decisions are still under review by the Administrator and because some hospitals may withdraw their requests for reclassification.

Any changes to the wage index that result from withdrawals of requests for reclassification, wage index corrections, appeals, and the Administrator's review process will be incorporated into the wage index values published in the final rule. The changes may affect not only the wage index value for specific geographic areas, but also whether redesignated hospitals receive the wage index value for the area to which they are redesignated, or a wage index value that includes the data for both the hospitals already in the area and the redesignated hospitals. Further, the wage index value for the area from which the hospitals are redesignated may be affected.

Under § 412.273, hospitals that have been reclassified by the MGCRB are permitted to withdraw their applications within 45 days of the publication of this **Federal Register** document. The request for withdrawal of an application for reclassification that would be effective in FY 1999 must be received by the MGCRB by June 22, 1998. A hospital that requests to withdraw its application may not later request that the MGCRB decision be reinstated.

G. Requests for Wage Data Corrections

As a part of the August 29, 1997 final rule with comment period, we implemented a new timetable for requesting wage data corrections (62 FR 45990). In February 1998, we notified hospitals again of these changes through a memorandum to the fiscal intermediaries. To allow hospitals time to evaluate the wage data used to construct the proposed FY 1999 hospital wage index, we made available to the public a data file containing the FY 1995 hospital wage data. In a memorandum dated February 2, 1998, we instructed all Medicare intermediaries to inform the prospective payment hospitals that they serve of the availability of the wage data file and the process and timeframe for requesting revisions. The wage data file was made available February 6, 1998, through the Internet at HCFA's home page (http://www.hcfa.gov). The intermediaries were also instructed to advise hospitals of the alternative availability of these data through their representative hospital organizations or directly from HCFA. Additional details on ordering this data file are discussed in section IX.A of this preamble, ''Requests for Data from the Public.''

In addition, Table 3C in the Addendum to this proposed rule contains each hospital's adjusted average hourly wage used to construct the proposed wage index values. A hospital can verify its adjusted average hourly wage, as calculated from Steps 4 and 5 of the computation of the wage index (see section III.E of this preamble, above) based on the wage data on the hospital's cost report (after taking into account any adjustments made by the intermediary), by dividing the adjusted average hourly wage in Table 3C by the applicable wage adjustment factors as set forth above in Step 5 of the computation of the wage index. As noted above, however, a hospital's average hourly wages using this calculation will vary from the average hourly wages shown on Line 32 of Worksheet S–3, Part III. An updated Table 3C (along with applicable wage adjustment factors) will be included in the final rule.

We believe hospitals have had ample time to ensure the accuracy of their FY 1995 wage data. Moreover, the ultimate responsibility for accurately completing the cost report rests with the hospital, which must attest to the accuracy of the data at the time the cost report is filed. However, if after review of the wage data file released February 6, a hospital believed that its FY 1995 wage data were incorrectly reported, the hospital was to submit corrections along with complete, detailed supporting documentation to its intermediary by March 9, 1998. To be reflected in the final wage index, any wage data corrections must be reviewed and verified by the intermediary and transmitted to HCFA on or before April 6, 1998. These deadlines are necessary

to allow sufficient time to review and process the data so that the final wage index calculation can be completed for development of the final prospective payment rates to be published by August 1, 1998. We cannot guarantee that corrections transmitted to HCFA after April 6 will be reflected in the final wage index.

After reviewing requested changes submitted by hospitals, intermediaries transmitted any revised cost reports to HCRIS and forwarded a copy of the revised Worksheet S–3, Parts III and IV to the hospitals. If requested changes were not accepted, fiscal intermediaries notified hospitals of the reasons why the changes were not accepted. This procedure ensures that hospitals have every opportunity to verify the data that will be used to construct their wage index values. We believe that fiscal intermediaries are generally in the best position to make evaluations regarding the appropriateness of a particular cost and whether it should be included in the wage index data. However, if a hospital disagrees with the intermediary's resolution of a requested change, the hospital may contact HCFA in an effort to resolve policy disputes. We note that the April 6 deadline also applies to these requested changes. We will not consider factual determinations at this time as these should have been resolved earlier in the process.

We have created the process described above to resolve all substantive wage data correction disputes before we finalize the wage data for the FY 1999 payment rates. Accordingly, hospitals that do not meet the procedural deadlines set forth above will not be afforded a later opportunity to submit wage corrections or to dispute the intermediary's decision with respect to requested changes.

We note that, beginning this year with the FY 1999 wage index, the final wage index that is published August 1 will incorporate all corrections, including those to correct data entry or tabulation errors of the final wage data by the intermediary or HCFA. The final wage data public use file will be released by May 7, 1998. Hospitals will have until June 5, 1998, to submit requests to correct errors in the final wage data due to data entry or tabulation errors by the intermediary or HCFA. The correction requests that will be considered after the March 9 deadline will be limited to errors in the entry or tabulation of the final wage data which the hospital could not have known about prior to March 9, 1998.

The final wage data file released in early May will contain the wage data that will be used to construct the wage index values in the final rule. As with the file made available in February, HCFA will make the final wage data file released in May available to hospital associations and the public (on the Internet). This file, however, is being made available only for the limited purpose of identifying any potential errors made by HCFA or the intermediary in the entry of the final wage data that result from the correction process described above (with the March 9 deadline), not for the initiation of new wage data correction requests. Hospitals are encouraged to review their hospital wage data promptly after the release of the final file.

If, after reviewing the final file, a hospital believes that its wage data are incorrect due to a fiscal intermediary or HCFA error in the entry or tabulation of the final wage data, it should send a letter to both its fiscal intermediary and HCFA. The letters should outline why the hospital believes an error exists and provide all supporting information, including dates. These requests must be received by HCFA and the intermediaries no later than June 5, 1998. Requests mailed to HCFA should be sent to: Health Care Financing Administration; Center for Health Plans and Providers; Attention: Stephen Phillips, Technical Advisor; Division of Acute Care; C5–06–27; 7500 Security Boulevard; Baltimore, MD 21244–1850. Each request also must be sent to the hospital's fiscal intermediary. The intermediary will review requests upon receipt and contact HCFA immediately to discuss its findings.

At this time, changes to the hospital wage data will be made only in those very limited situations involving an error by the intermediary or HCFA that the hospital could not have known about before its review of the final wage data file. Specifically, neither the intermediary nor HCFA will accept the following types of requests at this stage of the process:

- Requests for wage data corrections that were submitted too late to be included in the data transmitted to HCRIS on or before April 6, 1998.
- Requests for correction of errors that were not, but could have been, identified during the hospital's review of the February 1998 wage data file.
- Requests to revisit factual determinations or policy interpretations made by the intermediary or HCFA during the wage data correction process.

Verified corrections to the wage index received timely (that is, by June 5, 1998) will be incorporated into the final wage index to be published by August 1, 1998, and effective October 1, 1998.

Again, we believe the wage data correction process described above provides hospitals with sufficient opportunity to bring errors in their wage data to the intermediary's attention. Moreover, because hospitals will have access to the final wage data by early May, they will have the opportunity to detect any data entry or tabulation errors made by the intermediary or HCFA before the development and publication of the FY 1999 wage index by August 1, 1998, and the implementation of the FY 1999 wage index on October 1, 1998. If hospitals avail themselves of this opportunity, the wage index implemented on October 1 should be free of such errors. Nevertheless, in the unlikely event that errors should occur after that date, we retain the right to make midyear changes to the wage index under very limited circumstances.

Specifically, in accordance with § 412.63(w)(2), we may make midyear corrections to the wage index only in those limited circumstances where a hospital can show: (1) That the intermediary or HCFA made an error in tabulating its data; and (2) that the hospital could not have known about the error, or did not have an opportunity to correct the error, before the beginning of FY 1999 (that is, by the June 5, 1998 deadline). As indicated earlier, since a hospital will have the opportunity to verify its data, and the intermediary will notify the hospital of any changes, we do not foresee any specific circumstances under which midyear corrections would be made. However, should a midyear correction be necessary, the wage index change for the affected area will be effective prospectively from the date the correction is made.

IV.–V. Other Decisions and Changes to the Prospective Payment System for Inpatient Operating Costs

A. Definition of Transfers (§ 412.4)

Pursuant to section 1886(d)(5)(I) of the Act, the prospective payment system distinguishes between ''discharges,'' situations in which a patient leaves an acute care (prospective payment) hospital after receiving complete acute care treatment, and ''transfers,'' situations in which the patient is transferred to another acute care hospital for related care. If a full DRG payment were made to each hospital involved in a transfer situation, irrespective of the length of time the patient spent in the ''sending'' hospital prior to transfer, a strong incentive to increase transfers would be created, thereby unnecessarily endangering

patients' health. Therefore, our policy, which is set forth in the regulations at § 412.4, provides that, in a transfer situation, full payment is made to the final discharging hospital and each transferring hospital is paid a per diem rate for each day of the stay, not to exceed the full DRG payment that would have been made if the patient had been discharged without being transferred.

Currently, the per diem rate paid to a transferring hospital is determined by dividing the full DRG payment that would have been paid in a nontransfer situation by the geometric mean length of stay for the DRG into which the case falls. Hospitals receive twice the per diem for the first day of the stay and the per diem for every following day up to the full DRG amount. Transferring hospitals are also eligible for outlier payments for cases that meet the cost outlier criteria established for all other cases (nontransfer and transfer cases alike) classified to the DRG. Two exceptions to the transfer payment policy are transfer cases classified into DRG 385 (Neonates, Died or Transferred to Another Acute Care Facility) and DRG 456 (Burns, Transferred to Another Acute Care Facility), which receive the full DRG payment instead of being paid on a per diem basis.

Under section 1886(d)(5)(J) of the Act, which was added by section 4407 of the Balanced Budget Act of 1997, a ''qualified discharge'' from one of 10 DRGs selected by the Secretary to a postacute care provider will be treated as a transfer case beginning with discharges on or after October 1, 1998. Section 1886(d)(5)(J)(iii) confers broad authority on the Secretary to select 10 DRGs ''based upon a high volume of discharges classified within such group and a disproportionate use of'' certain post discharge services. Section 1886(d)(5)(J)(ii) defines a ''qualified discharge'' as a discharge from a prospective payment hospital of an individual whose hospital stay is classified in one of the 10 selected DRGs if, upon such discharge, the individual—

- Is admitted to a hospital or hospital unit that is not a prospective payment system hospital;
- Is admitted to a skilled nursing facility; or
- Is provided home health services by a home health agency if the services relate to the condition or diagnosis for which the individual received inpatient hospital services and if these services are provided within an appropriate period as determined by the Secretary.

The Conference Agreement that accompanied the law noted that ''(t)he Conferees are concerned that Medicare may in some cases be overpaying hospitals for patients who are transferred to a post acute care setting after a very short acute care hospital stay. The Conferees believe that Medicare's payment system should continue to provide hospitals with strong incentives to treat patients in the most effective and efficient manner, while at the same time, adjust PPS [prospective payment system] payments in a manner that accounts for reduced hospital lengths of stay because of a discharge to another setting.'' (H.R. Rep. No. 105–217, 740.) In its March 1, 1997 report, ProPAC expressed similar concerns: ''* * * length of stay declines have been greater in DRGs associated with substantial postacute care use, suggesting a shift in care from hospital inpatient to postacute settings'' (pp. 21–22).

In fact, based on the latest available data, overall Medicare hospital costs per case have decreased during FYs 1994 and 1995. This unprecedented real decline in costs per case has led to historically high Medicare operating margins (over 10 percent on average). Along with these declining lengths of stay and costs per case, there has been an increase in the utilization of postacute care. In 1990, the rate of skilled nursing facility services per 1,000 Medicare enrollees was 19. By 1995, it had grown to 33. Corresponding numbers for home health agency services are 58 per 1,000 Medicare enrollees during 1990 and 93 per 1,000 enrollees during 1995. Although home health services are not always directly related to a hospitalization episode, there does appear to be a trend toward increased use of home health for the provision of postacute care rehabilitation services. Previous analysis of the percentage of hospital discharges that receive postacute home health care showed a 10.3 percent increase in 1994 compared to 1992.

Our proposals to implement section 1886(d)(5)(J) of the Act are set forth below.

1. Selection of 10 DRGs

Section 1886(d)(5)(J)(iii)(I) of the Act provides that the Secretary select 10 DRGs based on a high volume of discharges to postacute care and a disproportionate use of postacute care services. Therefore, in order to select the DRGs to be paid as transfers, we first identified those DRGs with the highest percentage of postacute care.

We used the FY 1996 MedPAR file because the complete FY 1997 MedPAR file was not available at the time we conducted our analysis. To identify postacute care utilization, we merged hospital inpatient bill files with postacute care bill files matching beneficiary identification numbers and discharge and admission dates. We created this file rather than depend on information concerning discharge destination on the inpatient bill because we have found that the discharge destination codes included on the hospital bills are often inaccurate in identifying discharges to a facility other than another prospective payment hospital.

Section 1886(d)(5)(J)(ii)(III) of the Act requires the Secretary to choose an appropriate window of days in which the home health services start in order for the discharge to meet the definition of a transfer. In order to include postdischarge home health utilization in our analysis, we identified all hospital discharges for patients who received any home health care within 7 days after the date of discharge. (As described below in section IV.A.2., we ultimately decided to propose 3 days as the window for home health services.)

Starting with the DRG with the highest percentage of postacute care discharges and continuing in descending order, we selected the first 20 DRGs that had a relatively large number of discharges to postacute care (our lower limit was 14,000 cases). In order to select 10 DRGs from the 20 DRGs on our list, for each of the DRGs we considered the volume and percent age of discharges to postacute care that occurred before the mean length of stay and whether the discharges occurring early in the stay were more likely to receive postacute care. The following table lists the 10 DRGs we are proposing to include under our expanded transfer definition, their percentage of postacute utilization compared to total cases, and the total number of cases identified as going to postacute care.

DRG	Title and type of DRG (surgical or medical)	Percent of postacute utilization	Number of postacute cases
14	Specific Cerebrovascular Disorders Except Transient Ischemic Attack (Medical)	49.5	186,845
113	Amputation for Circulatory System Disorders Excluding Upper Limb and Toe (Surgical)	59.0	28,402
209	Major Joint Limb Reattachment Procedures of Lower Extremity (Surgical)	71.9	257,875
210	Hip and Femur Procedures Except Major Joint Age >17 With CC (Surgical)	77.8	111,799
211	Hip and Femur Procedures Except Major Joint Age >17 Without CC (Surgical)	74.2	19,548
236	Fractures of Hip and Pelvis (Medical)	61.2	24,498
263	Skin Graft and/or Debridement for Skin Ulcer or Cellulitis With CC (Surgical)	49.4	14,499
264	Skin Graft and/or Debridement for Skin Ulcer or Cellulitis W/O CC (Surgical)	39.3	1,328
429	Organic Disturbances and Mental Retardation (Medical)	45.4	19,314
483	Tracheostomy Except for Face, Mouth and Neck Diagnoses (Surgical)	45.3	18,254

We included DRG 263 on the list because of its ranking in the top 20 DRGs in terms of postacute utilization and volume of discharges to postacute care. DRGs 263 and 264 are paired DRGS; that is, the only difference in the cases assigned to DRG 263 as opposed to DRG 264 is that the patient has a complicating or comorbid condition. If we included only DRG 263 in the list, it would be possible for a transfer case with a relatively short length of stay that should be assigned to DRG 263 and receive a relatively small transfer payment to be assigned instead to DRG 264, and receive the full DRG payment, simply by failing to include the CC diagnosis code on the bill. Therefore, our choice was to either delete DRG 263 from the list or add DRG 264. We decided to include DRG 264 in the proposed list because DRG 263 fully meets all the conditions for inclusion on the list of 10 DRGS.

2. Postacute Care Settings

Section 1886(d)(5)(J)(ii) of the Act requires the Secretary to define and pay as transfers cases from one of 10 DRGs selected by the Secretary if the individual is discharged to one of the following settings:

- A hospital or hospital unit that is not a subsection [1886](d) hospital, that is a hospital or unit excluded from the inpatient prospective payment system.
- A skilled nursing facility that is, a facility that meets the definition of a skilled nursing facility set forth at section 1819 of the Act.
- Home health services provided by a home health agency, if the services are related to the condition or diagnosis for which the individual received inpatient hospital services, and if the home health services are provided within an appropriate period (as determined by the Secretary).

Section 1886(d)(1)(B) of the Act defines the hospitals and hospital units that are excluded from the prospective payment system as the following: psychiatric, rehabilitation, childrens', long-term care, and cancer hospitals and psychiatric and rehabilitation distinct part units of a hospital. Therefore, any discharge from a prospective payment hospital from one of the 10 proposed DRGS that is admitted to one of these types of facilities on the date of discharge from the acute hospital, on or after October 1, 1998, would be considered a transfer and paid accordingly under the prospective payment systems (operating and capital) for inpatient hospital services.

A discharge from a prospective payment hospital to a skilled nursing facility would include cases discharged from one of the 10 DRGS from an inpatient bed in the hospital to a bed in the same hospital that has been designated for the provision of skilled nursing care (a ''swing'' bed). The swing bed provision allows certain small rural hospitals to furnish services in inpatient beds which, if furnished by a skilled nursing facility, would constitute extended care services. In addition, any patient who receives swing-bed services is deemed to have received extended care services as if furnished by a skilled nursing facility. Thus, if swing beds are not included in the transfer policy, those hospitals with swing bed agreements could move patients assigned to one of the 10 selected DRGs as if it were a discharge from an inpatient bed to a swing bed and receive payment. We do not believe that this would be a fair policy in that it would create a payment advantage for swing bed hospitals. Therefore, we are providing in the regulations that a discharge to a swing bed will be paid as a transfer when the patient is classified to one of the 10 selected DRGs.

Section 1886(d)(5)(J)(ii)(III) of the Act states that the discharge of an individual who receives home health services upon discharge will be treated as a transfer if ''such services are provided within an appropriate period (as determined by the Secretary) * * *.'' As discussed above in section IV.A.1, we began our analysis using 7 days (one week) as the time period we would consider. We now believe that 3 days after the date of discharge is a more appropriate timeframe. Based on our analysis of the FY 1996 bills, approximately 90 percent of patients began receiving home health care within 3 days. We are particularly interested in receiving comments on the appropriate period of time in which home health services should begin in the context of the transfer policy.

With regard to an appropriate definition of ''home health services * * * relate[d] to the condition or diagnosis for which the individual received inpatient hospital services * * *'', we considered several possible approaches. Under one approach we could compare the principal diagnosis of the inpatient stay to the diagnosis code indicated on the home health bill, similar to our policy on the 3-day payment window for preadmission services. However, we believe that is far too restrictive in terms of qualifying discharges for transfer payment. In addition, a hospital will not know when it discharges a patient to home health what diagnosis code the home health agency will put on the bill. Therefore, the hospital would not be able to correctly code the inpatient bill as a transfer or discharge.

We also considered proposing that any home health care that begins within the designated timeframe be included ''as related'' in our definition. However, this definition might be too broad and the hospital would not be able to predict which cases should be coded as transfers because the hospital often may not know about home health services that are provided upon discharge but were not ordered or planned for as part of the hospital discharge plan.

We are proposing that home health services would be considered related to the hospital discharge if the patient is discharged from the hospital with a written plan of care for the provision of home health care services from a home health agency. In this way, the hospital would be fully aware of the status of the patient when discharged and could be held responsible for correctly coding the

discharge as a transfer on the inpatient bill. In general, this would mean that the home health service would qualify as a Part A home health benefit under section 1861(tt) of the Act as added by section 4611(b) of the BBA.

We note, however, that we plan to compare inpatient bills with home health service bills for care provided within 3 days after discharge, similar to our current claims edit for hospital to hospital transfers. If we find that home health services were provided within the postdischarge window, the hospital will be notified and the hospital payment adjusted unless the hospital can submit documentation verifying the discharge status of the patient. This will alert hospitals if there are problems with their discharge/transfer billing and allow them to adjust their discharge planning process and billing practices. If we find a continued pattern of a hospital billing for cases from the 10 DRGs as discharges and our records indicate that the patients are receiving postacute care services from an excluded hospital, a skilled nursing facility, or within the 3-day home health service window, the hospitals may be investigated for fraudulent or abusive billing practices.

3. Payment Methodology

The statute does not dictate the payment methodology we must use for these transfer cases. However, section 1886(d)(5)(J)(i) of the Act provides that the payment amount for a case may not exceed the sum of half the full DRG payment amount and half of the payment amount under the current per diem payment methodology.

Based on our analysis comparing the costs per case for the transfers in the 10 DRGs with payments under our current transfer payment methodology, we found that most of the 10 DRGs are appropriately paid using our current methodology (that is, twice the per diem for the first day and the per diem for each subsequent day). In fact, this payment would, on average, slightly exceed costs. However, this is not true of DRGs 209, 210, and 211. For those three DRGs, a disproportionate percentage (about 50 percent) of the costs of the case are incurred on the first day of the stay. Therefore, we are proposing to pay DRGs 209, 210, and 211 based on 50 percent of the DRG payment for the first day of the stay and 50 percent of the per diem for the remaining days of the stay. The other seven DRGs would be paid under the current transfer payment methodology.

In Appendix E to this proposed rule, we have included tables that illustrate, for 9 of the 10 DRGs, the number of total and postacute discharges by length of stay, the geometric mean lengths of stay from FY 1983 through FY 1997, and the estimated average costs and transfer payments by length of stay. (The summary information for DRG 264 was not available at the time of publication because it was not included in the original data file of 20 DRGs used for our analysis.) For DRGs 209, 210, and 211, the payment line is determined on the basis of the alternative payment formula described above.

These tables demonstrate that a very large number of discharges from these 10 DRGs receive postacute care. In addition, the length of stay for these DRGs has decreased sharply over the last several years. We believe that this proposed policy will both decrease the hospitals' financial incentive to discharge patients very early in the stay, often before the full course of acute care treatment has ended, as well as pay the hospital at an appropriate level when it does move patients into postacute care.

We would revise § 412.4 to reflect these proposed policies. In addition, we would delete the reference in current § 412.4(d)(2) to DRG 456 (Burns, Transferred to Another Acute Care Facility) because we are proposing to replace that DRG, as discussed in section II.B.3 of this preamble. There would no longer be any burn DRG with a transfer designation.

B. Rural Referral Centers (§ 412.96)

Under the authority of section 1886(d)(5)(C)(i) of the Act, § 412.96 sets forth the criteria a hospital must meet in order to receive special treatment under the prospective payment system as a rural referral center. For discharges occurring before October 1, 1994, rural referral centers received the benefit of payment based on the other urban rather than the rural standardized amount. As of that date, the other urban and rural standardized amounts were the same. However, rural referral centers continue to receive special treatment under both the disproportionate share hospital payment adjustment and the criteria for geographic reclassification.

One of the criteria under which a rural hospital may qualify as a rural referral center is to have 275 or more beds available for use. A rural hospital that does not meet the bed size criterion can qualify as a rural referral center if the hospital meets two mandatory criteria (specifying a minimum case-mix index and a minimum number of discharges) and at least one of the three optional criteria (relating to specialty composition of medical staff, source of inpatients, or volume of referrals). With respect to the two mandatory criteria, a hospital may be classified as a rural referral center if its—

- Case-mix index is at least equal to the lower of the median case-mix index for urban hospitals in its census region, excluding hospitals with approved teaching programs, or the median case-mix index for all urban hospitals nationally; and
- Number of discharges is at least 5,000 discharges per year or, if fewer, the median number of discharges for urban hospitals in the census region in which the hospital is located. (The number of discharges criterion for an osteopathic hospital is at least 3,000 discharges per year.)

1. Case-Mix Index

Section 412.96(c)(1) provides that HCFA will establish updated national and regional case-mix index values in each year's annual notice of prospective payment rates for purposes of determining rural referral center status. The methodology we use to determine the proposed national and regional case-mix index values, is set forth in regulations at § 412.96(c)(1)(ii). The proposed national case-mix index value includes all urban hospitals nationwide, and the proposed regional values are the median values of urban hospitals within each census region, excluding those with approved teaching programs (that is, those hospitals receiving indirect medical education payments as provided in § 412.105).

These values are based on discharges occurring during FY 1997 (October 1, 1996 through September 30, 1997) and include bills posted to HCFA's records through December 1997. Therefore, in addition to meeting other criteria, for hospitals with fewer than 275 beds, we are proposing that to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 1998, a hospital's case-mix index value for FY 1997 would have to be at least—

- 1.3578; or
- Equal to the median case-mix index value for urban hospitals (excluding hospitals with approved teaching programs as identified in § 412.105) calculated by HCFA for the census region in which the hospital is located.

The median case-mix values by region are set forth in the table below:

Region	Case-mix index value
1. New England (CT, ME, MA, NH, RI, VT)	1.2533
2. Middle Atlantic (PA, NJ, NY)	1.2499
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.3468

Region	Case-mix index value
4. East North Central (IL, IN, MI, OH, WI)	1.2717
5. East South Central (AL, KY, MS, TN)	1.2965
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.2264
7. West South Central (AR, LA, OK, TX)	1.3351
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.3752
9. Pacific (AK, CA, HI, OR, WA)	1.3405

The above numbers will be revised in the final rule to the extent required to reflect the updated MedPAR file, which will contain data from additional bills received for discharges through March 31, 1997.

For the benefit of hospitals seeking to qualify as referral centers or those wishing to know how their case-mix index value compares to the criteria, we are publishing each hospital's FY 1997 case-mix index value in Table 3C in section IV. of the Addendum to this proposed rule. In keeping with our policy on discharges, these case-mix index values are computed based on all Medicare patient discharges subject to DRG-based payment.

2. Discharges

Section 412.96(c)(2)(i) provides that HCFA will set forth the national and regional numbers of discharges in each year's annual notice of prospective payment rates for purposes of determining referral center status. As specified in section 1886(d)(5)(C)(ii) of the Act, the national standard is set at 5,000 discharges. However, we are proposing to update the regional standards. The proposed regional standards are based on discharges for urban hospitals' cost reporting periods that began during FY 1996 (that is, October 1, 1995 through September 30, 1996). That is the latest year for which we have complete discharge data available.

Therefore, in addition to meeting other criteria, we are proposing that to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 1998, the number of discharges a hospital must have for its cost reporting period that began during FY 1997 would have to be at least—

- 5,000; or
- Equal to the median number of discharges for urban hospitals in the census region in which the hospital is located, as indicated in the table below.

Region	Number of discharges
1. New England (CT, ME, MA, NH, RI, VT)	6658
2. Middle Atlantic (PA, NJ, NY)	8477
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	7505
4. East North Central (IL, IN, MI, OH, WI)	7273
5. East South Central (AL, KY, MS, TN)	6852
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	5346
7. West South Central (AR, LA, OK, TX)	5179
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	7926
9. Pacific (AK, CA, HI, OR, WA)	5945

We note that the number of discharges for hospitals in each census region is greater than the national standard of 5,000 discharges. Therefore, 5,000 discharges is the minimum criteria for all hospitals. These numbers will be revised in the final rule based on the latest FY 1996 cost report data.

We reiterate that, to qualify for rural referral center status for cost reporting periods beginning on or after October 1, 1998, an osteopathic hospital's number of discharges for its cost reporting period that began during FY 1996 would have to be at least 3,000.

C. Payments to Disproportionate Share Hospitals: Conforming Change Regarding Interpretation of Medicaid Patient Days Included in Disproportionate Patient Percentage (§ 412.106)

Effective for discharges beginning on or after May 1, 1986, hospitals that treat a disproportionately large number of low-income patients receive additional payments through the disproportionate share (DSH) adjustment. One means of determining a hospital's DSH payment adjustment for a cost reporting period requires calculation of its disproportionate patient percentage for the period. The disproportionate patient percentage is the sum of a prescribed Medicare fraction and a Medicaid fraction for the hospital's fiscal period. Under clause (I) of section 1886(d)(5)(F)(vi) of the Act and § 412.106(b)(2), the Medicare fraction is determined by dividing the number of the hospital's patient days for patients who were entitled (for such days) to benefits under both Medicare Part A and Supplemental Security Income (SSI) under Title XVI of the Act, by the total number of the hospital's patient days for the patients who were entitled to Medicare Part A. The Medicaid fraction is determined, in accordance with clause (II) of section 1886(d)(5)(F)(vi) of the Act and § 412.106(b)(4), by dividing the number of the hospital's patient days for patients who (for such days) were eligible for medical assistance under a State Medicaid plan approved under Title XIX of the Act but who were not entitled to Medicare Part A, by the total number of the hospital's patient days for that period.

Initially, HCFA calculated the Medicaid fraction by interpreting section 1886(d)(5)(F)(vi)(II) of the Act to recognize as Medicaid patient days only those days for which the hospital received Medicaid payment for inpatient hospital services. See 51 FR 31454, 31460 (1986). The agency's interpretation was declared invalid by four Federal circuit courts of appeals. See *Cabell Huntington Hosp., Inc.* v. *Shalala*, 101 F.3d 984, 990–91 (4th Cir. 1996) (following three other circuits). These courts held that the statute requires, for purposes of calculating the Medicaid fraction, inclusion of each patient day of service for which a patient was eligible on that day for medical assistance under an approved State Medicaid plan. Specifically, the statute requires inclusion of each hospital patient day for a patient eligible for Medicaid on such day, regardless of whether particular items or services were covered or paid under the State Medicaid plan.

On February 27, 1997, the HCFA Administrator issued HCFA Ruling 97–2, which acquiesced in the four adverse appellate court decisions. The Ruling changed the agency's statutory construction to comport with those decisions, in order to facilitate nationwide uniformity in the calculation of the Medicaid fraction. Like the court decisions, the Ruling provides that a hospital's Medicaid patient days include each patient day of service for which a patient was eligible on such day for medical assistance under an approved State Medicaid plan, regardless of whether particular items or services were covered or paid under the State plan. The Ruling also reflects the hospital's burden of furnishing data adequate to prove each claimed Medicaid patient day, and of verifying with the State that a patient was eligible for Medicaid during each day of the inpatient hospital stay.

The Ruling further provides that the agency's new interpretation is effective February 27, 1997 for each cost reporting period that: (1) Begins on or after that effective date; (2) was not settled, as of that date, on the Medicaid patient days issue, by means of an applicable notice of program reimbursement (NPR) (see § 405.1803); or (3) was settled through such an NPR

as of the Ruling's effective date and is the subject of a pending administrative appeal or civil action that satisfies all applicable jurisdictional requirements of the Medicare statute and regulations. The Ruling also provides, however, that the change in statutory interpretation effected by the Ruling is not a basis for reopening a hospital cost reporting period (see §§ 405.1885–405.1889) that was finalized previously on the same matter at issue.

We propose to revise § 412.106(b)(4) in order to conform the Medicare regulations to the new statutory construction issued in HCFA Ruling 97–2. The revisions are necessary to ensure that the regulations comport with the four appellate court decisions that declared invalid the agency's prior interpretation and led to the issuance of the HCFA Ruling. The proposed revisions will further facilitate nationwide uniformity in the calculation of the Medicaid fraction.

Since the proposed revisions are intended simply to conform the regulations to HCFA Ruling 97–2 (and hence to the four adverse court decisions), revised § 412.106(b)(4) would reiterate the Ruling's change of interpretation that the Medicaid fraction under section 1886(d)(5)(F)(vi)(II) of the Act includes each hospital patient day for a patient eligible for Medicaid on such day, regardless of whether particular items or services were covered or paid under the State Medicaid Plan. Our proposed revisions to § 412.106(b)(4), like the Ruling, would continue to place on the hospital the burdens of production, proof, and verification as to each claimed Medicaid patient day.

Under our proposal, revised § 412.106(b)(4) would apply to cost reporting periods beginning on or after October 1, 1998. HCFA Ruling 97–2, which includes the same provisions as proposed § 412.106(b)(4), would continue to apply to any cost reporting period beginning before October 1, 1998 provided that, as of February 27, 1997, there is for such period: no submitted cost report; no cost report settled on the Medicaid patient days issue through an applicable NPR; or a cost report settled on that issue, which is also the subject of a jurisdictionally proper administrative appeal or civil action on the issue.

D. Payment for Bad Debts (§ 413.80)

Section 4451 of the Balanced Budget Act of 1997 reduces the payment for enrollee bad debt for hospitals. Specifically, this provision reduces the amount of bad debts otherwise treated as allowable costs, attributable to the deductibles and coinsurance amounts under this title, by 25 percent for cost reporting periods beginning during fiscal year 1998, by 40 percent for cost reporting periods beginning during fiscal year 1999, and by 45 percent for cost reporting periods beginning during a subsequent fiscal year. This proposed rule would conform the regulations to the statute.

Section 4451 of the Balanced Budget Act of 1997 also provides that in determining such reasonable costs for hospitals, any copayments reduced under the election available for hospital outpatient services under section 1833(t)(5)(B) of the Act will not be treated as a bad debt. This provision will be implemented in the outpatient prospective payment system regulation that implements section 4521, 4522, and 4523 of the Balanced Budget Act of 1997, to be published later this year.

E. Payment for Direct Costs of Graduate Medical Education to Hospitals and Nonhospital Providers (§§ 405.2468, 413.85, and 413.86)

1. Introduction

Currently, under section 1886(h) of the Act, Medicare pays only hospitals for the costs of graduate medical education (GME) training. We do not pay nonhospital sites for the costs they incur in training medical residents. There has been a general trend to shift patient care from the inpatient setting to the less expensive nonhospital setting where appropriate. Consistent with this trend in patient care, the BBA allows for direct GME payment to qualified nonhospital providers to encourage more training of future physicians in nonhospital settings.

Under section 1886(k) of the Act, as added by section 4625 of the BBA, the Secretary is now authorized, but not required, to pay qualified nonhospital providers for the direct costs of GME training. The Conference Report also notes that the Conferees believe paying nonhospital providers for GME costs may help alleviate physician shortages in underserved rural areas. We believe that providing Medicare payment directly to nonhospital providers may facilitate more training and better quality training in nonhospital sites.

2. Statutory Background

Section 1886(k) of the Act states: ''For cost reporting periods beginning on or after October 1, 1997, the Secretary may establish rules for payment to qualified nonhospital providers for their direct costs of medical education, if those costs are incurred in the operation of an approved medical residency training programs described in subsection (h).'' The statute further provides that, to the extent the Secretary exercises this broad discretionary authority, the rules ''shall specify the amounts, form, and manner in which such payments will be made and the portion of such payments that will be made from each of the trust funds under this title.''

a. Payments Only to ''Qualified Nonhospital Providers''. The statute confers broad discretion on the Secretary regarding whether and how to pay nonhospital providers for direct GME costs. However, the statute does specify the entities whom the Secretary can pay—''qualified nonhospital providers.'' Section 1886(k)(2) of the Act defines ''qualified nonhospital providers'' to include: Federally Qualified Health Centers (FQHCs), as defined in section 1861(aa)(4); Rural Health Centers (RHCs), as defined in section 1861(aa)(2); Medicare+Choice organizations; and such other providers (other than hospitals) as the Secretary determines to be appropriate.

b. Payments Only for the ''Direct Costs'' of Training. The statute also specifies the costs the Secretary can pay for under section 1886(k) of the Act. Medicare pays hospitals for both the direct and indirect costs of medical education under sections 1886(h) and 1886(d)(5)(B) of the Act respectively, but section 1886(k) of the Act provides for payment to nonhospital providers only for the direct costs of medical education.

In addition, section 1886(k) of the Act provides for payment for the direct costs of training medical residents only if those costs are incurred in the operation of an ''approved medical residency training program.'' Section 1886(h)(5)(A) of the Act defines an ''approved medical residency training program'' as a ''residency or other postgraduate medical training program participation in which may be counted toward certification in a specialty or subspecialty and includes formal postgraduate training programs in geriatric medicine approved by the Secretary.'' Implementing regulations at § 413.86(b) state that an approved medical residency training program includes allopathic and osteopathic training programs as well as training programs for dentistry and podiatry. Therefore, the statute authorizes Medicare payments to nonhospital providers only for the costs of training medical residents, not for the costs of training other health professionals.

In addition to adding section 1886(k) of the Act, section 4625 of the BBA amends section 1886(h)(3)(B) of the Act to prohibit double payments for direct

GME to a hospital and a qualified nonhospital provider. This prohibition on double payments requires that the Secretary reduce a hospital's GME payments (the ''aggregate approved amount'' as defined in section 1886(h)(3)(b) of the Act) to the extent we pay a nonhospital provider for GME under section 1886(k) of the Act.

3. Proposed Policies

Pursuant to section 4625 of the BBA, we are proposing policies to provide Medicare payment to nonhospital providers for the direct costs of GME training, effective for portions of cost reporting periods occurring on or after January 1, 1999. We believe that these payments will serve the Congressional intent to encourage and support training in nonhospital settings.

a. Definition of ''Qualified Non-Hospital Providers''. Under our proposed policy, Medicare would make GME payments to the following ''qualified nonhospital providers''—FQHCs, RHCs, and Medicare+Choice organizations. Under the authority of section 1886(k)(2)(D) of the Act, the Secretary may expand the definition of a ''qualified nonhospital provider'' to include such other providers (other than hospitals) as the Secretary determines to be appropriate. Once we have gained experience providing direct GME payments to FQHCs, RHCs, and Medicare+Choice organizations, we may consider including other types of nonhospital providers in the definition of a ''qualified nonhospital provider.''

Additionally, we propose that, under certain circumstances, a hospital may continue to receive GME payments for residents who train in the nonhospital setting. In those instances where a hospital is eligible to continue receiving GME payments for residents who train in the nonhospital setting, the nonhospital provider could receive payment from the hospital for costs they incur in training medical residents. Thus, our policy promotes the intent of section 4625 of the BBA to provide financial support, either directly from Medicare or through the hospital, to nonhospital providers for the direct costs of training residents in the nonhospital site.

b. Definition of ''Direct Costs'' of Medical Education for Non-Hospital Providers. Section 4625 of the BBA provides for payment to nonhospital providers only for the direct costs of training residents. Our proposed definition of ''direct costs'' for nonhospital providers is comparable to the direct costs for hospitals under section 1886(h) of the Act. Under our proposed policy, direct GME costs are those costs that are incurred by the nonhospital site for the education activities of the approved program and that are the proximate result of training medical residents in the nonhospital site. Direct costs for nonhospital providers would include:

- Residents' salaries and fringe benefits (including related travel and lodging expenses where applicable);
- That portion of costs of the teaching physicians' salaries and fringe benefits that are related to the time spent in teaching and supervision of residents; and
- Other related GME overhead costs.

Consistent with our policies on direct GME costs for hospitals, direct GME costs for nonhospital providers would not include normal operating costs or the marginal increase in costs that the nonhospital site experiences as a result of having an approved medical residency training program. For example, a decrease in productivity and increased intensity in treatment patterns as the result of a training program do not constitute ''direct costs'' of training residents in the nonhospital setting; rather, these are the ''indirect costs'' of such training.

Also consistent with our policies for direct GME payments to hospitals, we propose to pay qualified nonhospital providers only for training that is related to the delivery of patient care services. Sections 1886(h) (''Payments for Direct GME Costs'') and 1886(h)(4)(E) of the Act (''Counting Time Spent in Outpatient Settings'') provide support continuing our longstanding policy of paying only for training that is associated with patient care services. In particular, section 1886(h)(4)(E) of the Act states:

> Such rules shall provide that *only time spent in activities relating to patient care* shall be counted and that all the time so spent by a resident under an approved medical residency training program shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs all, or substantially all, of the costs for the training program in that setting.

In addition, section 1861(b) of the Act describes the types of patient care services that are reimbursable. Specifically, section 1861(b)(6) of the Act indicates that the training of interns or residents under an approved teaching program are included as reimbursable patient care costs.

Moreover, direct GME costs for nonhospital providers, like direct GME costs for hospitals, would include only that portion of costs of the teaching physicians' salaries and fringe benefits associated with time spent in teaching and supervising residents. Specifically, a teaching physician's time spent on teaching of a general nature would constitute a direct GME cost, while teaching of a patient-specific nature would not constitute a direct cost. In addition, direct costs in the nonhospital setting would include that portion of teaching physicians' salaries and fringe benefits associated with time spent developing resident schedules and evaluating or rating the residents. Direct costs would also include a teaching physician's office costs allocated to GME.

By contrast, direct GME costs for nonhospital providers would not include the following: A teaching physician's time spent in the care of individual patients which results in billable services; teaching physicians' activities that are related to the education of other health professionals (i.e., classroom instruction in connection with approved activities other than GME such as provider-operated nursing programs); teaching physicians' time spent on administrative and supervisory services to the provider that are unrelated to approved educational activities (i.e. operating costs); and teaching physician activities that involve nonallowable costs such as research and medical school activities that are not related to patient care in the nonhospital setting.

GME overhead costs include only those costs that are allocable to direct GME and that are not used in patient care. For example, a portion of administrative and general costs could be appropriately allocated to an RHC or FQHC's GME cost center. Similarly, a conference room that is dedicated specifically for the training of residents could be appropriately allocated to an RHC or FQHC's GME cost center. By contrast, patient care rooms added to an RHC or an FQHC cannot be appropriately allocated to an RHC or FQHC's GME cost center.

One of the advantages of our proposed definition of ''direct costs'' is that it is administratively feasible. Our definition of ''direct costs'' for nonhospital providers is comparable to the direct costs that are included in the per resident amount paid to hospitals under section 1886(h) of the Act. At present, there is limited information regarding the actual costs of training residents in nonhospital sites. After we gain experience providing direct GME payments to qualified nonhospital providers and have reviewed the GME costs separately reported by these nonhospital providers, we may revise the definition of ''direct costs.'' We are

soliciting comments on other elements that may constitute direct costs of GME in the nonhospital site that can be identified, reported, and verified as directly attributable to GME activities through the cost reporting process. We are interested in comments on whether we should include other costs in the definition of ''direct costs'' for nonhospital providers and on the administrative feasibility of identifying the GME portion of those costs.

c. Determining Direct Costs. One of our major concerns in developing policies for paying nonhospital providers for the direct costs of GME is the administrative feasibility of determining the amount of direct costs incurred by the nonhospital provider. It is our understanding that, currently, hospitals and nonhospital sites often share, to varying degrees, the costs of training residents in the nonhospital site. Because of the difficulty in apportioning costs between the hospital and the nonhospital for the training in the nonhospital site, we believe that it is not administratively feasible to pay both the hospital and the nonhospital site for the cost of training in the nonhospital site. We have been unable to devise a method for accurately apportioning costs between the two entities.

Furthermore, the potential for both the hospital and the nonhospital site to be paid for the same direct GME expenses poses a significant problem for complying with section 1886(h)(3)(B) of the Act, as amended by the BBA, which specifically prohibits double payments. Under this provision, the Secretary shall reduce the hospital's GME payment (the ''aggregate approved amount'') to the extent we pay nonhospital providers for GME costs under section 1886(k) of the Act. Consequently, our policy must ensure that Medicare does not pay two entities for the same training time in the nonhospital site.

Given that the hospital's per resident amount can include, but is not necessarily based on the costs of training in the nonhospital site, we were not able to devise an equitable way of reducing the hospital's per resident payment to reflect payments made under section 1886(k) of the Act. It would not be equitable to subtract the exact amount of payment made to the qualified nonhospital provider from the hospital's per resident payment because the payment made to the nonhospital site is unrelated to the hospital's per resident amount. The hospital per resident amount is based on specific GME costs incurred by the hospital in the 1984 base year. Those costs included in the per resident amount have no relevance to the costs incurred in the nonhospital setting almost 15 years after the 1984 base year. We believe that the residents' salaries, teaching physicians' salaries, and overhead costs for the nonhospital setting will constitute a different proportion of the total GME costs in the nonhospital setting as compared with the hospital setting. Rather, it would be more equitable to determine the proportion of costs incurred by each entity and reduce the hospital's per resident payment by the proportion of GME costs incurred by the nonhospital site; however, since specific components of the per resident amount were not identified in the hospital's GME base year (1984), we cannot accurately determine the appropriate amount to reduce the current year hospital per resident payment amount. Moreover, to reduce the hospital's GME payments based solely on the amount paid to the nonhospital site could result in inequitable payments to the hospital, which has ongoing costs even when the resident is training in the nonhospital site. In fact, it could leave the hospital at risk of receiving no payment for the GME costs it has incurred.

In order to encourage training in nonhospital sites, it is important to develop a policy that, while providing payment to nonhospital providers, would also be equitable to hospitals. We believe that paying only the nonhospital site for the training costs could result in hospitals choosing not to rotate their residents to the nonhospital site. We have been unable to devise an equitable and accurate method for dividing up the GME payment for training in the nonhospital site if neither the hospital, nor the nonhospital site incurs ''all or substantially all'' of the costs. As such, we are soliciting comment on possible methods for allocating the GME payments for training in the nonhospital site where neither the hospital nor the nonhospital provider is incurring ''all or substantially all'' of the costs for the training program. We believe that the proposed policies discussed below are equitable to both hospital and nonhospital providers and will achieve Congress' objective of encouraging and supporting training in the nonhospital setting.

Given our concerns about administrative feasibility, the statutory prohibition on double payments, and developing policies that are equitable to hospitals as well as nonhospital providers, we believe the only feasible way to pay for training in nonhospital settings is to pay either the hospital or the nonhospital provider. Currently, hospitals may receive payment for the time residents spend in the nonhospital setting if the hospital incurs ''all or substantially all'' of the training costs. We propose to adopt a similar policy for nonhospital providers; that is, a qualified nonhospital provider may receive payment for the direct costs of GME if the nonhospital provider incurs ''all or substantially all'' of the training costs.

d. Modifications of Policy To Pay Hospitals For GME. In the course of developing our policies for nonhospital providers, we have reviewed our method for paying hospitals for the costs of training residents in the nonhospital site. Accordingly, as part of our policy to pay nonhospital providers for the costs of training residents, we are proposing necessary and appropriate modifications to our current policy for paying hospitals for such nonhospital training. Specifically, as part of our proposal to implement section 1886(k) of the Act, we propose to modify the regulations at § 413.86(f).

Presently, under sections 1886(d)(5)(B)(iv) and 1886(h)(4)(E) of the Act, if a hospital incurs ''all or substantially all'' of the costs of training residents in the nonhospital site, then the hospital may include the resident in its indirect medical education (IME) and direct GME full-time equivalent count. Under § 413.86(f)(1)(iii), currently a hospital incurs ''all or substantially all'' of the costs of training the resident in the nonhospital site if the hospital pays the residents' salaries and fringe benefits. Based on our review of data in Medicare cost reports on the Hospital Cost Reporting Information System (HCRIS), we decided to reexamine the issue of what constitutes ''all or substantially all'' of the costs of training the resident. In our analysis, we determined that, on average, residents' salaries and fringe benefits are less than half of the total amount of the direct costs of a hospital's GME program. Therefore, we are proposing to revise the standard for incurring ''all or substantially all'' of the costs for the training program in the nonhospital setting.

We propose to redefine ''all or substantially all'' of the costs for the training program in the nonhospital setting to include at a minimum:

- the portion of costs of the teaching physicians' salaries and fringe benefits that are related to the time spent in teaching and supervision of residents; and
- residents' salaries and fringe benefits (including travel and lodging expenses where applicable).

e. Payment Proposal. In light of the numerous considerations discussed

above, we are proposing a system whereby we will pay either the hospital or the nonhospital site for the cost of training in the nonhospital site, depending on which entity incurs ''all or substantially all'' of the costs of training in the nonhospital site. An entity incurs ''all or substantially all'' of the costs for the training program in the nonhospital setting if it pays for, at a minimum: that portion of the costs of the teaching physicians' salaries and fringe benefits that are related to the time spent in teaching and supervision of residents; and residents' salaries and fringe benefits (including travel and lodging expenses where applicable). Our proposal accommodates three alternative payment scenarios that are discussed below.

i. Payment to FQHCs and RHCs. In the first payment scenario, if the FQHC or RHC incurs ''all or substantially all'' of the costs for the training program in the nonhospital setting, we are proposing to pay the nonhospital site cost-based reimbursement for the direct costs of training. By reporting these direct GME costs in a reimbursable cost center on the cost report, an FQHC or RHC would be attesting that it is incurring ''all or substantially all'' of the costs for the training program in the nonhospital site. Conversely, where an FQHC or RHC is not incurring ''all or substantially all'' of the costs of training residents in the nonhospital site, the FQHC or RHC would report these training costs in a nonreimbursable cost center on the cost report.

As previously stated, we propose to define the direct costs of training to include:

- Residents' salaries and fringe benefits (including related travel and lodging expenses where applicable);
- That portion of the costs of teaching physicians' salaries and fringe benefits that are related to the time spent in teaching and supervision of residents; and
- Other related overhead costs that are allocated to GME.

We are proposing that the FQHC's and RHC's allowable direct GME costs be subject to reasonable cost principles in 42 CFR part 413 and other relevant provisions referenced in part 413. As such we are proposing to add language to § 415.60 to make the reasonable cost principles applicable to FQHC's and RHC's. In addition, the FQHC's and RHC's direct GME costs would be subject to the Reasonable Compensation Equivalency limits under §§ 415.60 and 415.70. Accordingly, we are proposing to add language to § 415.70 to make the reasonable compensation equivalency limits applicable to FQHC's and RHC's.

Also, Medicare would pay only for Medicare's share of the direct costs of training in the nonhospital site. We are proposing that the FQHC's and RHC's Medicare share equal the nonhospital provider's ratio of Medicare visits to total visits. Thus, the amount of Medicare payment would equal the product of the clinic's Medicare allowed direct GME costs and the clinic's ratio of Medicare visits to total visits.

For FQHCs and RHCs that incur ''all or substantially all'' of the costs for the training program in the nonhospital setting, the direct GME costs are not subject to the existing per visit payment caps for reimbursement under sections 505.1 and 505.2 of the Medicare Rural Health Clinic and Federally Qualified Health Centers Manual. Moreover, we believe participation in GME training should not affect any FQHCs or RHCs ability to meet the productivity standards outlined in section 503 of the Medicare Rural Health Clinic and Federally Qualified Health Centers Manual. Therefore, we are proposing that, where payment is available under section 1886(k) of the Act for residents working in either an FQHC or an RHC, the FQHCs and RHCs do not need to include residents as health care staff in the calculation of productivity standards under section 503 of the Manual.

ii. Payment to Medicare+Choice organizations. In the second payment scenario, if a Medicare+Choice organization incurs ''all or substantially all'' of the costs for the training program in the nonhospital setting, we propose making the direct GME payment to the Medicare+Choice organization. The Medicare+Choice organization would be eligible to receive cost-based reimbursement for the residents' salaries and fringe benefits only for the time that the resident spends in the nonhospital setting. In addition, we are proposing that the Medicare+Choice organization's allowed costs include only that portion of the teaching physician salaries and fringe benefits that is related to training in the nonhospital setting.

Unlike our proposed policy in paying FQHCs and RHCs for GME, at this time we are not proposing to pay Medicare+Choice organizations for the costs of overhead that are directly associated with a GME program. We have no historical data on the GME costs of managed care organizations and the extent to which these costs are incurred directly or indirectly under contracts between the managed care organization and physician groups or other providers engaged in ambulatory care. Moreover, we have an established methodology for allocating and reporting overhead costs for FQHCs and RHCs on Medicare cost reports that does not currently exist for Medicare+Choice organizations. Since Medicare+Choice organizations do not use the Medicare cost report, there is currently no mechanism to review and audit these costs in the managed care context. Because Medicare+Choice organizations are paid on a capitated basis, we have no method for paying Medicare+Choice organizations for variable costs such as GME overhead that require a sophisticated cost allocation methodology. By contrast, it is currently feasible to pay Medicare+Choice organizations for the costs of the residents' salaries and teaching physicians' salaries because those costs are more readily documented and auditable.

However, we are open to suggestions about how we can create a methodology for allocating and reporting overhead costs for Medicare+Choice organizations. Any comments should include not only a proposed methodology for paying Medicare+Choice organizations for GME overhead costs, but also proposed mechanisms for the audit and review of the costs of these organizations.

Similar to our proposed policy for paying FQHCs and RHCs for direct costs of GME, the Medicare+Choice organization's reimbursement for residents' salaries and fringe benefits (including related travel and lodging expenses where applicable) would be subject to the reasonable cost principles in 42 CFR part 413 and any other relevant provisions referenced in part 413. As such we are proposing to add language to § 415.60 to make the reasonable cost principles applicable to Medicare+Choice organizations. In addition, the Medicare+Choice organization's GME reimbursement would also be subject to the Reasonable Compensation Equivalency limits under §§ 415.60 and 415.70. Accordingly, we are proposing to add language to § 415.70 to make reasonable compensation equivalency limits applicable to Medicare+Choice organizations. While we would pay the Medicare+Choice organization for certain GME costs in nonhospital settings under this proposal, the cost of residents' and teaching physicians' salaries and fringe benefits in the hospital setting would be paid to the hospital, not the Medicare+Choice organization.

The Medicare+Choice organization would receive direct GME payment only for the direct costs of training in the nonhospital site that are associated with the delivery of patient care services. In

determining the amount of direct GME payments to Medicare+Choice organizations, we must adjust for Medicare's share of those education costs. Medicare's share would equal the ratio of the total number of Medicare enrollees in the Medicare+Choice organization to total enrollees in the Medicare+Choice organization.

We are proposing that, in order to receive the direct GME payment, the Medicare+Choice organization must produce a contractual agreement between itself and the nonhospital providers. Medicare+Choice organizations may contract with any nonhospital patient care site, including freestanding clinics, nursing homes, and physicians' offices in connection with approved programs. The contract between the Medicare+Choice organization and the nonhospital site must indicate that, for the time that residents spend in the nonhospital site, the Medicare+Choice organization agrees to pay for the cost of residents' salaries and fringe benefits. In addition, the contract must indicate that the Medicare+Choice organization agrees to pay the portion of the costs of teaching physicians' salaries and fringe benefits that is related to the time spent in teaching and supervision of residents and that is unrelated to the volume of services. The contract must stipulate the portion of each teaching physician's time that will be spent training residents in the nonhospital setting. Moreover, the contract must indicate that the Medicare+Choice organization agrees to identify an amount for the cost of the teaching physician's salary based on the time that the resident spends in the nonhospital setting, not based upon a capitated rate for the delivery of physician services.

Under our proposed rule, we could pay a Medicare+Choice organization for the direct costs of training medical residents in a physician's office if such office had a contractual agreement with the organization whereby the organization agrees to pay for ''all or substantially all'' of the costs for the training program in the nonhospital setting. However, an independent physician office would not be eligible to receive payment directly from Medicare for the cost of training residents because it would not be a ''qualified nonhospital provider'' under our proposed policy. Similarly, if a hospital rotates a resident through a physician's office, the hospital must pay for ''all or substantially all'' of the costs of training the resident in the physician's office in order to include that resident in its FTE count for IME and direct GME purposes. (In this instance, the hospital's responsibility in assuming ''all or substantially all'' of the costs of training the resident in the nonhospital site would not be based on section 4625 of BBA which permits payment to nonhospital providers.) The hospital would have to assume ''all or substantially all'' of the training costs for that nonhospital training time in order to avail itself of the benefit of including the resident in the hospital's FTE count for IME and direct GME purposes based on the proposed modifications to § 413.86.

iii. Payment to Hospitals. In the third payment scenario, if the hospital itself incurs ''all or substantially all'' of the costs for the training program in the nonhospital setting, then the hospital may include the residents' training time in the nonhospital setting in the hospital's FTE counts for direct GME and for IME. In order to include the residents' training in the nonhospital site, the hospital must produce a contractual agreement between the hospital and the nonhospital provider. Under § 413.86(f)(1)(iii), hospitals may contract with any nonhospital patient care provider such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs.

Currently, a hospital must produce a written agreement between the hospital and the nonhospital provider that states that the resident's compensation for training time spent outside of the hospital setting is to be paid by the hospital. Since this proposal changes the definition of what constitutes ''all or substantially all'' of the costs of training in the nonhospital site, hospitals must produce a written agreement that demonstrates that they are assuming responsibility for more of the costs of training in the nonhospital site than had previously been required.

In accordance with our proposed definition of what constitutes ''all or substantially all'' of the costs of training while the resident is in the nonhospital site, we are proposing that the contract must indicate that the hospital is assuming financial responsibility for, at a minimum, the cost of residents' salaries and fringe benefits (including travel and lodging expenses where applicable) and the costs for that portion of teaching physicians' salaries and fringe benefits related to the time spent in teaching and supervision of residents.

The contract must indicate that the hospital is assuming financial responsibility for these costs directly or that the hospital agrees to reimburse the nonhospital provider for such costs. The contract must also contain an acknowledgment on the part of the nonhospital provider that, since the residents' time is being counted by the hospital, the nonhospital site cannot claim GME costs on their Medicare cost report. The nonhospital provider must agree to report its direct GME costs as well as any money received from the hospital for GME purposes in a nonallowable cost center on its cost report. In addition, in order to determine teaching physician compensation that may be allocated to direct GME, the nonhospital provider must specify the portion of the teaching physicians' time that will be spent training residents in the nonhospital setting. Finally, any payment to the hospital for the direct costs of GME training in the nonhospital setting will continue to reflect Medicare's share, which equals the hospital's ratio of Medicare inpatient days to total inpatient days.

Hospitals that have residents who rotate to nonhospital sites are, like all teaching hospitals, subject to an institutional cap on the number of FTE residents that may be counted for both indirect and direct GME under sections 1886(d)(5)(B)(v) and 1886(h)(6)(F) of the Act. For hospitals that have residents who rotate to a nonhospital site, those residents will be subject to the hospital's FTE caps.

f. Trust Funds. Under section 1886(k)(1) of the Act, the rules established by the Secretary for paying nonhospital providers for GME must specify the portion of Medicare payments that will be made from each of the Medicare trust funds. We propose that GME payments made directly to an FQHC, RHC, or Medicare+Choice organization would be made from the Federal Supplementary Medical Insurance Trust Fund.

g. Conclusion. Under this proposed rule, clinics that are presently ineligible to receive payments for direct GME may now receive such payments. Moreover, this proposal provides Medicare+Choice organizations the opportunity to receive direct GME payments for training residents in the nonhospital setting. As Medicare+Choice organizations, managed care entities will, for the first time, be eligible to receive direct GME payments for training residents in various types of nonhospital sites. This proposed rule would help bridge the disparity between hospital and nonhospital providers in obtaining payment for direct GME costs.

We believe this proposed rule may encourage the development of new programs in nonhospital settings. Similarly, it may also encourage approved residency training programs to

rotate additional residents to nonhospital sites.

In developing this proposed rule, we considered establishing a fixed payment rate for the direct costs of training residents in the nonhospital setting. We are not proposing a policy of a fixed payment at this time because we presently have no reliable data on the direct costs of training residents in nonhospital settings. Moreover, we are concerned that a fixed payment for these costs may not be appropriate if there is significant variation in cost among participating nonhospital sites.

Given these considerations, our policy to pay FQHCs, RHCs, and Medicare+Choice organizations on a cost reimbursement basis may be revised in the future. Once we have acquired data such that we can estimate the direct costs of training residents in the nonhospital site, we will revisit our payment methodology for paying FQHCs, RHCs, and Medicare+Choice organizations for direct GME. We believe that ultimately it might be appropriate to pay FQHCs, RHCs, and Medicare+Choice organizations using a national average per resident amount. This national per resident amount would be based on the national average for the direct costs of training medical residents in the nonhospital site. As such, we are interested in receiving comments on a fixed payment methodology and on how to derive such a payment. These comments should include empirical data on training costs in nonhospital sites.

The effective date of these provisions for FQHCs, RHCs, Medicare+Choice organizations, and hospitals will be January 1, 1999. In particular, the effective date for IME payments to hospitals under this provision applies to discharges occurring on or after January 1, 1999. In addition, the effective date for direct medical education payments to FQHCs, RHCs, Medicare+Choice organizations, and hospitals applies to that portion of cost reporting periods occurring on or after January 1, 1999.

VI. Changes to the Prospective Payment System for Capital-Related Costs

A. Proposed Cap on the Capital Indirect Medical Education Adjustment Ratio (§ 417.322)

Under section 1886(g) of the Act, the Secretary has broad discretion in implementing the capital prospective payment system. Section 412.322 of the regulations specifies the formula for the capital indirect medical education (IME) adjustment factor. The capital IME adjustment is intended to pay the capital prospective payment system share of the indirect costs of medical education to teaching hospitals. The formula was adopted in the August 30, 1991 final rule for the capital prospective payment system (56 FR 43380) and uses the ratio of interns and residents to average daily census (defined as total inpatient days divided by the number of days in the cost reporting period). Section 1886(d)(5)(B) of the Act requires the use of the ratio of residents-to-beds to calculate the IME adjustment for the operating Prospective payment system. However, pursuant to our authority under section 1886(g) of the Act, we adopted the resident to average daily census ratio for the capital prospective payment system because we believed it was a more appropriate method for measuring teaching intensity and because we believed it was less subject to manipulation.

The IME adjustment factor increases by approximately 2.8 percentage points for each .10 increase in the hospital's ratio of residents to average daily census. The IME adjustment for inpatient capital-related costs for hospitals paid under the prospective payment system takes the form of e raised to the power (.2822 × ratio of interns and residents to average daily census)-1] where e is the natural antilogy of 1, based on the total cost regression results. In order to determine the Federal rate portion of the hospital's payment, the IME adjustment factor is multiplied by the standard federal rate, the DRG weight, the geographic adjustment factor, and any other relevant payment adjustments such as the DSH adjustment or the large urban add-on. The formula is as follows: (Standard Federal Rate) × (DRG weight) × (GAF) × (Large Urban Add-on, if applicable) × (COLA adjustment for hospitals located in Alaska and Hawaii) × (1 + Disproportionate Share Adjustment Factor + IME Adjustment Factor, if applicable).

It has come to our attention that because of the application of the capital IME adjustment, one hospital would receive a capital IME payment greater than its total hospital costs. We have also recently learned that of the approximately 1,200 teaching hospitals in the United States, based on December 1997 data, 8 hospitals have a resident to average daily census ratio of more than 1.5. A resident to average daily census ratio of 1.5 results in a capital IME adjustment factor of .53, which increases the Federal rate portion of the hospital's capital payment by 53 percent.

To address this unintended effect of the capital IME methodology, we are proposing to cap the capital IME ratio at 1.5. A ratio greater than 1.5 means a hospital has, on average, considerably more residents than inpatients. Capping the ratio at 1.5 would allow for one resident per patient on the inpatient side plus some outpatient training, and would keep capital IME payments more consistent with the costs incurred. Because of the large number of unoccupied beds in most hospitals, the operating IME ratio has only slightly exceeded 1.0 in two cases. This change would ensure that the capital IME adjustment is more in line with hospital costs.

B. Payment Methodology for Mergers Involving New Hospitals (§ 412.331)

The August 30, 1991 final rule (56 FR 43418), which implemented the capital prospective payment system, established special payment provisions for new hospitals. Under § 412.324(b), a new hospital is paid 85 percent of its allowable Medicare capital-related costs through its first cost reporting period ending at least 2 years after the hospital accepts its first patient. The first cost reporting period beginning at least 1 year after the hospital accepts its first patient is the hospital's base year for purposes of determining its hospital-specific rate. Section 412.302(b) defines a new hospital's old capital costs as allowable capital-related costs for land and depreciable assets that were put in use for patient care on or before the last day of the hospital's base year cost reporting period. Beginning with the third year, the hospital is paid under the fully prospective or hold-harmless payment methodology, as appropriate. If the hospital is paid under the hold-harmless payment methodology, the hospital's hold-harmless payments for its old capital costs can continue for up to 8 years.

In the August 30, 1991 final rule, we defined a new hospital as one that had operated (under previous or present ownership) for less than 2 years and did not have a 12-month cost reporting period that ended on or before December 31, 1990. In the September 1, 1992 final rule (57 FR 39789), as a result of situations brought to our attention after publication of the prospective payment system final rule, we clarified the new hospital exemption under the capital prospective payment system. We explained that the new hospital exemption would not apply to a facility that opened as an acute care hospital if that hospital had previously operated under current or prior ownership and had a historic asset base. We also clarified that a hospital that replaced its entire facility (with or without a change of ownership) would not qualify for a

new hospital exemption and that a previously existing excluded hospital (paid under section 1886(b) of the Act) that became an acute care hospital (paid under section 1886(d)) of the Act would not qualify.

We explained our belief that the reasonable cost payment protection under the new hospital exemption should only be available to those hospitals that had not received reasonable cost payments in the past and needed special protection during their initial period of operation. We also stated in the June 4, 1992 proposed rule (57 FR 23649) that we were clarifying the new hospital exemption to ensure that hospitals that had an existing asset base before December 31, 1990 were not provided with an extended transition period and inappropriately higher payments relative to other hospitals. We also explained our belief that it was essential to maintain the integrity of the capital prospective payment system by allowing only truly new providers of hospital care to qualify for the new hospital exemption.

Since publication of our last clarification of the payment rules for new hospitals, questions have arisen regarding application of our rules for payment of new hospitals in merger situations. Consistent with our previously stated policy that only truly new hospitals without an existing asset base should be eligible for the new hospital exemption, we are further clarifying the new hospital payment provisions.

If during the period it is eligible for payment as a new hospital (as defined at § 412.300(b) and § 412.328(b)), a new hospital merges with one or more existing hospitals and the merger meets the existing capital-related reasonable cost rules regarding the criteria for recognizing a merger at § 413.134 and the new hospital is the surviving corporation (as defined in § 413.134(l)(2)) we would treat as old capital only those assets of the existing hospital that met the definition of old capital (as defined in § 412.302(b)) prior to the merger, for purposes of determining payments after the merger.

Any assets of the existing hospital that were considered new capital prior to the merger will still be considered new capital after the merger. The merger cannot be used to convert the existing hospital's new capital into old capital. After the merger, the discharges of each campus of the merged entity would maintain their pre-merger payment methodology until the end of the 2 year period that the ''new hospital'' campus was eligible for reasonable cost reimbursement as defined at § 412.324(b). At the end of this period, the intermediary would devise a hospital specific rate for the ''new'' campus of the merged hospital. Finally, the calculation methodology for hospital mergers at new § 412.331(a)(1) and (2) would be performed and a combined hospital-specific rate would be determined and a payment methodology selected for the merged hospital as a whole.

The calculation at § 412.331(a)(1) and (2) uses each hospital's base year old capital costs. Any new capital of the previously existing hospital would not be used in the determination. If the new merged entity qualifies for the hold-harmless payment methodology, only the capital which meets the definition of old capital at § 412.302(b) would be eligible for hold-harmless payments.

We note that this proposed change is consistent with the principles underlying existing § 412.331(a)(3), which provides that in the case of a merger only the existing capital-related costs related to the assets of each merged or consolidated hospital as of December 31, 1990 are recognized as old capital costs during the transition period. If the hospital is paid under the hold-harmless methodology after merger or consolidation, only that original base year old capital is eligible for hold-harmless payments.

Example: Hospital A is a new hospital in its first 2 years of operation and is being paid 85 percent of its allowable Medicare inpatient hospital capital-related costs. Hospital A's base year for establishing its hospital-specific rate will end September 30, 1998. Hospital B is an existing hospital whose base year for capital prospective payment system purposes was June 30, 1990. Hospital B is a hold-harmless hospital paid 100 percent of the Federal rate. Hospital A merged with Hospital B (in accordance with to § 413.134(l)) on March 1, 1998, and Hospital A is a new merged entity, with two campuses: one which used to be the original Hospital A—the ''new'' hospital, and one which used to be hospital B—the ''existing'' hospital). The merged Hospital A retains the corporate structure, provider number, and cost reporting period of the original Hospital A, which is the surviving hospital. The merged Hospital A's discharges will be paid under two different payment methodologies until the ''new'' campus completes its base period under the payment rules for new hospitals and a hospital-specific rate and a payment methodology can be determined for the merged Hospital A. Until that time, the discharges of the ''new'' hospital campus (previously the original Hospital A) will be paid in accordance with § 412.324(b) as a new hospital. Any capital that meets the definition of old capital acquired by the ''new'' campus before the end of its base year will be accorded old capital status in accordance with § 412.302(b). The ''existing'' hospital campus (previously hospital B) will continue to be paid on a hold-harmless basis. Any capital acquired by the ''existing'' campus will be accorded new capital status in accordance with section 2807.3A of the Provider Reimbursement Manual (PRM). At the end of the ''new'' campus' base year, a hospital-specific rate will be determined for that campus. After a hospital specific rate is determined, the calculation methodology for hospital mergers at § 412.331(a)(1) and (2) will be performed. As part of the calculation and before combining the data, the base years of the two hospitals used to establish the hospital-specific rate are brought to the same point by discharge-weighting and updating. The calculation uses only the old capital costs of each hospital in order to determine a combined hospital-specific rate and payment methodology. After a payment methodology determination is made, the two campuses will be paid using the same payment methodology for all of their discharges.

VII. Changes for Hospitals and Units Excluded From the Prospective Payment System

Limits on and Adjustments to the Target Amounts for Excluded Hospitals and Units (§ 413.40(g))

1. Updated Caps

Section 1886(b)(3) of the Act as amended by section 4414 of the BBA established caps on the target amounts for excluded hospitals and units for cost reporting periods beginning on or after October 1, 1997, through September 30, 2002. The caps on the target amounts apply to the following three categories of excluded hospitals: psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals.

A discussion of how the caps on the target amounts were calculated can be found in the August 29, 1997 final rule with comment period (62 FR 46018). For purposes of calculating the caps for cost reporting periods beginning during FY 1999 through FY 2002, the statute requires us to calculate the 75th percentile of the target amounts for each class of hospital (psychiatric, rehabilitation, or long-term care) for cost reporting periods ending during FY 1996. The resulting amounts are updated by the market basket percentage to the applicable fiscal year.

The projected market basket for excluded hospitals and units for FY 1999 is 2.5 percent. Accordingly, the caps on the target amount for FY 1999 as follows:

(1) Psychiatric hospitals and units: $10,443

(2) Rehabilitation hospitals and units: $18,938

(3) Long-term care hospitals: $37,360

2. Classification of Hospitals and Units

Since publication of the August 29, 1997 final rule with comment period, some excluded facilities have suggested that if they are currently excluded as one class of hospital or unit but also qualify for exclusion as another class of hospital, they should be permitted to choose which classification applies for purposes of applying the cap on target amounts. For example, some hospitals that participate in Medicare as psychiatric hospitals (defined under section 1861(f) of the Act, and the special conditions of participation in 42 CFR part 482 subpart E) have noted that they have average lengths of stay greater than 25 days. Those hospitals have asked to be ''reclassified'' as long-term care hospitals and given the benefit of the higher cap on target amounts applicable to that hospital class.

We have considered these hospitals' suggestions, but we believe it would not be appropriate to adopt them. Section 1886(b)(3)(H)(iv) of Act makes it clear that each category of hospital and corresponding units—psychiatric (section 1886(d)(1)(B)(I)), rehabilitation (section 1886(d)(1)(B)(ii)), and long-term care hospitals (section 1886(d)(1)(B)(iv)) is treated separately. We believe it is consistent with effective implementation of this provision to prevent hospitals or units that could potentially be assigned to more than one category of excluded facility from choosing the category to which they wish to be assigned. Even though some hospitals or units in one group might potentially have been assigned to a different group, each group has its own limit based on the target amounts for similarly classified facilities. It would not be appropriate to apply a limit to a hospital or unit based on the target amount derived from the cost experience of differently classified hospitals and units.

In addition, there are a number of hospitals that could potentially move from the psychiatric hospital cap to the long-term care hospital cap. This movement would have a significant impact on the appropriateness of both caps. In the case of the psychiatric hospitals, had those hospitals with the longest lengths of stay and therefore higher per discharge target amount been excluded in the original calculation of the caps, the cap for all remaining psychiatric hospitals would invariably have been lower. Furthermore, had those psychiatric hospitals been included in the calculation of the long-term care hospital cap, that cap could also have been lower. To allow such a significant change in the application of the caps is to raise a serious question as to the appropriateness of the current caps for all psychiatric and long-term care hospitals.

Thus, to clarify the application of the caps, we propose to revise § 413.40(c)(4)(iii) to specify that, for purposes of that paragraph, the classification of a hospital that was excluded from the prospective payment system for its cost reporting period ending in FY 1996 will be determined by its classification (that is, the basis on which it was excluded) in FY 1996. If a hospital or unit was not excluded for a cost reporting period ending in FY 1996 but could be excluded on more than one basis (for example, as either a rehabilitation or long-term care hospital) it will be assigned to the classification group with the lowest limit.

3. Exceptions

The August 29, 1997 final rule with comment period (62 FR 46018) specified that a hospital that has a target amount that is capped at the 75th percentile would not be granted an adjustment payment to the target amount (also referred to as an exception payment) as governed by § 413.40(g) based solely on a comparison of its costs or patient mix in its base year to its costs or patient mix in the payment year. Since the hospital's target amount would not be determined based on its own experience in a base year, any comparison of costs or patient mix in its base year to costs or patient mix in the payment year would be irrelevant.

We propose to clarify that, to the extent we grant an exception to a hospital not affected by the cap, the amount of the exception would be limited to the cap on the hospital's target amount. This policy is consistent with the caps. By establishing caps on TEFRA target amounts, Congress has limited payments to individual hospitals based on amounts that reflect the cost experience of other hospitals. Therefore, in determining the extent of any adjustment paid to a hospital as an exception under our regulations at § 413.40(g)(3), we believe it is consistent with Congressional intent to limit the extent of the adjustment to the hospital's cap on its target amount.

We propose to revise § 413.40(g)(1) to set forth the limitation on the adjustment payments.

VIII. MedPAC Recommendations

We have reviewed the March 1998 report submitted by MedPAC to Congress and have given its recommendations careful consideration in conjunction with the proposals set forth in this document. Recommendations concerning the update factors for inpatient operating costs and for hospitals and hospital distinct-part units excluded from the prospective payment system are discussed in Appendix D, to this proposed rule. The remaining recommendations are discussed below.

A. Disproportionate Share Hospitals (DSH)

Recommendation: The Medicare Payment Advisory Commission (MedPAC) made several recommendations concerning the Medicare disproportionate share adjustment calculation. In general, the Commission's proposal would base the amount of DSH payment each hospital receives on its volume and mix of cases paid under the prospective payment system and its share of low-income patients. The low-income share measure would reflect the costs of care provided to low-income individuals (Medicare patients eligible for Supplemental Security Income (SSI), Medicaid patients, patients sponsored by local indigent care programs, and patients receiving uncompensated care) as a proportion of total patient care expenses. Both inpatient and outpatient costs were included in the data used to calculate the low-income shares, although payment would be made only on inpatient discharges.

The same formula would be applied to all prospective payment hospitals. Under the recommendation, there would be a threshold or minimum low-income share, that must be reached for a hospital to receive any Medicare disproportionate share adjustment. The payment the hospital would receive is proportionate to the segment of its low-income share that lies above the threshold. MedPAC simulated the potential effects of applying their approach on the distribution of Medicare disproportionate share payments made in 1995. For purposes of MedPAC's simulations, the threshold was set at a level that would limit payments to about 40 percent of prospective payment hospitals—roughly the same as under the current DSH adjustment. MedPAC stated that this proportion could be adjusted, or the threshold could be set using a different method, as deemed appropriate by policy makers. (For more information see Volume 1, chapter 6, page 63 of the March 1998 report.)

Response: Section 1886(d)(5)(F) of the Act, as amended by section 4403(b) of the BBA, requires us to prepare a report to Congress, due by August 5, 1998, which will include our recommendations for an appropriate

formula for determining DSH payments. We appreciate MedPAC's efforts to assist HCFA in restructuring the Medicare disproportionate share adjustment and we will further examine and consider their recommendations as we develop our report to Congress.

B. Potential Effects of Target Amount Caps

Recommendation: The wage-related portion of the excluded hospital target amount caps should be adjusted by the appropriate hospital wage index to account for geographic differences in wages. (For more information see Volume 1, chapter 7, page 71 of the March 1998 report.)

Response: As MedPAC indicated in its recommendation, legislation would be required to adjust the target amount caps in such a substantial manner as to adjust for differences in area labor costs.

IX. Other Required Information

A. Requests for Data From the Public

In order to respond promptly to public requests for data related to the prospective payment system, we have set up a process under which commenters can gain access to the raw data on an expedited basis. Generally, the data are available in computer tape or cartridge format; however, some files are available on diskette as well as on the Internet at HTTP://WWW.HCFA.GOV/STATS/PUBFILES.HTML. Data files are listed below with the cost of each. Anyone wishing to purchase data tapes, cartridges, or diskettes should submit a written request along with a company check or money order (payable to HCFA–PUF) to cover the cost to the following address: Health Care Financing Administration, Public Use Files, Accounting Division, P.O. Box 7520, Baltimore, Maryland 21207–0520, (410) 786–3691. Files on the Internet may be downloaded without charge.

1. Expanded Modified MEDPAR-Hospital (National)

The Medicare Provider Analysis and Review (MedPAR) file contains records for 100 percent of Medicare beneficiaries using hospital inpatient services in the United States. (The file is a Federal fiscal year file, that is, discharges occurring October 1 through September 30 of the requested year.)

The records are stripped of most data elements that will permit identification of beneficiaries. The hospital is identified by the 6-position Medicare billing number. The file is available to persons qualifying under the terms of the Notice of Proposed New Routine Uses for an Existing System of Records published in the **Federal Register** on December 24, 1984 (49 FR 49941), and amended by the July 2, 1985 notice (50 FR 27361). The national file consists of approximately 11 million records. Under the requirements of these notices, an agreement for use of HCFA Beneficiary Encrypted Files must be signed by the purchaser before release of these data. For all files requiring a signed agreement, please write or call to obtain a blank agreement form before placing an order. Two versions of this file are created each year. They support the following:

- Notice of Proposed Rulemaking (NPRM) published in the **Federal Register**, usually available by the end of May (April beginning in 1998). This file is derived from the MedPAR file with a cutoff of 3 months after the end of the fiscal year (December file).
- Final Rule published in the **Federal Register**, usually available by the first week of September (August beginning with the FY 1999 final rule). For final rules published before 1998, this file is derived from the MedPAR file with a cutoff of 9 months after the end of the fiscal year (June file). The FY 1997 MedPar file used for the FY 1999 final rule will have a cutoff of 6 months after the end of the fiscal year (March file).

Media: Tape/Cartridge
File Cost: $3,415.00 per fiscal year
Periods Available: FY 1988 through FY 1997

2. Expanded Modified MedPAR-Hospital (State)

The State MedPAR file contains records for 100 percent of Medicare beneficiaries using hospital inpatient services in a particular State. The records are stripped of most data elements that will permit identification of beneficiaries. The hospital is identified by the 6-position Medicare billing number. The file is available to persons qualifying under the terms of the Notice of Proposed New Routine Uses for an Existing System of Records published in the December 24, 1984 **Federal Register** notice, and amended by the July 2, 1985 notice. This file is a subset of the Expanded Modified MedPAR-Hospital (National) as described above. Under the requirements of these notices, an agreement for use of HCFA Beneficiary Encrypted Files must be signed by the purchaser before release of these data. Two versions of this file are created each year. They support the following:

- NPRM published in the **Federal Register**, usually available by the end of May (April beginning in 1998). This file is derived from the MedPAR file with a cutoff of 3 months after the end of the fiscal year (December file).
- Final Rule published in the **Federal Register**, usually available by the first week of September (August beginning with the FY 1999 final rule). For final rules published before 1998, this file is derived from the MedPAR file with a cutoff of 9 months after the end of the fiscal year (June file). The FY 1997 MedPar file used for the FY 1999 final rule will be cut off 6 months after the end of the fiscal year (March file).

Media: Tape/Cartridge
File Cost: $1,050.00 per State per year
Periods Available: FY 1988 through FY 1997

3. HCFA Wage Data

This file contains the hospital hours and salaries for 1995 used to create the proposed FY 1999 prospective payment system wage index. The file will be available by the beginning of February for the NPRM and the beginning of May for the final rule.

Processing year	Wage data year	PPS fiscal year
1998	1995	1999
1997	1994	1998
1996	1993	1997
1995	1992	1996
1994	1991	1995
1993	1990	1994
1992	1989	1993
1991	1988	1992

These files support the following:

- NPRM published in the **Federal Register**, usually by the end of April.
- Final Rule published in the **Federal Register**, usually by the first week of August.

Media: Diskette/Internet
File Cost: $145.00 per year
Periods Available: FY 1999 PPS Update

4. HCFA Hospital Wages Indices (Formally: Urban and Rural Wage Index Values Only)

This file contains a history of all wage indices since October 1, 1983.

Media: Diskette/Internet
File Cost: $145.00 per year
Periods Available: FY 1999 PPS Update

5. PPS SSA/FIPS MSA State and County Crosswalk

This file contains a crosswalk of State and county codes used by the Social Security Administration (SSA) and the Federal Information Processing Standards (FIPS), county name, and a historical list of Metropolitan Statistical Area (MSA).

Media: Diskette/Internet

File Cost: $145.00 per year
Periods Available: FY 1999 PPS Update

6. Reclassified Hospitals by Provider Only

This file contains a list of hospitals that were reclassified for the purpose of the proposed FY 1999 wage index. Two versions of these files are created each year.

They support the following:

- NPRM published in the **Federal Register**, usually by the end of April.
- Final Rule published in the **Federal Register**, usually by the first week of August.

Media: Diskette/Internet
File Cost: $145.00 per year
Periods Available: FY 1999 PPS Update

7. PPS–IV to PPS–XII Minimum Data Sets

The Minimum Data Set contains cost, statistical, financial, and other information from Medicare hospital cost reports. The data set includes only the most current cost report (as submitted, final settled, or reopened) submitted for a Medicare participating hospital by the Medicare Fiscal Intermediary to HCFA. This data set is updated at the end of each calendar quarter and is available on the last day of the following month.

MEDIA: TAPE/CARTRIDGE

	Periods beginning on or after	and before
PPS IV	10/01/86	10/01/87
PPS V	10/01/87	10/01/88
PPS VI	10/01/88	10/01/89
PPS VII	10/01/89	10/01/90
PPS VIII	10/01/90	10/01/91
PPS IX	10/01/91	10/01/92
PPS X	10/01/92	10/01/93
PPS XI	10/01/93	10/01/94
PPS XII	10/01/94	10/01/95

(**Note:** The PPS XIII Minimum Data Set covering FY 1997 will not be available until July 31, 1998.)

File Cost: $715.00 per year

8. PPS–IX to PPS–XII Capital Data Set

The Capital Data Set contains selected data for capital-related costs, interest expense and related information and complete balance sheet data from the Medicare hospital cost report. The data set includes only the most current cost report (as submitted, final settled or reopened) submitted for a Medicare certified hospital by the Medicare fiscal intermediary to HCFA. This data set is updated at the end of each calendar quarter and is available on the last day of the following month.

MEDIA: TAPE/CARTRIDGE

	Periods beginning on or after	and before
PPS IX	10/01/91	10/01/92
PPS X	10/01/92	10/01/93
PPS XI	10/01/93	10/01/94
PPS XII	10/01/94	10/01/95

(**Note:** The PPS XIII Capital Data Set covering FY 1997 will not be available until July 31, 1998.)

File Cost: $715.00 per year

9. Provider-Specific File

This file is a component of the PRICER program used in the fiscal intermediary's system to compute DRG payments for individual bills. The file contains records for all prospective payment system eligible hospitals, including hospitals in waiver States, and data elements used in the prospective payment system recalibration processes and related activities. Beginning with December 1988, the individual records were enlarged to include pass-through per diems and other elements.

Media: Diskette/Internet
File Cost: $265.00
Periods Available: FY 1998 PPS Update

10. HCFA Medicare Case-Mix Index File

This file contains the Medicare case-mix index by provider number as published in each year's update of the Medicare hospital inpatient prospective payment system. The case-mix index is a measure of the costliness of cases treated by a hospital relative to the cost of the national average of all Medicare hospital cases, using DRG weights as a measure of relative costliness of cases. Two versions of this file are created each year. They support the following:

- NPRM published in the **Federal Register**, usually by the end of May (April beginning in 1998).
- Final rule published in the **Federal Register**, usually by the first week of September (August beginning in 1998).

Media: Diskette/Internet
Price: $145.00 per year
Periods Available: FY 1985 through FY 1997 (Internet—FY 1997)

11. DRG Relative Weights (Formerly Table 5 DRG)

This file contains a listing of DRGs, DRG narrative description, relative weights, and geometric and arithmetic mean lengths of stay as published in the **Federal Register**. The hardcopy image has been copied to diskette. There are two versions of this file as published in the **Federal Register**:

a. NPRM, usually published by the end of May (April beginning in 1998).

b. Final rule, usually published by the first week of September (August beginning in 1999).

Media: Diskette/Internet
File Cost: $145.00
Periods Available: FY 1999 PPS Update

12. PPS Payment Impact File

This file contains data used to estimate payments under Medicare's hospital inpatient prospective payment systems for operating and capital-related costs. The data are taken from various sources, including the Provider-Specific File, Minimum Data Sets, and prior impact files. The data set is abstracted from an internal file used for the impact analysis of the changes to the prospective payment systems published in the **Federal Register**. This file is available for release 1 month after the proposed and final rules are published in the **Federal Register**.

Media: Diskette/Internet
File Cost: $145.00
Periods Available: FY 1999 PPS Update

13. AOR/BOR Tables

This file contains data used to develop the DRG relative weights. It contains mean, maximum, minimum, standard deviation, and coefficient of variation statistics by DRG for length of stay and standardized charges. The BOR tables are ''Before Outliers Removed'' and the AOR is ''After Outliers Removed.'' (Outliers refers to statistical outliers, not payment outliers.) Two versions of this file are created each year. They support the following:

- NPRM published in the **Federal Register**, usually by the end of April.
- Final rule published in the **Federal Register**, usually by the first week of August.

Media: Diskette/Internet
File Cost: $145.00
Periods Available: FY 1999 PPS Update

For further information concerning these data tapes, contact Mary R. White at (410) 786–3691.

Commenters interested in obtaining or discussing any other data used in constructing this rule should contact Stephen Phillips at (410) 786–4548.

B. Public Comments

Because of the large number of items of correspondence we normally receive on a proposed rule, we are not able to acknowledge or respond to them individually. However, in preparing the final rule, we will consider all comments concerning the provisions of this proposed rule that we receive by the date and time specified in the **DATES**

section of this preamble and respond to those comments in the preamble to that rule. We emphasize that, given the statutory requirement under section 1886(e)(5) of the Act that our final rule for FY 1999 be published by August 1, 1998, we will consider only those comments that deal specifically with the matters discussed in this proposed rule.

List of Subjects

42 CFR Part 405

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Chapter IV would be amended as set forth below:

A. Part 405 is amended as follows:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

1. The authority citation for part 405 is revised to read as follows:

Authority: Secs. 1102, 1861, 1862(a), 1871, 1874, 1881, and 1886(k) of the Social Security Act (42 U.S.C. 1302, 1395x, 1395y(a), 1395hh, 1395kk, 1395rr and 1395ww(k)), and sec. 353 of the Public Health Service Act (42 U.S.C. 263a), unless otherwise noted.

Subpart X—Rural Health Clinic and Federally Qualified Health Center Services

§ 405.2468 [Amended]

2. In § 405.2468, a new paragraph (f) is added to read as follows:

* * * * *

(f) *Graduate medical education.* (1) Effective for that portion of cost reporting periods occurring on or after January 1, 1999, if an RHC or an FQHC incurs ''all or substantially all'' of the costs for the training program in the nonhospital setting as defined in § 413.86(b) of this chapter, the RHC or FQHC may receive direct graduate medical education payment for those residents.

(2) Direct graduate medical education costs are not included as allowable cost under § 405.2466(b)(1)(i); and therefore, are not subject to the limit on the all-inclusive rate for allowable costs.

(3) Allowable graduate medical education costs must be reported on the RHC's or the FQHC's cost report under a separate cost center.

(4) Allowable direct graduate medical education costs under paragraphs (f)(5) and (6)(i) of this section, are subject to reasonable cost principles under part 413 and the reasonable compensation equivalency limits in §§ 415.60 and 415.70 of this chapter.

(5) The allowable direct graduate medical education costs are those costs incurred by the nonhospital site for the educational activities associated with patient care services of an approved program, subject to the redistribution and community support principles in § 413.85(c).

(i) The following costs are included in allowable direct graduate medical education costs to the extent that they are reasonable—

(A) The costs of the residents' salaries and fringe benefits (including travel and lodging expenses where applicable).

(B) The portion of teaching physicians' salaries and fringe benefits that are related to the time spent teaching and supervising residents.

(C) Facility overhead costs that are allocated to direct graduate medical education.

(ii) The following costs are not included as allowable graduate medical education costs—

(A) Costs associated with training, but not related to patient care services.

(B) Normal operating and capital-related costs.

(C) The marginal increase in patient care costs that the RHC or FQHC experiences as a result of having an approved program.

(D) The costs associated with activities described in § 413.85(d) of this chapter.

(6) Payment is equal to the product of—

(i) The RHC's or the FQHC's allowable direct graduate medical education costs; and

(ii) Medicare's share of the direct graduate medical education payment which is equal to the ratio of Medicare visits to the total number of visits (as defined in § 405.2463).

(7) Direct graduate medical education payments to RHCs and FQHCs made under this section are made from the Federal Supplementary Medical Insurance Trust Fund.

* * * * *

B. Part 412 is amended as set forth below:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

1. The authority citation for part 412 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1895hh).

Subpart A—General Provisions

2. Section 412.4 is revised to read as follows:

§ 412.4 Discharges and transfers.

(a) *Discharges.* Subject to the provisions of paragraphs (b) and (c) of this section, a hospital inpatient is considered discharged from a hospital paid under the prospective payment system when —

(1) The patient is formally released from the hospital; or

(2) The patient dies in the hospital.

(b) *Transfer—Basic rule.* A discharge of a hospital inpatient is considered to be a transfer for purposes of payment under this part if the discharge is made under any of the following circumstances:

(1) From a hospital to the care of another hospital that is—

(i) Paid under the prospective payment system; or

(ii) Excluded from being paid under the prospective payment system because of participation in an approved Statewide cost control program as described in subpart C of part 403 of this chapter.

(2) From one inpatient area or unit of a hospital to another inpatient area or unit of the hospital that is paid under the prospective payment system.

(c) *Transfers—Special 10 DRG rule.* For discharges occurring on or after October 1, 1998, a discharge of a hospital inpatient is considered to be a transfer for purposes of this part when the patient's discharge is assigned, as described in § 412.60(c), to one of the qualifying diagnosis-related groups (DRGs) listed in paragraph (d) of this section and the discharge is made under any of the following circumstances—

(1) To a hospital or distinct part hospital unit excluded from the prospective payment system under subpart B of this part.

(2) To a skilled nursing facility or to a swing bed in the hospital that meets the provisions of § 482.66 of this chapter.

(3) To home under a written plan of care for the provision of home health services from a home health agency and those services begin within 3 days after the date of discharge.

(d) *Qualifying DRGs.* The qualifying DRGs for purposes of paragraph (c) of this section are DRGs 14, 113, 209, 210, 211, 236, 263, 264, 429, and 483.

(e) *Payment for discharges.* The hospital discharging an inpatient (under paragraph (a) of this section) is paid in full, in accordance with § 412.2(b).

(f) *Payment for transfers*—(1) *General rule.* Except as provided in paragraph (f)(2) or (f)(3) of this section, a hospital that transfers an inpatient under the circumstances described in paragraph (b) or (c) of this section, is paid a graduated per diem rate for each day of the patient's stay in that hospital, not to exceed the amount that would have been paid under subparts D and M of this part if the patient had been discharged to another setting. The per diem rate is determined by dividing the appropriate prospective payment rates (as determined under subparts D, and M of this part) by the geometric mean length of stay for the specific which the case is assigned. Payment is graduated by paying twice the per diem amount for the first day of the stay, and the per diem amount for each subsequent day, up to the full DRG payment.

(2) *Special rule for DRGs 209, 210, and 211.* A hospital that transfers an inpatient under the circumstances described in paragraph (c) of this section and the transfer is assigned to DRGs 209, 210 or 211 is paid as follows:

(i) 50 percent of the appropriate prospective payment rate (as determined under subparts D and M of this part) for the first day of the stay; and

(ii) 50 percent of the per diem amount as calculated under paragraph (f)(1) of this section for the remaining days of the stay, up to the full DRG payment.

(3) *Transfer assigned to DRG 385.* If a transfer is classified into DRG No. 385 (Neonates, died or transferred) the transferring hospital is paid in accordance with § 412.2(e).

(4) *Outliers.* Effective with discharges occurring on or after October 1, 1994, a transferring hospital may qualify for an additional payment for extraordinarily high-cost cases that meet the criteria for cost outliers as described in subpart F of this part.

Subpart G—Special Treatment of Certain Facilities Under the Prospective Payment System for Inpatient Operating Costs

3. In § 412.106, paragraph (b)(4) is revised to read as follows:

§ 412.106 Special treatment: Hospitals that serve a disproportionate share of low-income patients.

* * * * *

(b) * * *

(4) *Second computation.* The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.

(i) For purpose of paragraph (b)(4), a patient is deemed eligible for Medicaid on a given day if the patient is eligible for medical assistance under an approved State Medicaid plan on such day, regardless of whether particular items or services were covered or paid under the State plan.

(ii) The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

* * * * *

Subpart M—Prospective Payment System for inpatient Hospital Capital Costs

4. In § 412.322, a new sentence is added at the end of paragraph (a)(3) to read as follows:

§ 412.322 Indirect medical education adjustment factor.

(a) * * *

(3) * * * This ratio cannot exceed 1.5.

* * * * *

5. In § 412.331, paragraphs (a) and (b) are redesignated as paragraphs (b) and (c) respectively, a new paragraph (a) is added, and the first sentences of new paragraphs (b) introductory text and (b)(2) are revised to read as follows:

§ 412.331 Determining hospital-specific rates in cases of hospital merger, consolidation, or dissolution.

(a) *New hospital merger or consolidation.* If, after a new hospital accepts its first patient but before the end of its base year, it merges with one or more existing hospitals, and two or more separately located hospital campuses are maintained, hospital specific rate and payment determination for the merged entity are determined as follows—

(1) The ''new'' campus continues to be paid based on reasonable costs until the end of its base year. The existing campus remains on its previous payment methodology until the end of the new campus' base year. Effective with the first cost reporting period beginning after the ''new'' campus, the intermediary determines a hospital-specific rate applicable to the new campus, and then determines a revised hospital-specific rate for the merged entity in accordance with paragraph(a) of this section.

(2) *Payment determination.* To determine the applicable payment methodology under § 412.336 and for payment purposes under § 412.340 or § 412.344, the discharge-weighted hospital-specific rate is compared to the Federal rate. The revised payment methodology is effective on the first day of the cost reporting period beginning after the end of the ''new'' campus'' base year.

(b) *Hospital merger or consolidation.* If, after the base year, two or more hospitals merge or consolidate into one hospital as provided for under § 413.134(k) of this chapter and are not subject to the provisions of paragraph (a) of this section, the intermediary determines a revised hospital-specific rate applicable to the combined facility under § 412.328, which is effective beginning with the date of merger or consolidation. * * *

(2) *Payment determination.* To determine the applicable payment methodology under § 412.336 and for payment purposes under § 412.340 or § 412.344, the discharge-weighted hospital-specific rate is compared to the Federal rate. * * *

* * * * *

C. Part 413 is amended as set forth below:

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; OPTIONAL PROSPECTIVELY DETERMINED PAYMENT FOR SKILLED NURSING FACILITIES

1. The authority citation for part 413 is revised to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (I) and (n), 1861(v), 1871, 1881, 1883, and 1866 of the Social Security Act (42 U.S.C. 1302, 1395f(b), 1395g, 1395l, 1395l(a), (I) and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww).

Subpart C—Limits on Cost Reimbursement

2. In § 413.40, paragraph (c)(4)(iv) is redesignated as paragraph (v), a new paragraph (iv) is added, and paragraph (g)(1) is revised to read as follows:

§ 413.40 Ceiling on the rate of increase in hospital inpatient costs.

* * * * *

(c) * * *

(4) * * *

(iv) For purposes of the limits on target amounts established under paragraph (c)(4)(iii) of this section, each hospital or unit that was excluded from the prospective payment system for its cost reporting period ending during FY 1996 will be classified in the same way (that is, as a psychiatric hospital or unit, or a long-term care hospital) as it was classified under subpart B of part 412 of this chapter for purposes of exclusion from prospective payment systems for its cost reporting period ending during FY 1996. If a hospital or unit was not excluded from the prospective payment system for a cost reporting period ending during FY 1996 but could qualify to be classified in more than one way under the exclusion criteria in subpart B of part 412 of this chapter, the hospital is assigned to the classification group that has the lowest limit on its target amounts.

* * * * *

(g) *Adjustments*—(1) *General rule.* HCFA may adjust the amount of the operating costs considered in establishing the rate-of-increase ceiling for one or more cost reporting periods, including both periods subject to the ceiling and the hospital's base period, under the circumstances specified below. When an adjustment is requested by the hospital, HCFA makes an adjustment only to the extent that the hospital's operating costs are reasonable, attributable to the circumstances specified separately identified by the hospital, and verified by the intermediary. HCFA may grant an adjustment requested by the hospital only if the hospital's operating costs exceed the rate-of-increase ceiling imposed under this section. In the case of a psychiatric hospital or unit, rehabilitation hospital or unit, or long term care hospital, the amount of payment made to a hospital after an adjustment under paragraph (g)(3) of this section may not exceed the 75th percentile of the target amounts for hospitals of the same class as described in § 413.40(c)(4)(iii).

Subpart F—Specific Categories of Costs

3. In § 413.80, paragraph (h) is redesignated as paragraph (i), and a new paragraph (h) is added to read as follows:

§ 413.80 Bad debts, charity, and courtesy allowances.

* * * * *

(h) *Limitations on bad debts.* In determining reasonable costs for hospitals, the amount of bad debts otherwise treated as allowable costs (as defined in paragraph (e) of this section) is reduced—

(1) For cost reporting periods beginning during fiscal year 1998, by 25 percent;

(2) For cost reporting periods beginning during fiscal year 1999, by 40 percent; and

(3) For cost reporting periods beginning during a subsequent fiscal year, by 45 percent.

* * * * *

4. In § 413.85, a new paragraph (h) is added to read as follows:

§ 413.85 Cost of educational activities.

* * * * *

(h) *Medicare+Choice organizations.* (1) Effective for that portion of cost reporting periods occurring on or after January 1, 1999, Medicare+Choice organizations may receive direct graduate medical education payments for the time that residents spend in nonhospital provider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs.

(2) Medicare+Choice organizations may receive direct graduate medical education payments if all of the following conditions are met—

(i) The resident spends his or her time in patient care activities.

(ii) The Medicare+Choice organization incurs ''all or substantially all'' of the costs for the training program in the nonhospital setting as defined in § 413.86(b).

(iii) There is a written agreement between the Medicare+Choice organization and the nonhospital provider that contains—

(A) A statement by the nonhospital provider that, all or substantially all of the direct graduate medical education costs as defined in paragraph (f)(1)(ii) of this section are being assumed by the Medicare+Choice organization;

(B) A statement that the nonhospital site agrees to offset the revenue received from the Medicare+Choice organization.

(C) A statement that the nonhospital site agrees to report its direct graduate medical education costs in a nonreimbursable cost center on its cost report; and

(D) A statement indicating how much time the teaching physicians will spend training residents in the nonhospital setting, subject to the provisions of §§ 415.60 and 415.70 of this chapter.

(3) A Medicare+Choice organization's allowable direct graduate medical education costs, subject to the redistribution and community support principles in § 413.85(c), consist of—

(i) Residents' salaries and fringe benefits (including travel and lodging where applicable); and

(ii) The portion of teaching physicians' salaries and fringe benefits that are related to the time spent in teaching and supervising residents.

(4) Allowable direct graduate medical education costs under paragraph (h)(3) of this section are subject to the reasonable cost principles of part 413 and the reasonable compensation equivalency limits in §§ 415.60 and 415.70 of this chapter.

(5) The direct graduate medical education payment is equal to the product of—

(i) The Medicare+Choice organization's allowable direct graduate medical education costs as defined in paragraph (h)(3) of this section; and

(ii) Medicare's share of the Medicare+Choice organization's direct graduate medical education payment in the nonhospital site which is equal to the ratio of the number of Medicare beneficiaries enrolled to the total number of individuals enrolled in the Medicare+Choice organization.

(6) Direct graduate medical education payments made to Medicare+Choice organizations under this section are made from the Federal Supplementary Medical Insurance Trust Fund.

* * * * *

5. In § 413.86, the introductory text of paragraph (b) is republished, a new definition in alphabetical order is added to paragraph (b), paragraphs (i) and (j) are redesignated as paragraphs (j) and (k) respectively, paragraph (f)(2) is redesignated as new paragraph (i), paragraphs (f)(2)(i) through (vii) are redesignated as paragraphs (i)(1) through (7) respectively, the introductory text of paragraph (f)(1) is redesignated as the introductory text of paragraph (f), paragraphs (f)(1)(i) through (iii) are redesignated as paragraphs (f)(1) through (3) respectively, paragraphs (f)(1)(iii)(A) and (B) are redesignated as (f)(3)(i) and (ii) respectively, new paragraph (f)(2) and the introductory text of new paragraph (f)(3) are revised, and a new paragraph (f)(4) is added to read as follows:

§ 413.86 Direct graduate medical education payments.

* * * * *

(b) *Definitions.* For purposes of this section, the following definitions apply:

* * * * *

All or substantially all of the costs for the training program in the nonhospital setting means the residents' salaries and fringe benefits (including travel and lodging where applicable) and the

portion of the cost of teaching physicians' salaries and fringe benefits.

* * * * *

(f) * * *

(2) No individual may be counted as more than one FTE. If a resident spends time in more than one hospital or, except as provided in paragraphs (f)(3) and (4) of this section, in a nonprovider setting, the resident counts as partial FTE based on the proportion of time worked at the hospital to the total time worked. A part-time resident counts as a partial FTE based on the proportion of allowable time worked compared to the total time necessary to fill a full-time internship or residency slot.

(3) On or after July 1, 1987 and for the portion of the cost reporting period ocurring before January 1, 1999, the time residents spend in nonprovider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs is not excluded in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met—

* * * * *

(4) On or after July 1, 1987 and for the portion cost reporting period occurring on or after January 1, 1999, the time residents spend in nonprovider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs is not excluded in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met—

(i) The resident spends his or her time in patient care activities.

(ii) The written agreement between the hospital and the nonhospital provider must contain—

(A) A statement by the nonhospital provider that, all or substantially all of the direct graduate medical education costs as defined in paragraph (b) of this section are being assumed by the hospital;

(B) A statement that the nonhospital site agrees to offset the revenue received from the hospital;

(C) A statement that the nonhospital site agrees to report its direct graduate medical education costs on its cost report in a graduate medical education cost center; and

(D) A statement indicating how much time the teaching physicians will spend training residents in the nonhospital setting, subject to the provisions of §§ 415.60 and 415.70 of this chapter.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance)

Dated: April 28, 1998.

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

Dated: May 1, 1998.

Donna E. Shalala,

Secretary.

[**Editorial Note:** The following addendum and appendixes will not appear in the Code of Federal Regulations.]

Addendum—Proposed Schedule of Standardized Amounts Effective With Discharges Occurring On or After October 1, 1998 and Update Factors and Rate-of-Increase Percentages Effective With Cost Reporting Periods Beginning On or After October 1, 1998

I. Summary and Background

In this addendum, we are setting forth the proposed amounts and factors for determining prospective payment rates for Medicare inpatient operating costs and Medicare inpatient capital-related costs. We are also setting forth proposed rate-of-increase percentages for updating the target amounts for hospitals and hospital units excluded from the prospective payment system.

For discharges occurring on or after October 1, 1998, except for sole community hospitals, Medicare-dependent, small rural hospitals, and hospitals located in Puerto Rico, each hospital's payment per discharge under the prospective payment system will be based on 100 percent of the Federal national rate.

Sole community hospitals are paid based on whichever of the following rates yield the greatest aggregate payment: The Federal national rate, the updated hospital-specific rate based on FY 1982 cost per discharge, or the updated hospital-specific rate based on FY 1987 cost per discharge. Medicare-dependent, small rural hospitals are paid based on the Federal national rate or, if higher, the Federal national rate plus 50 percent of the difference between the Federal national rate and the updated hospital-specific rate based on FY 1982 or FY 1987 cost per discharge, whichever is higher. For hospitals in Puerto Rico, the payment per discharge is based on the sum of 50 percent of a Puerto Rico rate and 50 percent of a national rate.

As discussed below in section II, we are proposing to make changes in the determination of the prospective payment rates for Medicare inpatient operating costs. The changes, to be applied prospectively, would affect the calculation of the Federal rates. In section III of this addendum, we discuss our proposed changes for determining the prospective payment rates for Medicare inpatient capital-related costs. Section IV of this addendum sets forth our proposed changes for determining the rate-of-increase limits for hospitals excluded from the prospective payment system. The tables to which we refer in the preamble to the proposed rule are presented at the end of this addendum in section V.

II. Proposed Changes to Prospective Payment Rates for Inpatient Operating Costs for FY 1999

The basic methodology for determining prospective payment rates for inpatient operating costs is set forth at § 412.63 for hospitals located outside of Puerto Rico. The basic methodology for determining the prospective payment rates for inpatient operating costs for hospitals located in Puerto Rico is set forth at §§ 412.210 and 412.212. Below, we discuss the proposed factors used for determining the prospective payment rates. The Federal and Puerto Rico rate changes, once issued as final, would be effective with discharges occurring on or after October 1, 1998. As required by section 1886(d)(4)(C) of the Act, we must also adjust the DRG classifications and weighting factors for discharges in FY 1999.

In summary, the proposed standardized amounts set forth in Tables 1A and 1C of section V of this addendum reflect—

- Updates of 0.7 percent for all areas (that is, the market basket percentage increase of 2.6 percent minus 1.9 percentage points);
- An adjustment to ensure budget neutrality as provided for in sections 1886(d)(4)(C)(iii) and (d)(3)(E) of the Act by applying new budget neutrality adjustment factors to the large urban and other standardized amounts;
- An adjustment to ensure budget neutrality as provided for in section 1886(d)(8)(D) of the Act by removing the FY 1998 budget neutrality factor and applying a revised factor;
- An adjustment to apply the revised outlier offset by removing the FY 1998 outlier offsets and applying a new offset; and
- An adjustment in the Puerto Rico standardized amounts to reflect the application of a Puerto Rico-specific wage index.

The standardized amounts set forth in Tables 1E and 1F of section V of this addendum, which apply to ''temporary relief'' hospitals (see 62 FR 46001 for a discussion of these hospitals), reflect updates of 1.0 percent for all areas but otherwise reflect the same adjustments

as the national standardized amounts. As described in § 412.107, these hospitals receive an update that is 0.3 percentage points more than the update factor applicable to all other prospective payment hospitals for FY 1999.

A. Calculation of Adjusted Standardized Amounts

1. Standardization of Base-Year Costs or Target Amounts

Section 1886(d)(2)(A) of the Act required the establishment of base-year cost data containing allowable operating costs per discharge of inpatient hospital services for each hospital. The preamble to the September 1, 1983 interim final rule (48 FR 39763) contains a detailed explanation of how base-year cost data were established in the initial development of standardized amounts for the prospective payment system and how they are used in computing the Federal rates.

Section 1886(d)(9)(B)(i) of the Act required that Medicare target amounts be determined for each hospital located in Puerto Rico for its cost reporting period beginning in FY 1987. The September 1, 1987 final rule contains a detailed explanation of how the target amounts were determined and how they are used in computing the Puerto Rico rates (52 FR 33043, 33066).

The standardized amounts are based on per discharge averages of adjusted hospital costs from a base period or, for Puerto Rico, adjusted target amounts from a base period, updated and otherwise adjusted in accordance with the provisions of section 1886(d) of the Act. Sections 1886(d)(2)(B) and (C) of the Act required that the base-year per discharge costs be updated for FY 1984 and then standardized in order to remove from the cost data the effects of certain sources of variation in cost among hospitals. These include case mix, differences in area wage levels, cost of living adjustments for Alaska and Hawaii, indirect medical education costs, and payments to hospitals serving a disproportionate share of low-income patients.

Under sections 1886(d)(2)(H) and (d)(3)(E) of the Act, in making payments under the prospective payment system, the Secretary estimates from time to time the proportion of costs that are wages and wage-related costs. Since October 1, 1997, when the market basket was last revised, we have considered 71.1 percent of costs to be labor-related for purposes of the prospective payment system. We are revising the Puerto Rico standardized amounts by the average labor share in Puerto Rico of 71.3 percent. We are revising the discharge-weighted national standardized amount for Puerto Rico to reflect the proportion of discharges in large urban and other areas from the FY 1997 MedPAR file.

2. Computing Large Urban and Other Area Averages

Sections 1886(d) (2)(D) and (3) of the Act require the Secretary to compute two average standardized amounts for discharges occurring in a fiscal year: One for hospitals located in large urban areas and one for hospitals located in other areas. In addition, under sections 1886(d)(9)(B)(iii) and (C)(i) of the Act, the average standardized amount per discharge must be determined for hospitals located in urban and other areas in Puerto Rico. Hospitals in Puerto Rico are paid a blend of 50 percent of the applicable Puerto Rico standardized amount and 50 percent of a national standardized payment amount.

Section 1886(d)(2)(D) of the Act defines ''urban area'' as those areas within a Metropolitan Statistical Area (MSA). A ''large urban area'' is defined as an urban area with a population of more than 1,000,000. In addition, section 4009(i) of Public Law 100–203 provides that a New England County Metropolitan Area (NECMA) with a population of more than 970,000 is classified as a large urban area. As required by section 1886(d)(2)(D) of the Act, population size is determined by the Secretary based on the latest population data published by the Bureau of the Census. Urban areas that do not meet the definition of a ''large urban area'' are referred to as ''other urban areas.'' Areas that are not included in MSAs are considered ''rural areas'' under section 1886(d)(2)(D) of the Act. Payment for discharges from hospitals located in large urban areas will be based on the large urban standardized amount. Payment for discharges from hospitals located in other urban and rural areas will be based on the other standardized amount.

Based on 1996 population estimates published by the Bureau of the Census, 60 areas meet the criteria to be defined as large urban areas for FY 1999. These areas are identified by a footnote in Table 4A.

3. Updating the Average Standardized Amounts

Under section 1886(d)(3)(A) of the Act, we update the area average standardized amounts each year. In accordance with section 1886(d)(3)(A)(iv) of the Act, we are proposing to update the large urban and the other areas average standardized amounts for FY 1999 using the applicable percentage increases specified in section 1886(b)(3)(B)(i) of the Act. Section 1886(b)(3)(B)(i)(XIV) of the Act specifies that, for hospitals in all areas, the update factor for the standardized amounts for FY 1999 is equal to the market basket percentage increase minus 1.9 percentage points. The ''temporary relief'' provision under section 4401 of Public Law 105–33 provides for an update equal to the market basket percentage increase minus 1.6 percentage points for hospitals that are not Medicare-dependent, small rural hospitals, that receive no IME or DSH payments, that are located in a state in which aggregate Medicare operating payments for such hospitals were less than their aggregate allowable Medicare operating costs for their cost reporting periods beginning during FY 1995, and whose Medicare operating payments are less than their allowable Medicare operating costs for their cost reporting period beginning during FY 1999.

The percentage change in the market basket reflects the average change in the price of goods and services purchased by hospitals to furnish inpatient care. The most recent forecast of the proposed hospital market basket increase for FY 1999 is 2.6 percent. Thus, for FY 1999, the proposed update to the average standardized amounts equals 0.7 percent (1.0 percent for those hospitals qualifying under the ''temporary relief'' provision of Public Law 105–33).

As in the past, we are adjusting the FY 1998 standardized amounts to remove the effects of the FY 1998 geographic reclassifications and outlier payments before applying the FY 1999 updates. That is, we are increasing the standardized amounts to restore the reductions that were made for the effects of geographic reclassification and outliers. We then apply the new offsets to the standardized amounts for outliers and geographic reclassifications for FY 1999.

Although the update factor for FY 1999 is set by law, we are required by section 1886(e)(3) of the Act to report to Congress on our initial recommendation of update factors for FY 1999 for both prospective payment hospitals and hospitals excluded from the prospective payment system. For general information purposes, we have included the report to Congress as Appendix C to this proposed rule. Our proposed recommendation on the update factors (which is required by sections 1886(e)(4)(A) and (e)(5)(A) of the Act), as well as our responses to MedPAC's recommendation concerning the update factor, are set forth as Appendix D to this proposed rule.

4. Other Adjustments to the Average Standardized Amounts

a. Recalibration of DRG Weights and Updated Wage Index—Budget Neutrality Adjustment. Section 1886(d)(4)(C)(iii) of the Act specifies that beginning in FY 1991, the annual DRG reclassification and recalibration of the relative weights must be made in a manner that ensures that aggregate payments to hospitals are not affected. As discussed in section II of the preamble, we normalized the recalibrated DRG weights by an adjustment factor, so that the average case weight after recalibration is equal to the average case weight prior to recalibration.

Section 1886(d)(3)(E) of the Act specifies that the hospital wage index must be updated on an annual basis beginning October 1, 1993. This provision also requires that any updates or adjustments to the wage index must be made in a manner that ensures that aggregate payments to hospitals are not affected by the change in the wage index.

To comply with the requirement of section 1886(d)(4)(C)(iii) of the Act that DRG reclassification and recalibration of the relative weights be budget neutral, and the requirement in section 1886(d)(3)(E) of the Act that the updated wage index be budget neutral, we used historical discharge data to simulate payments and compared aggregate payments using the FY 1998 relative weights and wage index to aggregate payments using the proposed FY 1999 relative weights and wage index. The same methodology was used for the FY 1998 budget neutrality adjustment. (See the discussion in the September 1, 1992 final rule (57 FR 39832).) Based on this comparison, we computed a budget neutrality adjustment factor equal to 0.999227. We adjust the Puerto Rico-specific standardized amounts for the effect of DRG reclassification and recalibration. We computed a budget neutrality adjustment factor for Puerto Rico-specific standardized amounts equal to 0.998946. These budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the FY 1998 budget neutrality adjustments. We do not remove the prior budget neutrality adjustment because estimated aggregate payments after the changes in the DRG relative weights and wage index should equal estimated aggregate payments prior to the changes. If we removed the prior year adjustment, we would not satisfy this condition.

In addition, we are proposing to continue to apply the same FY 1999 adjustment factor to the hospital-specific rates that are effective for cost reporting periods beginning on or after October 1, 1998, in order to ensure that we meet the statutory requirement that aggregate payments neither increase nor decrease as a result of the implementation of the FY 1999 DRG weights and updated wage index. (See the discussion in the September 4, 1990 final rule (55 FR 36073).)

b. Reclassified Hospitals—Budget Neutrality Adjustment. Section 1886(d)(8)(B) of the Act provides that certain rural hospitals are deemed urban effective with discharges occurring on or after October 1, 1988. In addition, section 1886(d)(10) of the Act provides for the reclassification of hospitals based on determinations by the Medicare Geographic Classification Review Board (MGCRB). Under section 1886(d)(10) of the Act, a hospital may be reclassified for purposes of the standardized amount or the wage index, or both.

Under section 1886(d)(8)(D) of the Act, the Secretary is required to adjust the standardized amounts so as to ensure that total aggregate payments under the prospective payment system after implementation of the provisions of sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act are equal to the aggregate prospective payments that would have been made absent these provisions. To calculate this budget neutrality factor, we used historical discharge data to simulate payments, and compared total prospective payments (including IME and DSH payments) prior to any reclassifications to total prospective payments after reclassifications. We are applying an adjustment factor of 0.994019 to ensure that the effects of reclassification are budget neutral.

The adjustment factor is applied to the standardized amounts after removing the effects of the FY 1998 budget neutrality adjustment factor. We note that the proposed FY 1999 adjustment reflects wage index and standardized amount reclassifications approved by the MGCRB or the Administrator as of February 27, 1998. The effects of any additional reclassification changes resulting from appeals and reviews of the MGCRB decisions for FY 1999 or from a hospital's request for the withdrawal of a reclassification request will be reflected in the final budget neutrality adjustment required under section 1886(d)(8)(D) of the Act and published in the final rule for FY 1999.

c. Outliers. Section 1886(d)(5)(A) of the Act provides for payments in addition to the basic prospective payments for ''outlier'' cases, cases involving extraordinarily high costs (cost outliers). Section 1886(d)(3)(B) of the Act requires the Secretary to adjust both the large urban and other area national standardized amounts by the same factor to account for the estimated proportion of total DRG payments made to outlier cases. Similarly, section 1886(d)(9)(B)(iv) of the Act requires the Secretary to adjust the large urban and other standardized amounts applicable to hospitals in Puerto Rico to account for the estimated proportion of total DRG payments made to outlier cases. Furthermore, under section 1886(d)(5)(A)(iv) of the Act, outlier payments for any year must be projected to be not less than 5 percent nor more than 6 percent of total payments based on DRG prospective payment rates.

For FY 1998, the fixed loss cost outlier threshold is equal to the prospective payment for the DRG plus $11,050 ($10,080 for hospitals that have not yet entered the prospective payment system for capital-related costs). The marginal cost factor for cost outliers (the percent of costs paid after costs for the case exceed the threshold) is 80 percent. We applied an outlier adjustment to the FY 1998 standardized amounts of 0.948840 for the large urban and other areas rates and 0.9382 for the capital Federal rate.

We are proposing a fixed loss cost outlier threshold in FY 1999 equal to the prospective payment rate for the DRG plus $11,350 ($10,355 for hospitals that have not yet entered the prospective payment system for capital-related costs). In addition, we are proposing to maintain the marginal cost factor for cost outliers at 80 percent.

In accordance with section 1886(d)(5)(A)(iv) of the Act, we calculated proposed outlier thresholds so that outlier payments are projected to equal 5.1 percent of total payments based on DRG prospective payment rates. In accordance with section 1886(d)(3)(E), we reduced the proposed FY 1999 standardized amounts by the same percentage to account for the projected proportion of payments paid to outliers.

As stated in the September 1, 1993 final rule (58 FR 46348), we establish outlier thresholds that are applicable to both inpatient operating costs and inpatient capital-related costs. When we modeled the combined operating and capital outlier payments, we found that using a common set of thresholds resulted in a higher percentage of outlier payments for capital-related costs than for operating costs. We project that the proposed thresholds for FY 1999 will result in outlier payments equal to 5.1

percent of operating DRG payments and 6.2 percent of capital payments based on the Federal rate.

The proposed outlier adjustment factors applied to the standardized amounts for FY 1999 are as follows:

	Operating standardized amounts	Capital federal rate
National	0.948819	0.9378
Puerto Rico	0.972962	0.9626

We apply the proposed outlier adjustment factors after removing the effects of the FY 1998 outlier adjustment factors on the standardized amounts.

Table 8A in section V of this addendum contains the updated Statewide average operating cost-to-charge ratios for urban hospitals and for rural hospitals to be used in calculating cost outlier payments for those hospitals for which the intermediary is unable to compute a reasonable hospital-specific cost-to-charge ratio. These Statewide average ratios would replace the ratios published in the August 29, 1997 final rule with comment period (62 FR 46113), effective October 1, 1998. Table 8B contains comparable Statewide average capital cost-to-charge ratios. These average ratios would be used to calculate cost outlier payments for those hospitals for which the intermediary computes operating cost-to-charge ratios lower than 0.217279 or greater than 1.28985 and capital cost-to-charge ratios lower than 0.01281 or greater than 0.18084. This range represents 3.0 standard deviations (plus or minus) from the mean of the log distribution of cost-to-charge ratios for all hospitals. We note that the cost-to-charge ratios in Tables 8A and 8B would be used during FY 1999 when hospital-specific cost-to-charge ratios based on the latest settled cost report are either not available or outside the three standard deviations range.

In the August 29, 1997 final rule with comment period (62 FR 46041), we stated that, based on available data, we estimated that actual FY 1997 outlier payments would be approximately 4.8 percent of actual total DRG payments. This was computed by simulating payments using actual FY 1996 bill data available at the time. That is, the estimate of actual outlier payments did not reflect actual FY 1997 bills but instead reflected the application of FY 1997 rates and policies to available FY 1996 bills. Our current estimate, using available FY 1997 bills, is that actual outlier payments for FY 1997 were approximately 5.5 percent of actual total DRG payments. We note that the MedPAR file for FY 1997 discharges continues to be updated.

We currently estimate that actual outlier payments for FY 1998 will be approximately 5.4 percent of actual total DRG payments, slightly higher than the 5.1 percent we projected in setting outlier policies for FY 1998. This estimate is based on simulations using the December 1997 update of the provider-specific file and the December 1997 update of the FY 1997 MedPAR file (discharge data for FY 1997 bills). We used these data to calculate an estimate of the actual outlier percentage for FY 1998 by applying FY 1998 rates and policies to available FY 1997 bills.

In FY 1994, we began using a cost inflation factor rather than a charge inflation factor to update billed charges for purposes of estimating outlier payments. This refinement was made to improve our estimation methodology. For FY 1998, we used a cost inflation factor of minus 2.005 percent (a cost per case decrease of 2.005 percent). For FY 1999, based on more recent data, we are proposing a cost inflation factor of minus 1.831 percent to set outlier thresholds. We will reevaluate this factor when we develop the final rule for FY 1999. At that time, more recent data should be available for analysis, specifically, cost report data for cost reporting periods beginning in FY 1997.

5. FY 1999 Standardized Amounts

The adjusted standardized amounts are divided into labor and nonlabor portions. Table 1A (Table 1E for ''temporary relief'' hospitals) contains the two national standardized amounts that we are proposing to be applicable to all hospitals, except for hospitals in Puerto Rico. Under section 1886(d)(9)(A)(ii) of the Act, the Federal portion of the Puerto Rico payment rate is based on the discharge-weighted average of the national large urban standardized amount and the national other standardized amount (as set forth in Table 1A and 1E). The labor and nonlabor portions of the national average standardized amounts for Puerto Rico hospitals are set forth in Table 1C (Table 1F for ''temporary relief'' hospitals). These tables also include the Puerto Rico standardized amounts.

B. Adjustments for Area Wage Levels and Cost of Living

Tables 1A, 1C, 1E and 1F, as set forth in this addendum, contain the proposed labor-related and nonlabor-related shares that would be used to calculate the prospective payment rates for hospitals located in the 50 States, the District of Columbia, and Puerto Rico. This section addresses two types of adjustments to the standardized amounts that are made in determining the prospective payment rates as described in this addendum.

1. Adjustment for Area Wage Levels

Sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act require that an adjustment be made to the labor-related portion of the prospective payment rates to account for area differences in hospital wage levels. This adjustment is made by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. In section III of the preamble, we discuss certain revisions we are making to the wage index. The wage index is set forth in Tables 4A through 4F of this addendum.

2. Adjustment for Cost of Living in Alaska and Hawaii

Section 1886(d)(5)(H) of the Act authorizes an adjustment to take into account the unique circumstances of hospitals in Alaska and Hawaii. Higher labor-related costs for these two States are taken into account in the adjustment for area wages described above. For FY 1999, we propose to adjust the payments for hospitals in Alaska and Hawaii by multiplying the nonlabor portion of the standardized amounts by the appropriate adjustment factor contained in the table below. If the Office of Personnel Management releases revised cost-of-living adjustment factors before July 1, 1998, we will publish them in the final rule and use them in determining FY 1999 payments.

TABLE OF COST-OF-LIVING ADJUSTMENT FACTORS, ALASKA AND HAWAII HOSPITALS

Alaska—All areas	1.25
Hawaii:	
County of Honolulu	1.225
County of Hawaii	1.15
County of Kauai	1.225
County of Maui	1.225
County of Kalawao	1.225

(The above factors are based on data obtained from the U.S. Office of Personnel Management.)

C. DRG Relative Weights

As discussed in section II of the preamble, we have developed a classification system for all hospital discharges, assigning them into DRGs, and have developed relative weights for each DRG that reflect the resource utilization of cases in each DRG relative

to Medicare cases in other DRGs. Table 5 of section V of this addendum contains the relative weights that we propose to use for discharges occurring in FY 1999. These factors have been recalibrated as explained in section II of the preamble.

D. Calculation of Prospective Payment Rates for FY 1999

General Formula for Calculation of Prospective Payment Rates for FY 1999

Prospective payment rate for all hospitals located outside of Puerto Rico except sole community hospitals and Medicare-dependent, small rural hospitals = Federal rate.

Prospective payment rate for sole community hospitals = Whichever of the following rates yields the greatest aggregate payment: 100 percent of the Federal rate, 100 percent of the updated FY 1982 hospital-specific rate, or 100 percent of the updated FY 1987 hospital-specific rate.

Prospective payment rate for Medicare-dependent, small rural hospitals = 100 percent of the Federal rate plus, if the greater of the updated FY 1982 hospital-specific rate or the updated FY 1987 hospital-specific rate is higher than the Federal rate, 50 percent of the difference between the applicable hospital-specific rate and the Federal rate.

Prospective payment rate for Puerto Rico = 50 percent of the Puerto Rico rate + 50 percent of a discharge-weighted average of the national large urban standardized amount and the national other standardized amount.

1. Federal Rate

For discharges occurring on or after October 1, 1998 and before October 1, 1999, except for sole community hospitals, Medicare-dependent, small rural hospitals, and hospitals in Puerto Rico, the hospital's payment is based exclusively on the Federal national rate.

The payment amount is determined as follows:

Step 1—Select the appropriate national standardized amount considering the type of hospital and designation of the hospital as large urban or other (see Tables 1A or 1E, in section V of this addendum).

Step 2—Multiply the labor-related portion of the standardized amount by the applicable wage index for the geographic area in which the hospital is located (see Tables 4A, 4B, and 4C of section V of this addendum).

Step 3—For hospitals in Alaska and Hawaii, multiply the nonlabor-related portion of the standardized amount by the appropriate cost-of-living adjustment factor.

Step 4—Add the amount from Step 2 and the nonlabor-related portion of the standardized amount (adjusted if appropriate under Step 3).

Step 5—Multiply the final amount from Step 4 by the relative weight corresponding to the appropriate DRG (see Table 5 of section V of this addendum).

2. Hospital-Specific Rate (Applicable Only to Sole Community Hospitals and Medicare-Dependent, Small Rural Hospitals)

Sections 1886(d)(5)(D)(i) and (b)(3)(C) of the Act provide that sole community hospitals are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal rate, the updated hospital-specific rate based on FY 1982 cost per discharge, or the updated hospital-specific rate based on FY 1987 cost per discharge.

Sections 1886(d)(5)(G) and (b)(3)(D) of the Act provide that Medicare-dependent, small rural hospitals are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal rate or the Federal rate plus 50 percent of the difference between the Federal rate and the greater of the updated hospital-specific rate based on FY 1982 and FY 1987 cost per discharge.

Hospital-specific rates have been determined for each of these hospitals based on both the FY 1982 cost per discharge and the FY 1987 cost per discharge. For a more detailed discussion of the calculation of the FY 1982 hospital-specific rate and the FY 1987 hospital-specific rate, we refer the reader to the September 1, 1983 interim final rule (48 FR 39772); the April 20, 1990 final rule with comment (55 FR 15150); and the September 4, 1990 final rule (55 FR 35994).

a. Updating the FY 1982 and FY 1987 Hospital-Specific Rates for FY 1999. We are proposing to increase the hospital-specific rates by 0.7 percent (the hospital market basket percentage increase of 2.6 percent minus 1.9 percentage points) for sole community hospitals and Medicare-dependent, small rural hospitals located in all areas for FY 1999. Section 1886(b)(3)(C)(iv) of the Act provides that the update factor applicable to the hospital-specific rates for sole community hospitals equals the update factor provided under section 1886(b)(3)(B)(iv) of the Act, which, for FY 1999, is the market basket rate of increase minus 1.9 percentage points. Section 1886(b)(3)(D) of the Act provides that the update factor applicable to the hospital-specific rates for Medicare-dependent, small rural hospitals equals the update factor provided under section 1886(b)(3)(B)(iv) of the Act, which, for FY 1999, is the market basket rate of increase minus 1.9 percentage points.

b. Calculation of Hospital-Specific Rate. For sole community hospitals and Medicare-dependent, small rural hospitals, the applicable FY 1999 hospital-specific rate would be calculated by increasing the hospital's hospital-specific rate for the preceding fiscal year by the applicable update factor (0.7 percent), which is the same as the update for all prospective payment hospitals except ''temporary relief'' hospitals. In addition, the hospital-specific rate would be adjusted by the budget neutrality adjustment factor (that is, 0.999227) as discussed in section II.A.4.a of this Addendum. This resulting rate would be used in determining under which rate a sole community hospital or Medicare-dependent, small rural hospital is paid for its discharges beginning on or after October 1, 1998, based on the formula set forth above.

3. General Formula for Calculation of Prospective Payment Rates for Hospitals Located in Puerto Rico Beginning On or After October 1, 1998 and Before October 1, 1999.

a. Puerto Rico Rate. The Puerto Rico prospective payment rate is determined as follows:

Step 1—Select the appropriate adjusted average standardized amount considering the large urban or other designation of the hospital (see Table 1C or 1F of section V of the addendum).

Step 2—Multiply the labor-related portion of the standardized amount by the appropriate Puerto Rico-specific wage index (see Table 4F of section V of the addendum).

Step 3—Add the amount from Step 2 and the nonlabor-related portion of the standardized amount.

Step 4—Multiply the result in Step 3 by 50 percent.

Step 5—Multiply the amount from Step 4 by the appropriate DRG relative weight (see Table 5 of section V of the addendum).

b. National Rate. The national prospective payment rate is determined as follows:

Step 1—Multiply the labor-related portion of the national average standardized amount (see Table 1C or 1F of section V of the addendum) by the appropriate national wage index (see Tables 4A and 4B of section V of the addendum).

Step 2—Add the amount from Step 1 and the nonlabor-related portion of the national average standardized amount.

Step 3—Multiply the result in Step 2 by 50 percent.

Step 4—Multiply the amount from Step 3 by the appropriate DRG relative weight (see Table 5 of section V of the addendum).

The sum of the Puerto Rico rate and the national rate computed above equals the prospective payment for a given discharge for a hospital located in Puerto Rico.

III. Proposed Changes to Payment Rates for Inpatient Capital-Related Costs for FY 1999

The prospective payment system for hospital inpatient capital-related costs was implemented for cost reporting periods beginning on or after October 1, 1991. Effective with that cost reporting period and during a 10-year transition period extending through FY 2001, hospital inpatient capital-related costs are paid on the basis of an increasing proportion of the capital prospective payment system Federal rate and a decreasing proportion of a hospital's historical costs for capital.

The basic methodology for determining Federal capital prospective rates is set forth at §§ 412.308 through 412.352. Below we discuss the factors that we used to determine the proposed Federal rate and the hospital-specific rates for FY 1999. The rates will be effective for discharges occurring on or after October 1, 1998.

For FY 1992, we computed the standard Federal payment rate for capital-related costs under the prospective payment system by updating the FY 1989 Medicare inpatient capital cost per case by an actuarial estimate of the increase in Medicare inpatient capital costs per case. Each year after FY 1992 we update the standard Federal rate, as provided in § 412.308(c)(1), to account for capital input price increases and other factors. Also, § 412.308(c)(2) provides that the Federal rate is adjusted annually by a factor equal to the estimated proportion of outlier payments under the Federal rate to total capital payments under the Federal rate. In addition, § 412.308(c)(3) requires that the Federal rate be reduced by an adjustment factor equal to the estimated proportion of payments for exceptions under § 412.348. Furthermore, § 412.308(c)(4)(ii) requires that the Federal rate be adjusted so that the annual DRG reclassification and the recalibration of DRG weights and changes in the geographic adjustment factor are budget neutral. For FYs 1992 through 1995, § 412.352 required that the Federal rate also be adjusted by a budget neutrality factor so that aggregate payments for inpatient hospital capital costs were projected to equal 90 percent of the payments that would have been made for capital-related costs on a reasonable cost basis during the fiscal year. That provision expired in FY 1996. Section 412.308(b)(2) describes the 7.4 percent reduction to the rate which was made in FY 1994, and § 412.308(b)(3) describes the 0.28 percent reduction to the rate made in FY 1996 as a result of the revised policy of paying for transfers. In the FY 1998 final rule with comment period (62 FR 45966) we implemented section 4402 of the BBA, which required that for discharges occurring on or after October 1, 1997, and before October 1, 2002, the unadjusted standard Federal rate was reduced by 17.78 percent. A small part of that reduction will be restored effective October 1, 2002.

For each hospital, the hospital-specific rate was calculated by dividing the hospital's Medicare inpatient capital-related costs for a specified base year by its Medicare discharges (adjusted for transfers), and dividing the result by the hospital's case mix index (also adjusted for transfers). The resulting case-mix adjusted average cost per discharge was then updated to FY 1992 based on the national average increase in Medicare's inpatient capital cost per discharge and adjusted by the exceptions payment adjustment factor and the budget neutrality adjustment factor to yield the FY 1992 hospital-specific rate. Since FY 1992, the hospital-specific rate has been updated annually for inflation and for changes in the exceptions payment adjustment factor. For FYs 1992 through 1995, the hospital-specific rate was also adjusted by a budget neutrality adjustment factor. In the FY 1998 final rule with comment period (62 FR 46012) we implemented section 4402 of the BBA, which required that for discharges occurring on or after October 1, 1997, and before October 1, 2002, the unadjusted hospital-specific rate should be reduced by 17.78 percent. A small part of that reduction will also be restored effective October 1, 2002.

To determine the appropriate budget neutrality adjustment factor and the exceptions payment adjustment factor, we developed a dynamic model of Medicare inpatient capital-related costs, that is, a model that projects changes in Medicare inpatient capital-related costs over time. With the expiration of the budget neutrality provision, the model is still used to estimate the exceptions payment adjustment and other factors. The model and its application are described in greater detail in Appendix B of this proposed rule.

In accordance with section 1886(d)(9)(A) of the Act, under the prospective payment system for inpatient operating costs, hospitals located in Puerto Rico are paid for operating costs under a special payment formula. Prior to FY 1998, hospitals in Puerto Rico were paid a blended rate that consisted of 75 percent of the applicable standardized amount specific to Puerto Rico hospitals and 25 percent of the applicable national average standardized amount. However, effective October 1, 1998, as a result of section 4406 of the BBA, operating payments to hospitals in Puerto Rico are based on a blend of 50 percent of the applicable standardized amount specific to Puerto Rico hospitals and 50 percent of the applicable national average standardized amount. In conjunction with this change to the operating blend percentage, effective with discharges on or after October 1, 1997, we compute capital payments to hospitals in Puerto Rico based on a blend of 50 percent of the Puerto Rico rate and 50 percent of the Federal rate. Section 412.374 provides for the use of this blended payment system for payments to Puerto Rico hospitals under the prospective payment system for inpatient capital-related costs. Accordingly, for capital-related costs we compute a separate payment rate specific to Puerto Rico hospitals using the same methodology used to compute the national Federal rate for capital.

A. Determination of Federal Inpatient Capital-Related Prospective Payment Rate Update

For FY 1998, the Federal rate is $371.51. With the changes we are proposing to the factors used to establish the Federal rate, the proposed FY 1999 Federal rate is $377.25.

In the discussion that follows, we explain the factors that were used to determine the proposed FY 1999 Federal rate. In particular, we explain why the proposed FY 1999 Federal rate has increased 1.55 percent compared to the FY 1998 Federal rate. Even though we estimate that Medicare hospital inpatient discharges will decline by approximately 2.25 between FY 1998 and FY 1999, we also estimate that aggregate capital payments will increase by 2.60 percent during this same period. This aggregate increase is primarily due to the change in the federal rate blend percentage from 70 percent to 80 percent, the 1.55 percent increase in the rate, and a projected increase in case mix.

The major factor contributing to the increase in the proposed capital Federal rate for FY 1999 relative to FY 1998 is

that the proposed FY 1999 exceptions reduction factor is 1.06 percent higher than the factor for FY 1998. The exceptions reduction factor equals 1 minus the projected percentage of exceptions payments. We estimate that the projected percentage of exceptions payments for FY 1999 will be lower than the projected percentage for FY 1998; accordingly, the proposed FY 1999 rate reflects less of a reduction to account for exceptions than the FY 1998 rate.

Total payments to hospitals under the prospective payment system are relatively unaffected by changes in the capital prospective payments. Since capital payments constitute about 10 percent of hospital payments, a 1 percent change in the capital Federal rate yields only about 0.1 percent change in actual payments to hospitals. Aggregate payments under the capital prospective payment transition system are estimated to increase in FY 1999 compared to FY 1998.

1. Standard Federal Rate Update

a. Description of the Update Framework. Under section 412.308(c)(1), the standard Federal rate is updated on the basis of an analytical framework that takes into account changes in a capital input price index and other factors. The update framework consists of a capital input price index (CIPI) and several policy adjustment factors. Specifically, we have adjusted the projected CIPI rate of increase as appropriate each year for case-mix index related changes, for intensity, and for errors in previous CIPI forecasts. The proposed update factor for FY 1999 under that framework is 0.2 percent. This proposal is based on a projected 0.8 percent increase in the CIPI, policy adjustment factors of -0.2, and a forecast error correction of −0.4 percent. We explain the basis for the FY 1999 CIPI projection in section II.D of this addendum. Here we describe the policy adjustments.

The case-mix index is the measure of the average DRG weight for cases paid under the prospective payment system. Because the DRG weight determines the prospective payment for each case, any percentage increase in the case-mix index corresponds to an equal percentage increase in hospital payments.

The case-mix index can change for any of several reasons:

- The average resource use of Medicare patients changes (''real'' case-mix change);
- Changes in hospital coding of patient records result in higher weight DRG assignments (''coding effects''); and
- The annual DRG reclassification and recalibration changes may not be budget neutral (''reclassification effect'').

We define real case-mix change as actual changes in the mix (and resource requirements) of Medicare patients as opposed to changes in coding behavior that result in assignment of cases to higher-weighted DRGs but do not reflect higher resource requirements. In the update framework for the prospective payment system for operating costs, we adjust the update upwards to allow for real case-mix change, but remove the effects of coding changes on the case-mix index. We also remove the effect on total payments of prior changes to the DRG classifications and relative weights, in order to retain budget neutrality for all case-mix index-related changes other than patient severity. (For example, we adjusted for the effects of the FY 1992 DRG reclassification and recalibration as part of our FY 1994 update recommendation.) The operating adjustment consists of a reduction for total observed case-mix change, an increase for the portion of case-mix change that we determine is due to real case-mix change rather than coding modifications, and an adjustment for the effect of prior DRG reclassification and recalibration changes. We have adopted this case-mix index adjustment in the capital update framework as well.

For FY 1999, we are projecting a 1.0 percent increase in the case-mix index. We estimate that real case-mix increase will equal 0.8 percent in FY 1999. Therefore, the proposed net adjustment for case-mix change in FY 1999 is -0.2 percentage points.

We estimate that DRG reclassification and recalibration result in a 0.0 percent change in the case mix when compared with the case-mix index that would have resulted if we had not made the reclassification and recalibration changes to the DRGs.

The capital update framework contains an adjustment for forecast error. The input price index forecast is based on historical trends and relationships ascertainable at the time the update factor is established for the upcoming year. In any given year there may be unanticipated price fluctuations that may result in differences between the actual increase in prices faced by hospitals and the forecast used in calculating the update factors. In setting a prospective payment rate under the proposed framework, we make an adjustment for forecast error only if our estimate of the capital input price index rate of increase for any year is off by 0.25 percentage points or more. There is a 2-year lag between the forecast and the measurement of the forecast error. Thus, for example, we would adjust for a forecast error made in FY 1997 through an adjustment to the FY 1999 update. Because we only introduced this analytical framework in FY 1996, FY 1998 was the first year in which a forecast error adjustment could be required. We estimate that the FY 1997 CIPI was 0.4 percentage points higher than our current data show, which means that we estimate a forecast error of -0.4 percentage points for FY 1997. Therefore we are making an -0.4 percent adjustment for forecast error in FY 1999.

Under the capital prospective payment system framework, we also make an adjustment for changes in intensity. We calculate this adjustment using the same methodology and data as in the framework for the operating prospective payment system. The intensity factor for the operating update framework reflects how hospital services are utilized to produce the final product, that is, the discharge. This component accounts for changes in the use of quality-enhancing services, changes in within-DRG severity, and expected modification of practice patterns to remove cost-ineffective services.

We calculate case-mix constant intensity as the change in total charges per admission, adjusted for price level changes (the CPI hospital component), and changes in real case mix. The use of total charges in the calculation of the proposed intensity factor makes it a total intensity factor, that is, charges for capital services are already built into the calculation of the factor. We have, therefore, incorporated the intensity adjustment from the operating update framework into the capital update framework. Without reliable estimates of the proportions of the overall annual intensity increases that are due, respectively, to ineffective practice patterns and to the combination of quality-enhancing new technologies and within-DRG complexity, we assume, as in the revised operating update framework, that one-half of the annual increase is due to each of these factors. The capital update framework thus provides an add-on to the input price index rate of increase of one-half of the estimated annual increase in intensity to allow for within-DRG severity increases and the adoption of quality-enhancing technology.

For FY 1999, we have developed a Medicare-specific intensity measure based on a 5-year average using FY 1993–1997 data. In determining case-mix constant intensity, we found that observed case-mix increase was 0.9 percent in FY 1993, 0.8 percent in FY

1994, 1.7 percent in FY 1995, 1.6 percent in FY 1996, and 0.3 percent in FY 1997. For FY 1995 and FY 1996, we estimate that real case-mix increase was 1.0 to 1.4 percent each year. The estimate for those years is supported by past studies of case-mix change by the RAND Corporation. The most recent study was ''Has DRG Creep Crept Up? Decomposing the Case Mix Index Change Between 1987 and 1988'' by G. M. Carter, J. P. Newhouse, and D. A. Relles, R–4098–HCFA/ProPAC(1991). The study suggested that real case-mix change was not dependent on total change, but was usually a fairly steady 1.0 to 1.5 percent per year. We use 1.4 percent as the upper bound because the RAND study did not take into account that hospitals may have induced doctors to document medical records more completely in order to improve payment. Following that study, we consider up to 1.4 percent of observed case-mix change as real for FY 1992 through FY 1997. Based on this analysis, we believe that all of the observed case-mix increase for FY 1993, FY 1994 and FY 1997 is real.

We calculate case-mix constant intensity as the change in total charges per admission, adjusted for price level changes (the CPI hospital component), and changes in real case-mix. Given estimates of real case mix of 0.9 percent for FY 1993, 0.8 percent for FY 1994, 1.0 percent for FY 1995, and 1.0 percent for FY 1996, and 0.3 percent for FY 1997, we estimate that case-mix constant intensity declined by an average 1.5 percent during FYs 1993 through 1997, for a cumulative decrease of 7.3 percent. If we assume that real case-mix increase was 0.9 percent for FY 1993, 0.8 percent for FY 1994, 1.4 percent for FY 1995, 1.4 percent for FY 1996 and 0.3 percent for FY 1997, we estimate that case-mix constant intensity declined by an average 1.6 percent during FYs 1993 through 1997, for a cumulative decrease of 7.7 percent. Since we estimate that intensity has declined during that period, we are recommending a 0.0 percent intensity adjustment for FY 1999.

b. Comparison of HCFA and MedPAC Update Recommendations. MedPAC recommends a 0.0 to 0.7 percent update to the standard Federal rate and we are recommending a 0.2 percent update. There are some significant differences between the HCFA and MedPAC update frameworks, which account for the difference in the respective update recommendations. A major difference is the input price index which each framework uses as a beginning point to estimate the change in input prices since the previous year. The HCFA capital input price index (the CIPI) includes price measures for interest expense, which are an indicator of the interest rates facing hospitals during their capital purchasing decisions. The MedPAC capital market basket does not include interest expense; instead the MedPAC update framework includes an adjustment when necessary to account for the prolonged changes in interest rates. HCFA's CIPI is vintage-weighted, meaning that it takes into account price changes from past purchases of capital when determining the current period update. MedPAC's capital market basket is not vintage-weighted, accounting only for the current year price changes. This year, due to the difference between HCFA's and MedPAC's input price index, the percentage change in HCFA's CIPI is 0.8 percent, and the percentage change in MedPAC's market basket is 2.4 percent.

MedPAC and HCFA also differ in the adjustments they make to their price indices. (See Table 1 for a comparison of HCFA and MedPAC's update recommendations.) MedPAC makes an adjustment for productivity, while HCFA has not adopted an adjustment for capital productivity or efficiency. MedPAC employs the same productivity adjustment in its operating and capital framework. We have identified a total intensity factor but have not identified an adequate total productivity measure. The Commission also includes a product change adjustment to account for changes in the service content of hospital stays, which adjusts the base payment rates to eliminate overpayments in the future. MedPAC recommends a −3.0 to a −1.0 adjustment for product change for FY 1999. For FY 1999 MedPAC recommends a −0.7 to a −0.3 adjustment for productivity. We recommend a 0.0 intensity adjustment.

We recommend a −0.2 total case mix adjustment since we are projecting a 1.0 percent increase in the case mix index and we estimate that real case-mix increase will equal 0.8 percent in FY 1999. MedPAC makes a two part adjustment for case mix changes, which takes into account changes in case mix in the past year. They recommend a −0.2 to −0.0 adjustment for coding change and an 0.0 to 0.2 adjustment for within-DRG complexity change. We recommend a −0.4 adjustment for forecast error correction, and MedPAC recommends a −0.4 adjustment for forecast error correction.

The net result of these adjustments is that MedPAC's capital update framework suggests a −1.9 to 1.4 percent update. MedPAC has recommended a 0.0 to 0.7 percent update to the rate for FY 1999. This range is consistent with the PPS operating update recommended by the Commission. We describe the basis for our proposed 0.2 percent total update in the preceding section. HCFA and MedPAC's update recommendations are quite close, with HCFA's recommendation within the range recommended by MedPAC.

TABLE 1.—HCFA'S FY 1999 UPDATE FACTOR AND MEDPAC'S RECOMMENDATION

	HCFA's update factor	MedPAC's recommendation
Capital Input Price Index	0.8	2.4
Policy Adjustment Factors:		
Productivity		−0.7 to −0.3
Intensity	0.0	
Science and Technology		0.0 to 0.5
Intensity		(1)
Real within DRG Change		(2)
Product Change		−3.0 to −1.0
Subtotal	0.0	−3.7 to −0.8
Case-Mix Adjustment Factors:		
Projected Case-Mix Change	−1.0	
Real Across DRG Change	0.8	

TABLE 1.—HCFA'S FY 1999 UPDATE FACTOR AND MEDPAC'S RECOMMENDATION—Continued

	HCFA's update factor	MedPAC's recommendation
Coding Change		−0.2 to −0.0
Real within DRG Change	(3)	0.0 to 0.2
Subtotal	−0.2	−0.2 to 0.2
Effect of FY 1996 Reclassification and Recalibration	0.0	
Forecast Error Correction	−0.4	−0.4
Total Update	0.2	−1.9 to 1.4

[1] Included in MedPAC's productivity measure.
[2] Included in MedPAC's case-mix adjustment.
[3] Included in HCFA's intensity factor.

2. Outlier Payment Adjustment Factor

Section 412.312(c) establishes a unified outlier methodology for inpatient operating and inpatient capital-related costs. A single set of thresholds is used to identify outlier cases for both inpatient operating and inpatient capital-related payments. Outlier payments are made only on the portion of the Federal rate that is used to calculate the hospital's inpatient capital-related payments (for example, 80 percent for cost reporting periods beginning in FY 1999 for hospitals paid under the fully prospective methodology). Section 412.308(c)(2) provides that the standard Federal rate for inpatient capital-related costs be reduced by an adjustment factor equal to the estimated proportion of outlier payments under the Federal rate to total inpatient capital-related payments under the Federal rate. The outlier thresholds are set so that operating outlier payments are projected to be 5.1 percent of total operating DRG payments. The inpatient capital-related outlier reduction factor reflects the inpatient capital-related outlier payments that would be made if all hospitals were paid 100 percent of the Federal rate. For purposes of calculating the outlier thresholds and the outlier reduction factor, we model payments as if all hospitals were paid 100 percent of the Federal rate because, as explained above, outlier payments are made only on the portion of the Federal rate that is included in the hospital's inpatient capital-related payments.

In the August 29, 1997 final rule with comment period, we estimated that outlier payments for capital in FY 1998 would equal 6.18 percent of inpatient capital-related payments based on the Federal rate. Accordingly, we applied an outlier adjustment factor of 0.9382 to the Federal rate. Based on the thresholds as set forth in section II.A.4.d of this Addendum, we estimate that outlier payments for capital will equal 6.22 percent of inpatient capital-related payments based on the Federal rate in FY 1999. We are, therefore, proposing an outlier adjustment factor of 0.9378 to the Federal rate. Thus, estimated capital outlier payments for FY 1999 represent a higher percentage of total capital standard payments than in FY 1998.

The outlier reduction factors are not built permanently into the rates; that is, they are not applied cumulatively in determining the Federal rate. Therefore, the proposed net change in the outlier adjustment to the Federal rate for FY 1999 is 0.9996 (0.9378/0.9382). Thus, the outlier adjustment decreases the FY 1999 Federal rate by 0.04 percent (0.9996—1) compared with the FY 1998 outlier adjustment.

3. Budget Neutrality Adjustment Factor for Changes in DRG Classifications and Weights and the Geographic Adjustment Factor

Section 412.308(c)(4)(ii) requires that the Federal rate be adjusted so that aggregate payments for the fiscal year based on the Federal rate after any changes resulting from the annual DRG reclassification and recalibration and changes in the GAF are projected to equal aggregate payments that would have been made on the basis of the Federal rate without such changes. We use the actuarial model, described in Appendix B of this proposed rule, to estimate the aggregate payments that would have been made on the basis of the Federal rate without changes in the DRG classifications and weights and in the GAF. We also use the model to estimate aggregate payments that would be made on the basis of the Federal rate as a result of those changes. We then use these figures to compute the adjustment required to maintain budget neutrality for changes in DRG weights and in the GAF.

For FY 1998, we calculated a GAF/DRG budget neutrality factor of 0.9989. For FY 1999, we are proposing a GAF/DRG budget neutrality factor of 1.0032. The GAF/DRG budget neutrality factors are built permanently into the rates; that is, they are applied cumulatively in determining the Federal rate. This follows from the requirement that estimated aggregate payments each year be no more than they would have been in the absence of the annual DRG reclassification and recalibration and changes in the GAF. The proposed incremental change in the adjustment from FY 1998 to FY 1999 is 1.0032. The proposed cumulative change in the rate due to this adjustment is 1.0034 (the product of the incremental factors for FY 1993, FY 1994, FY 1995, FY 1996, FY 1997, FY 1998, and the proposed incremental factor for FY 1999: $0.9980 \times 1.0053 \times 0.9998 \times 0.9994 \times 0.9987 \times 0.9989 \times 1.0032 = 1.0034$).

This proposed factor accounts for DRG reclassifications and recalibration and for changes in the GAF. It also incorporates the effects on the GAF of FY 1999 geographic reclassification decisions made by the MGCRB compared to FY 1998 decisions. However, it does not account for changes in payments due to changes in the disproportionate share and indirect medical education adjustment factors or in the large urban add-on.

4. Exceptions Payment Adjustment Factor

Section 412.308(c)(3) requires that the standard Federal rate for inpatient capital-related costs be reduced by an adjustment factor equal to the estimated proportion of additional payments for exceptions under § 412.348 relative to total payments under the hospital-specific rate and Federal rate. We use the model originally developed for determining the budget neutrality adjustment factor to determine the

exceptions payment adjustment factor. We describe that model in Appendix B to this proposed rule.

For FY 1998, we estimated that exceptions payments would equal 3.41 percent of aggregate payments based on the Federal rate and the hospital-specific rate. Therefore, we applied an exceptions reduction factor of 0.9659 (1–0.0341) in determining the Federal rate. For this proposed rule, we estimate that exceptions payments for FY 1999 will equal 2.39 percent of aggregate payments based on the Federal rate and the hospital-specific rate. Therefore, we are proposing an exceptions payment reduction factor of 0.9761 to the Federal rate for FY 1999. The proposed exceptions reduction factor for FY 1999 is 1.06 percent higher than the factor for FY 1998.

The exceptions reduction factors are not built permanently into the rates; that is, the factors are not applied cumulatively in determining the Federal rate. Therefore, the proposed net adjustment to the FY 1999 Federal rate is 0.9761/0.9659, or 1.0106.

5. Standard Capital Federal Rate for FY 1999

For FY 1998, the capital Federal rate was $371.51. With the changes we are proposing to the factors used to establish the Federal rate, the FY 1999 Federal rate would be $377.25. The proposed Federal rate for FY 1999 was calculated as follows:

- The proposed FY 1999 update factor is 1.0020, that is, the proposed update is 0.20 percent.
- The proposed FY 1999 budget neutrality adjustment factor that is applied to the standard Federal payment rate for changes in the DRG relative weights and in the GAF is 1.0032.
- The proposed FY 1999 outlier adjustment factor is 0.9378.
- The proposed FY 1999 exceptions payments adjustment factor is 0.9761.

Since the Federal rate has already been adjusted for differences in case mix, wages, cost of living, indirect medical education costs, and payments to hospitals serving a disproportionate share of low-income patients, we propose to make no additional adjustments in the standard Federal rate for these factors other than the budget neutrality factor for changes in the DRG relative weights and the GAF.

We are providing a chart that shows how each of the factors and adjustments for FY 1999 affected the computation of the proposed FY 1999 Federal rate in comparison to the FY 1998 Federal rate. The proposed FY 1999 update factor has the effect of increasing the Federal rate by 0.20 percent compared to the rate in FY 1998, while the proposed geographic and DRG budget neutrality factor has the effect of increasing the Federal rate by 0.32 percent. The proposed FY 1999 outlier adjustment factor has the effect of decreasing the Federal rate by 0.04 percent compared to FY 1998. The proposed FY 1999 exceptions reduction factor has the effect of increasing the Federal rate by 1.06 percent compared to the exceptions reduction for FY 1998. The combined effect of all the proposed changes is to increase the proposed Federal rate by 1.55 percent compared to the Federal rate for FY 1998.

Comparison of Factors and Adjustments—FY 1998 Federal Rate and Proposed FY 1999 Federal Rate

	FY 98	Proposed FY 99	Change	Percent change
Update factor[1]	1.0090	1.0020	1.0020	0.20
GAF/DRG Adjustment Factor[1]	0.9989	1.0032	1.0032	0.32
Outlier Adjustment Factor[2]	0.9382	0.9378	0.9996	−0.04
Exceptions Adjustment Factor[2]	0.9659	0.9761	1.0106	1.06
Federal Rate	$371.51	$377.25	1.0155	1.55

[1] The update factor and the GAF/DRG budget neutrality factors are built permanently into the rates. Thus, for example, the incremental change from FY 1998 to FY 1999 resulting from the application of the 1.0032 GAF/DRG budget neutrality factor for FY 1999 is 1.0032.

[2] The outlier reduction factor and the exceptions reduction factor are not built permanently into the rates; that is, these factors are not applied cumulatively in determining the rates. Thus, for example, the net change resulting from the application of the FY 1999 outlier reduction factor is 0.9378/0.9382, or 0.9996.

6. Special Rate for Puerto Rico Hospitals

As explained at the beginning of this section, hospitals in Puerto Rico are paid based on 50 percent of the Puerto Rico rate and 50 percent of the Federal rate. The Puerto Rico rate is derived from the costs of Puerto Rico hospitals only, while the Federal rate is derived from the costs of all acute care hospitals participating in the prospective payment system (including Puerto Rico). To adjust hospitals' capital payments for geographic variations in capital costs, we apply a geographic adjustment factor (GAF) to both portions of the blended rate. The GAF is calculated using the operating PPS wage index and varies depending on the MSA or rural area in which the hospital is located. We use the Puerto Rico wage index to determine the GAF for the Puerto Rico part of the capital blended rate and the national wage index to determine the GAF for the national part of the blended rate.

Since we implemented a separate GAF for Puerto Rico, we also propose to apply separate budget neutrality adjustments for the national GAF and for the Puerto Rico GAF. We propose to apply the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. Separate adjustments were unnecessary for FY 1998 since the Puerto Rico specific GAF was implemented that year. The Puerto Rico GAF budget neutrality factor is 0.9989, while the DRG adjustment is 1.0033, for a combined cumulative adjustment of 1.0022. (For a more detailed explanation of this proposed change see Appendix B.)

In computing the payment for a particular Puerto Rico hospital, the Puerto Rico portion of the rate (50%) is multiplied by the Puerto Rico-specific GAF for the MSA in which the hospital is located, and the national portion of the rate (50%) is multiplied by the national GAF for the MSA in which the hospital is located (which is computed from national data for all hospitals in the United States and Puerto Rico). In FY 1998, we implemented a 17.78 percent reduction to the Puerto Rico rate as a result of the BBA.

For FY 1998, before application of the GAF, the special rate for Puerto Rico hospitals was $177.57. With the changes we are proposing to the factors used to determine the rate, the proposed FY 1999 special rate for Puerto Rico is $180.73.

B. Determination of Hospital-Specific Rate Update

Section 412.328(e) of the regulations provides that the hospital-specific rate for FY 1999 be determined by adjusting

the FY 1998 hospital-specific rate by the following factors:

1. Hospital-Specific Rate Update Factor

The hospital-specific rate is updated in accordance with the update factor for the standard Federal rate determined under § 412.308(c)(1). For FY 1999, we are proposing that the hospital-specific rate be updated by a factor of 1.0020.

2. Exceptions Payment Adjustment Factor

For FYs 1992 through FY 2001, the updated hospital-specific rate is multiplied by an adjustment factor to account for estimated exceptions payments for capital-related costs under § 412.348, determined as a proportion of the total amount of payments under the hospital-specific rate and the Federal rate. For FY 1999, we estimate that exceptions payments will be 2.39 percent of aggregate payments based on the Federal rate and the hospital-specific rate. Therefore, we propose that the updated hospital-specific rate be reduced by a factor of 0.9761. The exceptions reduction factors are not built permanently into the rates; that is, the factors are not applied cumulatively in determining the hospital-specific rate. The proposed net adjustment to the FY 1999 hospital-specific rate is 0.9761/0.9659, or 1.0106.

3. Net Change to Hospital-Specific Rate

We are providing a chart to show the net change to the hospital-specific rate. The chart shows the factors for FY 1998 and FY 1999 and the net adjustment for each factor. It also shows that the proposed cumulative net adjustment from FY 1998 to FY 1999 is 1.0126, which represents a proposed increase of 1.26 percent to the hospital-specific rate. For each hospital, the proposed FY 1999 hospital-specific rate is determined by multiplying the FY 1998 hospital-specific rate by the cumulative net adjustment of 1.0126.

PROPOSED FY 1999 UPDATE AND ADJUSTMENTS TO HOSPITAL-SPECIFIC RATES

	FY 98	Proposed FY 99	Net Adjustment	Percent Change
Update Factor	1.0090	1.0020	1.0020	0.20
Exceptions Payment Adjustment Factor	0.9659	0.9761	1.0106	1.06
Cumulative Adjustments	0.9746	0.9869	1.0026	1.26

Note: The update factor for the hospital-specific rate is applied cumulatively in determining the rates. Thus, the incremental increase in the update factor from FY 1998 to FY 1999 is 1.0020. In contrast, the exceptions payment adjustment factor is not applied cumulatively. Thus, for example, the incremental increase in the exceptions reduction factor from FY 1998 to FY 1999 is 0.9761/0.9659, or 1.0106.

C. Calculation of Inpatient Capital-Related Prospective Payments for FY 1999

During the capital prospective payment system transition period, a hospital is paid for the inpatient capital-related costs under one of two payment methodologies—the fully prospective payment methodology or the hold-harmless methodology. The payment methodology applicable to a particular hospital is determined when a hospital comes under the prospective payment system for capital-related costs by comparing its hospital-specific rate to the Federal rate applicable to the hospital's first cost reporting period under the prospective payment system.

The applicable Federal rate was determined by making adjustments as follows:

- For outliers by dividing the standard Federal rate by the outlier redution factor for that fiscal year; and,
- For the payment adjustment factors applicable to the hospital (that is, the hospital's GAF, the disproportionate share adjustment factor, and the indirect medical education adjustment factor, when appropriate).
- If the hospital-specific rate is above the applicable Federal rate, the hospital is paid under the hold-harmless methodology. If the hospital-specific rate is below the applicable Federal rate, the hospital is paid under the fully prospective methodology.

For purposes of calculating payments for each discharge under both the hold-harmless payment methodology and the fully prospective payment methodology, the standard Federal rate is adjusted as follows:

(Standard Federal Rate) x (DRG weight) x (GAF) x (Large Urban Add-on, if applicable) x (COLA adjustment for hospitals located in Alaska and Hawaii) x (1 + Disproportionate Share Adjustment Factor + IME Adjustment Factor, if applicable).

The result is the adjusted Federal rate.

Payments under the hold-harmless methodology are determined under one of two formulas. A hold-harmless hospital is paid the higher of the following:

- 100 percent of the adjusted Federal rate for each discharge; or
- An old capital payment equal to 85 percent (100 percent for sole community hospitals) of the hospital's allowable Medicare inpatient old capital costs per discharge for the cost reporting period plus a new capital payment based on a percentage of the adjusted Federal rate for each discharge. The percentage of the adjusted Federal rate equals the ratio of the hospital's allowable Medicare new capital costs to its total Medicare inpatient capital-related costs in the cost reporting period.

Once a hospital receives payment based on 100 percent of the adjusted Federal rate in a cost reporting period beginning on or after October 1, 1994 (or the first cost reporting period after obligated capital that is recognized as old capital under § 412.302(c) is put in use for patient care, if later), the hospital continues to receive capital prospective payment system payments on that basis for the remainder of the transition period.

Payment for each discharge under the fully prospective methodology is the sum of the following:

- The hospital-specific rate multiplied by the DRG relative weight for the discharge and by the applicable hospital-specific transition blend percentage for the cost reporting period; and
- The adjusted Federal rate multiplied by the Federal transition blend percentage.
- The blend percentages for cost reporting periods beginning in FY 1999 are 80 percent of the adjusted Federal rate and 20 percent of the hospital-specific rate.

Hospitals may also receive outlier payments for those cases that qualify under the thresholds established for each fiscal year. Section 412.312(c) provides for a single set of thresholds to identify outlier cases for both inpatient operating and inpatient capital-related payments. Outlier payments are made only on that portion of the Federal rate that is used to calculate the hospital's inpatient capital-related payments. For fully prospective hospitals, that portion is 80 percent of the Federal rate for

discharges occurring in cost reporting periods beginning during FY 1999. Thus, a fully prospective hospital will receive 80 percent of the capital-related outlier payment calculated for the case for discharges occurring in cost reporting periods beginning in FY 1999. For hold-harmless hospitals paid 85 percent of their reasonable costs for old inpatient capital, the portion of the Federal rate that is included in the hospital's outlier payments is based on the hospital's ratio of Medicare inpatient costs for new capital to total Medicare inpatient capital costs. For hold-harmless hospitals that are paid 100 percent of the Federal rate, 100 percent of the Federal rate is included in the hospital's outlier payments.

The proposed outlier thresholds for FY 1999 are in section II.A.4.c of this Addendum. For FY 1999, a case qualifies as a cost outlier if the cost for the case (after standardization for the indirect teaching adjustment and disproportionate share adjustment) is greater than the prospective payment rate for the DRG plus $11,350.

During the capital prospective payment system transition period, a hospital may also receive an additional payment under an exceptions process if its total inpatient capital-related payments are less than a minimum percentage of its allowable Medicare inpatient capital-related costs. The minimum payment level is established by class of hospital under § 412.348. The proposed minimum payment levels for portions of cost reporting periods occurring in FY 1999 are:

- Sole community hospitals (located in either an urban or rural area), 90 percent;
- Urban hospitals with at least 100 beds and a disproportionate share patient percentage of at least 20.2 percent ; and
- Urban hospitals with at least 100 beds that qualify for disproportionate share payments under § 412.106(c)(2), 80 percent; and
- All other hospitals, 70 percent.

Under § 412.348(d), the amount of the exceptions payment is determined by comparing the cumulative payments made to the hospital under the capital prospective payment system to the cumulative minimum payment levels applicable to the hospital for each cost reporting period subject to that system. Any amount by which the hospital's cumulative payments exceed its cumulative minimum payment is deducted from the additional payment that would otherwise be payable for a cost reporting period.

New hospitals are exempted from the capital prospective payment system for their first 2 years of operation and are paid 85 percent of their reasonable costs during that period. A new hospital's old capital costs are its allowable costs for capital assets that were put in use for patient care on or before the later of December 31, 1990 or the last day of the hospital's base year cost reporting period, and are subject to the rules pertaining to old capital and obligated capital as of the applicable date. Effective with the third year of operation, we will pay the hospital under either the fully prospective methodology, using the appropriate transition blend in that Federal fiscal year, or the hold-harmless methodology. If the hold-harmless methodology is applicable, the hold-harmless payment for assets in use during the base period would extend for 8 years, even if the hold-harmless payments extend beyond the normal transition period.

D. Capital Input Price Index

1. Background

Like the prospective payment hospital 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.

Using Medicare cost reports, AHA data, and Securities Data Corporation data, a vintage-weighted price index was developed to measure price increases associated with capital expenses. 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. Currently, the CIPI is based to FY 1992 and was last rebased in 1997. The most recent explanation of the CIPI was discussed in the final rule with comment period for FY 1998 published in the August 29, 1997 **Federal Register** (62 FR 46050). The following **Federal Register** documents also describe development and revisions of the methodology involved with the construction of the CIPI: September 1, 1992 (57 FR 40016), May 26, 1993 (58 FR 30448), September 1, 1993 (58 FR 46490), May 27, 1994 (59 FR 27876), September 1, 1994 (59 FR 45517), June 2, 1995 (60 FR 29229), and September 1, 1995 (60 FR 45815), May 31, 1996 (61 FR 27466), August 30, 1996 (61 FR 46196), and June 2, 1997 (62 FR 29953).

2. Forecast of the CIPI for Federal Fiscal Year 1999

DRI forecasts a 0.8 percent increase in the CIPI for FY 1999. This is the outcome of a projected 2.0 percent increase in vintage-weighted depreciation prices (building and fixed equipment, and movable equipment) and a 2.6 percent increase in other capital expense prices in FY 1999, partially offset by a 2.7 percent decline in vintage-weighted interest rates in FY 1999. The weighted average of these three factors produces the 0.8 percent increase for the CIPI as a whole.

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

A. Rate-of-Increase Percentages for Excluded Hospitals and Hospital Units

The inpatient operating costs of hospitals and hospital units excluded from the prospective payment system are subject to rate-of-increase limits established under the authority of section 1886(b) of the Act, which is implemented in § 413.40 of the regulations. Under these limits, an annual target amount (expressed in terms of the inpatient operating cost per discharge) is set for each hospital, based on the hospital's own historical cost experience trended forward by the applicable rate-of-increase percentages (update factors). In the case of a psychiatric hospital or unit, rehabilitation hospital or unit, or long-term care hospital, the target amount may not exceed the 75th percentile of target amounts for hospitals and units in the same class (psychiatric, rehabilitation, and long-term care). The target amount is multiplied by the number of Medicare discharges in a hospital's cost reporting period, yielding the ceiling on aggregate Medicare inpatient operating costs for the cost reporting period.

Each hospital's target amount is adjusted annually, at the beginning of its cost reporting period, by an applicable update factor. Section 1886(b)(3)(B) of the Act provides that for cost reporting periods beginning on or after October 1, 1998 and before October 1, 1999, the update factor is the market basket less a percentage point between 0 and 2.5 depending on the hospital's or

unit's costs in relation to the ceiling. For hospitals with costs exceeding the ceiling by 10 percent or more, the update factor is the market basket increase. For hospitals with costs exceeding the ceiling by less than 10 percent, the update factor is the market basket minus .25 percent for each percentage point by which costs are less than 10 percent over the ceiling. For hospitals with costs equal to or less than the ceiling but greater than 66.7 percent of the ceiling, the update factor is the greater of 0 percent or the market basket minus 2.5 percent. For hospitals with costs that do not exceed 66.7 percent of the ceiling, the update factor is 0.

The most recent forecast of the market basket increase for FY 1999 for hospitals and hospital units excluded from the prospective payment system is 2.5 percent; therefore, the update to a hospital's target amount for its cost reporting period beginning in FY 1999 would be between 0 and 2.5 percent.

In addition, section 1886(b)(3)(H) of the Act provides that for cost reporting periods beginning on or after October 1, 1998 and before October 1, 1999, the target amount for psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals will be the lower of the hospital's specific target amount or the 75th percentile target amount for hospitals in the same class. The FY 1998 75th percentile target amounts were $10,534 for psychiatric hospitals and units, $19,104 for rehabilitation hospital and units, and $37,688 for long-term care hospitals. For 1999, these 75th percentile figures must be updated by the market basket increase. Section 1886(b) of the Act was revised to change the formulas for determining bonus and relief payments for excluded hospitals and also establishes an additional bonus payment for continuous improvement, for cost reporting periods on or after October 1, 1997. Finally, a new statutory payment methodology for new hospitals and units (psychiatric, rehabilitation, and long-term care) was effective October 1, 1997 as governed by section 1886(b)(7) of the Act.

V. Tables

This section contains the tables referred to throughout the preamble to this proposed rule and in this Addendum. For purposes of this proposed 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, 1E, 1F, 3C, 4A, 4B, 4C, 4D, 4E, 4F, 5, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 7A, 7B, 8A, and 8B are presented below. The tables presented below are as follows:

Table 1A—National Adjusted Operating Standardized Amounts, Labor/Nonlabor
Table 1C—Adjusted Operating Standardized Amounts for Puerto Rico, Labor/Nonlabor
Table 1D—Capital Standard Federal Payment Rate
Table 1E—National Adjusted Operating Standardized Amounts for ''Temporary Relief'' Hospitals, Labor/Nonlabor
Table 1F—Adjusted Operating Standardized Amounts for ''Temporary Relief'' Hospitals in Puerto Rico, Labor/Nonlabor
Table 3C—Hospital Case Mix Indexes for Discharges Occurring in Federal Fiscal Year 1997 and Hospital Average Hourly Wage for Federal Fiscal Year 1999 Wage Index
Table 4A—Wage Index and Capital Geographic Adjustment Factor (GAF) for Urban Areas
Table 4B—Wage Index and Capital Geographic Adjustment Factor (GAF) for Rural Areas
Table 4C—Wage Index and Capital Geographic Adjustment Factor (GAF) for Hospitals That Are Reclassified
Table 4D—Average Hourly Wage for Urban Areas
Table 4E—Average Hourly Wage for Rural Areas
Table 4F—Puerto Rico Wage Index and Capital Geographic Adjustment Factor (GAF)
Table 5—List of Diagnosis Related Groups (DRGs), Relative Weighting Factors, Geometric Mean Length of Stay, and Arithmetic Mean Length of Stay Points Used in the Prospective Payment System
Table 6A—New Diagnosis Codes
Table 6B—New Procedure Codes
Table 6C—Invalid Diagnosis Codes
Table 6D—Invalid Procedure Codes
Table 6E—Revised Diagnosis Code Titles
Table 6F—Additions to the CC Exclusions List
Table 6G—Deletions to the CC Exclusions List
Table 7A—Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 97 MEDPAR Update 12/97 GROUPER V15.0
Table 7B—Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 97 MEDPAR Update 12/97 GROUPER V16.0
Table 8A—Statewide Average Operating Cost-to-Charge Ratios for Urban and Rural Hospitals (Case Weighted) March 1998
Table 8B—Statewide Average Capital Cost-to-Charge Ratios (Case Weighted) March 1998

TABLE 1A.—NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR

Large urban areas		Other areas	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
2,776.21	1,128.44	2,732.26	1,110.58

TABLE 1C.—ADJUSTED OPERATING STANDARDIZED AMOUNTS FOR PUERTO RICO, LABOR/NONLABOR

	Large urban areas		Other areas	
	Labor	Nonlabor	Labor	Nonlabor
National	2,752.36	1,118.74	2,752.36	1,118.74
Puerto Rico	1,323.01	532.55	1,302.07	524.11

TABLE 1D.—CAPITAL STANDARD FEDERAL PAYMENT RATE

	Rate
National	371.51
Puerto Rico	177.57

TABLE 1E.—NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS FOR ''TEMPORARY RELIEF'' HOSPITALS, LABOR/NONLABOR

Large urban areas		Other areas	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
2,790.09	1,134.08	2,745.92	1,116.13

TABLE 1F.—ADJUSTED OPERATING STANDARDIZED AMOUNTS FOR ''TEMPORARY RELIEF'' HOSPITALS IN PUERTO RICO, LABOR/NONLABOR

	Large urban areas		Other areas	
	Labor	Nonlabor	Labor	Nonlabor
National	2,766.12	1,124.33	2,766.12	1,124.33
Puerto Rico	1,329.63	535.21	1,308.58	526.73

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1997; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 1999 WAGE INDEX

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Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
010001	01.4634	15.97	010097	00.9183	14.87	030006	01.5689	18.22	040005	01.0400	13.38	040118	01.3520	15.27
010004	01.0055	13.79	010098	01.1894	13.02	030007	01.3034	17.95	040007	01.8696	18.99	040119	01.1640	15.33
010005	01.1699	15.89	010099	01.1010	09.13	030008	02.2412	14.19	040008	01.0301	13.20	040124	01.0549	16.23
010006	01.4636	16.19	010100	01.3314	15.67	030009	01.2640	17.83	040010	01.3262	16.83	040126	00.9551	13.26
010007	01.1300	14.09	010101	01.0382	14.69	030010	01.4386	20.05	040011	00.9590	11.65	040134	02.6975	.....
010008	01.0838	13.76	010102	00.9504	12.71	030011	01.4734	19.48	040014	01.2138	18.12	050002	01.5241	27.86
010009	01.1456	17.50	010103	01.8119	17.65	030012	01.2358	18.04	040015	01.1668	14.80	050006	01.5662	20.69
010010	01.0888	15.40	010104	01.6869	18.66	030013	01.2951	20.90	040016	01.6762	16.66	050007	01.5312	27.11
010011	01.6411	20.28	010108	01.2192	16.69	030014	01.5263	19.07	040017	01.2700	14.62	050008	01.4438	25.60
010012	01.2728	17.45	010109	01.1224	13.41	030016	01.1871	19.00	040018	01.2583	18.08	050009	01.6484	24.26
010015	01.1428	14.04	010110	01.0248	14.97	030017	01.4718	19.72	040019	01.1438	12.08	050013	01.8476	23.25
010016	01.2538	17.40	010112	01.1997	14.59	030018	01.8083	27.57	040020	01.5404	15.42	050014	01.1816	23.57
010018	00.9607	17.72	010113	01.6522	15.97	030019	01.2636	23.65	040021	01.2056	16.15	050015	01.3820	24.35
010019	01.2435	15.00	010114	01.3201	16.49	030022	01.4160	18.79	040022	01.5321	23.41	050016	01.1889	18.74
010021	01.2461	15.83	010115	00.8706	08.92	030023	01.4822	20.04	040024	01.0031	13.38	050017	02.0973	24.47
010022	01.0069	18.25	010117	00.8624	.....	030024	01.6963	20.87	040025	00.9000	12.48	050018	01.2579	17.02
010023	01.6877	16.06	010118	01.3033	28.66	030025	01.0483	14.97	040026	01.5700	17.88	050021	01.4154	24.41
010024	01.4236	15.62	010119	00.8398	16.57	030027	01.0392	17.17	040027	01.2930	13.77	050022	01.5819	23.22
010025	01.3834	14.53	010120	01.0107	16.62	030030	01.7154	18.21	040028	01.0462	14.24	050024	01.3639	20.68
010027	00.8180	36.37	010121	01.3471	13.03	030033	01.2640	15.67	040029	01.2975	17.64	050025	01.8279	21.99
010029	01.6109	17.24	010123	01.2883	16.28	030034	01.0795	17.44	040030	00.8325	12.20	050026	01.5433	28.62
010031	01.2801	17.36	010124	01.2886	16.44	030035	01.2315	17.93	040032	00.9669	11.81	050028	01.3707	15.51
010032	00.9803	13.81	010125	01.0743	15.15	030036	01.2603	20.35	040035	00.9837	10.12	050029	01.4900	21.71
010033	01.9671	18.82	010126	01.2171	18.91	030037	02.0594	20.18	040036	01.5104	17.85	050030	01.3267	20.82
010034	01.1086	14.54	010127	01.3575	18.07	030038	01.6264	20.57	040037	01.1061	12.40	050032	01.2557	19.03
010035	01.1827	17.08	010128	00.9738	.....	030040	01.1572	14.74	040039	01.2394	13.39	050033	01.4502	24.74
010036	01.1899	17.99	010129	01.0590	12.94	030041	00.9538	14.31	040040	00.9817	15.09	050036	01.6546	15.95
010038	01.3028	19.03	010130	00.9980	15.85	030043	01.2213	17.92	040041	01.2978	17.08	050038	01.4456	29.35
010039	01.7055	17.67	010131	01.3864	17.25	030044	00.9736	16.04	040042	01.2567	15.12	050039	01.6097	21.59
010040	01.6110	18.52	010134	00.8391	10.86	030047	00.9401	18.63	040044	01.0524	13.02	050040	01.2411	32.71
010043	01.0489	11.63	010137	01.2373	18.84	030049	00.9939	20.75	040045	01.0079	17.86	050042	01.2889	22.76
010044	01.1028	15.92	010138	00.9399	12.43	030054	00.8332	14.41	040047	01.1013	15.48	050043	01.5649	31.83
010045	01.2056	14.77	010139	01.6766	20.38	030055	01.2012	17.65	040050	01.1795	12.44	050045	01.2364	18.69
010046	01.5054	17.67	010143	01.2743	15.07	030059	01.3005	22.74	040051	01.1670	13.51	050046	01.1880	22.24
010047	00.9884	12.14	010144	01.3459	16.59	030060	01.1528	17.75	040053	01.1178	15.65	050047	01.5646	34.07
010049	01.1575	13.82	010145	01.3390	16.15	030061	01.6564	20.08	040054	01.0532	13.50	050051	01.1348	20.91
010050	01.1489	14.17	010146	01.2470	16.83	030062	01.2455	16.61	040055	01.4655	15.78	050054	01.1263	18.44
010051	00.9234	11.17	010148	00.9483	.....	030064	01.7664	18.45	040058	01.0463	15.12	050055	01.3276	22.45
010052	01.0479	13.68	010149	01.3349	17.75	030065	01.7843	19.91	040060	00.9290	11.03	050056	01.3074	24.36
010053	01.0750	08.17	010150	01.1552	15.82	030067	01.0939	16.99	040062	01.6786	15.55	050057	01.5828	20.60
010054	01.1995	17.28	010152	01.2892	16.12	030068	01.1092	15.82	040064	01.0657	13.92	050058	01.4871	25.22
010055	01.4737	16.47	010155	01.0788	10.90	030069	01.4037	21.66	040066	01.1801	16.36	050060	01.5008	18.49
010056	01.3306	19.46	020001	01.5208	27.19	030071	01.0057	.....	040067	01.2165	12.63	050061	01.3507	22.13
010058	00.9765	13.47	020002	01.0595	24.09	030072	00.8620	.....	040069	01.1095	15.47	050063	01.4701	23.89
010059	01.0774	15.44	020004	01.1712	25.49	030073	01.0041	.....	040070	00.9098	14.25	050065	01.7005	21.95
010061	01.1893	15.80	020005	00.9285	28.73	030074	00.9408	.....	040071	01.6234	16.49	050066	01.2265	19.77
010062	01.0206	13.27	020006	01.1834	25.07	030075	00.8242	.....	040072	01.0982	15.41	050067	01.3204	21.48
010064	01.7552	20.86	020007	00.9834	25.64	030076	00.9614	.....	040074	01.2503	16.30	050068	01.1315	19.98
010065	01.3692	15.35	020008	01.1238	30.06	030077	00.8060	.....	040075	01.0369	12.15	050069	01.6246	24.57
010066	00.9184	10.89	020009	00.8881	25.77	030078	01.0727	.....	040076	01.0407	16.99	050070	01.3716	31.44
010068	01.2837	17.18	020010	01.0169	25.93	030079	00.8528	.....	040077	01.0621	12.57	050071	01.3791	33.07
010069	01.1851	12.84	020011	00.9299	25.75	030080	01.5008	19.77	040078	01.5099	22.64	050072	01.4414	32.14
010072	01.1579	15.22	020012	01.2746	26.15	030083	01.3763	22.10	040080	01.0790	16.38	050073	01.3063	33.68
010073	01.0650	11.04	020013	01.0266	26.76	030084	01.1228	.....	040081	00.9679	10.85	050075	01.3412	32.86
010078	01.2573	17.97	020014	01.1152	22.90	030085	01.4617	18.59	040082	01.2191	14.71	050076	01.9181	32.26
010079	01.2411	14.42	020017	01.4752	25.14	030086	01.4318	20.19	040084	01.1006	16.62	050077	01.6304	24.52
010081	01.8296	17.69	020018	00.9680	.....	030087	01.6536	19.77	040085	01.1954	15.29	050078	01.3632	25.59
010083	01.0337	15.64	020019	00.9067	.....	030088	01.4231	19.42	040088	01.4395	13.39	050079	01.5434	31.90
010084	01.5048	18.27	020020	00.7369	.....	030089	01.6391	19.70	040090	00.9349	14.77	050080	01.4214	19.44
010085	01.2796	17.32	020021	00.8551	.....	030092	01.6833	21.25	040091	01.1266	18.55	050082	01.6661	21.99
010086	01.0395	15.44	020024	01.1349	22.66	030093	01.3770	18.77	040093	00.9413	13.01	050084	01.6759	22.53
010087	01.6587	16.36	020025	01.0164	26.32	030094	01.2784	19.19	040100	01.2392	12.91	050088	00.9877	19.55
010089	01.2392	18.50	020026	01.2873	.....	030095	01.0461	18.85	040105	01.0353	13.05	050089	01.3688	18.85
010090	01.6235	17.44	020027	01.0891	.....	030099	00.9439	.....	040106	01.0675	13.53	050090	01.2668	23.85
010091	01.0247	13.51	030001	01.3399	19.87	040001	01.1079	13.42	040107	01.1428	16.75	050091	01.1370	21.99
010092	01.4011	15.82	030002	01.7944	20.96	040002	01.1468	13.33	040109	01.1342	13.95	050092	00.9386	16.26
010094	01.2128	16.01	030003	02.0396	22.65	040003	01.0880	13.97	040114	01.8758	17.98	050093	01.5500	23.90
010095	00.9779	12.73	030004	01.1011	12.52	040004	01.6709	17.69	040116	01.2656	16.72	050096	01.2374	21.29

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Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
050097	01.3873	18.48	050204	01.5825	24.52	050313	01.2044	22.00	050443	00.9057	18.82	050571	01.5096	20.05
050099	01.4747	23.55	050205	01.2709	21.52	050315	01.3579	20.47	050444	01.2967	22.54	050573	01.6294	28.41
050100	01.6983	33.49	050207	01.2640	20.02	050317	01.2655	21.86	050446	00.9770	10.06	050575	01.1367	.....
050101	01.4168	31.68	050211	01.3186	30.67	050320	01.2324	27.70	050447	01.0672	18.58	050577	01.4644	20.19
050102	01.3532	17.01	050213	01.5794	22.96	050324	01.9664	26.19	050448	01.0974	20.95	050578	01.4689	30.62
050103	01.5661	23.46	050214	01.4659	21.31	050325	01.2308	21.08	050449	01.3366	21.14	050579	01.4970	28.52
050104	01.4815	23.94	050215	01.5572	29.63	050327	01.5599	18.67	050454	01.8425	25.82	050580	01.4380	27.74
050107	01.4511	23.02	050217	01.3457	19.08	050329	01.2928	19.88	050455	01.7746	16.56	050581	01.3930	24.39
050108	01.8295	23.87	050219	01.1139	18.83	050331	01.4843	24.20	050456	01.1694	16.92	050583	01.6266	21.88
050110	01.1656	20.59	050222	01.6256	31.91	050333	01.1427	24.96	050457	02.0310	31.03	050584	01.1966	20.18
050111	01.3578	20.16	050224	01.5705	23.23	050334	01.7269	34.59	050459	01.2985	29.51	050585	01.2772	27.19
050112	01.4824	19.36	050225	01.6075	22.02	050335	01.4534	21.39	050464	01.8738	22.01	050586	01.3490	20.52
050113	01.3756	31.25	050226	01.4119	24.79	050336	01.3695	20.14	050468	01.3879	19.71	050588	01.3220	24.70
050114	01.3693	23.13	050228	01.2880	30.89	050342	01.3706	17.71	050469	01.0972	16.63	050589	01.2474	24.07
050115	01.5640	20.46	050230	01.3342	25.40	050343	01.0225	14.95	050470	01.1474	18.51	050590	01.3578	24.92
050116	01.4487	23.36	050231	01.6681	25.54	050348	01.6579	25.44	050471	01.8883	23.41	050591	01.3784	22.87
050117	01.4515	20.79	050232	01.7123	21.50	050349	00.8825	14.57	050476	01.3512	21.10	050592	01.3661	18.46
050118	01.1901	23.81	050234	01.2536	30.23	050350	01.3957	24.28	050477	01.4936	26.90	050593	01.1846	.....
050121	01.3531	24.60	050235	01.6014	24.55	050351	01.4653	32.84	050478	00.9635	21.11	050594	01.6739	19.05
050122	01.5966	26.85	050236	01.4693	25.40	050352	01.3034	19.07	050481	01.4648	27.13	050597	01.2665	21.36
050124	01.3182	17.12	050238	01.5517	24.76	050353	01.6669	24.77	050482	01.0978	16.07	050598	01.3875	32.07
050125	01.3970	27.55	050239	01.5877	21.67	050355	00.9808	16.04	050483	01.1821	22.22	050599	01.6318	23.23
050126	01.5414	24.94	050240	01.4863	21.17	050357	01.4011	23.77	050485	01.6561	23.81	050601	01.6150	32.05
050127	01.3406	24.15	050241	01.2337	26.32	050359	01.2854	19.11	050486	01.3493	23.00	050603	01.4035	22.60
050128	01.6211	21.63	050242	01.4284	29.91	050360	01.4136	31.05	050488	01.3349	32.94	050604	01.5622	37.27
050129	01.6194	14.25	050243	01.5930	22.58	050366	01.3455	22.32	050491	01.1935	21.97	050607	01.1545	20.69
050131	01.3023	29.90	050245	01.4385	23.33	050367	01.2485	27.64	050492	01.4113	22.37	050608	01.3080	15.26
050132	01.4257	23.74	050248	01.2618	27.54	050369	01.2376	21.58	050494	01.2167	26.20	050609	01.4505	32.31
050133	01.2911	25.55	050251	01.0989	14.91	050373	01.4446	24.31	050496	01.7259	31.88	050613	01.0696	31.83
050135	01.3964	25.36	050253	01.2992	25.63	050376	01.3991	26.32	050497	00.8270	10.59	050615	01.6042	23.31
050136	01.4011	24.04	050254	01.2141	14.11	050377	00.9333	19.49	050498	01.2434	24.96	050616	01.3591	22.85
050137	01.4012	30.81	050256	01.7518	23.91	050378	01.1364	20.86	050502	01.7222	22.74	050618	01.1163	22.63
050138	01.9630	33.22	050257	01.1275	19.38	050379	00.9589	15.15	050503	01.3400	23.15	050623	02.0034	27.05
050139	01.2532	31.55	050260	01.0044	24.07	050380	01.6867	29.30	050506	01.4395	27.49	050624	01.3554	22.18
050140	01.2757	31.54	050261	01.2723	18.81	050382	01.3984	23.86	050510	01.3791	31.86	050625	01.6074	25.23
050144	01.6355	29.12	050262	01.8576	27.43	050385	01.4021	26.64	050512	01.5743	33.03	050630	01.3401	23.93
050145	01.3861	31.48	050264	01.3335	27.45	050388	00.9019	20.64	050515	01.3473	32.36	050633	01.3131	21.95
050146	01.4762	.....	050267	01.6544	27.78	050390	01.1857	16.75	050516	01.5400	26.16	050636	01.5051	26.10
050148	01.1151	21.00	050270	01.3573	24.13	050391	01.3292	21.68	050517	01.1822	19.69	050638	01.1025	24.90
050149	01.4748	22.78	050272	01.3703	21.55	050392	00.9917	18.42	050522	01.2252	30.95	050641	01.2588	14.88
050150	01.2678	23.95	050274	00.9903	21.63	050393	01.4860	17.95	050523	01.2384	28.96	050643	00.8426	.....
050152	01.3850	23.39	050276	01.2072	33.01	050394	01.5488	20.22	050526	01.3236	13.42	050644	01.0506	22.44
050153	01.6231	28.40	050277	01.4723	19.05	050396	01.6148	24.12	050528	01.2785	19.70	050660	01.4613	.....
050155	01.0917	22.33	050278	01.5669	22.63	050397	00.9890	20.00	050531	01.1762	20.18	050661	00.8186	20.05
050158	01.3649	27.94	050279	01.3441	19.04	050401	01.1257	19.64	050534	01.4679	23.66	050662	00.8651	33.41
050159	01.2998	19.09	050280	01.7639	25.90	050404	01.0765	15.96	050535	01.3453	23.23	050663	01.1547	24.12
050167	01.2885	21.83	050281	01.5490	33.56	050406	01.0708	19.56	050537	01.3680	18.57	050666	00.9460	34.46
050168	01.5276	22.07	050282	01.3068	23.58	050407	01.3597	29.45	050539	01.2567	19.52	050667	01.0189	28.01
050169	01.4399	24.49	050283	01.5231	27.35	050410	01.0632	13.08	050541	01.5665	33.44	050668	01.1332	39.35
050170	01.4906	21.04	050286	00.8525	18.46	050411	01.3589	33.17	050542	01.1186	14.45	050670	00.7487	20.84
050172	01.2523	19.87	050289	01.6964	30.78	050414	01.3074	23.74	050543	00.9409	23.72	050674	01.3219	32.55
050173	01.3729	21.72	050290	01.6895	33.81	050417	01.3155	20.45	050545	00.8583	27.87	050675	01.9709	14.65
050174	01.6799	29.40	050291	01.1544	30.54	050419	01.4360	16.25	050546	00.6946	31.14	050676	00.9474	16.75
050175	01.3660	23.84	050292	01.0469	22.19	050420	01.3375	23.41	050547	00.8417	36.25	050677	01.3998	32.89
050177	01.2731	16.69	050293	01.1254	20.70	050423	01.0173	19.31	050549	01.7120	26.33	050678	01.2229	.....
050179	01.3003	21.22	050295	01.4947	21.01	050424	01.8153	23.48	050550	01.4607	22.49	050680	01.1971	28.94
050180	01.6017	32.17	050296	01.1902	23.74	050425	01.3094	34.22	050551	01.3289	24.83	050682	00.8928	22.32
050183	01.1126	19.44	050298	01.3275	22.54	050426	01.3708	25.47	050552	01.2293	20.52	050684	01.2450	17.19
050186	01.2933	27.51	050299	01.3607	20.49	050427	00.9189	19.93	050557	01.5109	21.78	050685	01.2468	28.37
050188	01.4286	26.90	050300	01.4936	19.23	050430	01.0555	19.53	050559	01.3996	23.82	050686	01.3134	32.42
050189	01.0831	22.39	050301	01.2481	24.81	050432	01.6129	22.37	050561	01.1996	32.15	050688	01.2792	25.15
050191	01.4729	20.67	050302	01.3482	27.55	050433	01.1058	20.42	050564	01.3309	06.57	050689	01.4155	30.16
050192	01.1901	20.19	050305	01.5457	29.10	050434	01.1365	19.87	050565	01.3544	13.81	050690	01.5124	32.17
050193	01.3308	22.67	050307	01.3027	19.99	050435	01.2208	29.08	050566	00.9061	13.99	050693	01.3049	29.48
050194	01.2435	27.41	050308	01.4832	27.92	050436	00.9412	15.20	050567	01.6269	24.54	050694	01.3586	18.36
050195	01.5834	33.92	050309	01.3376	24.61	050438	01.8098	19.83	050568	01.3990	19.06	050695	01.0960	28.46
050196	01.3052	15.36	050310	01.0912	20.24	050440	01.3403	18.63	050569	01.3783	23.26	050696	02.3021	26.75
050197	01.8716	30.49	050312	01.9222	24.66	050441	02.0343	26.41	050570	01.7110	23.79	050697	01.4515	20.60

Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
050698	00.9075	.....	060073	01.0655	16.43	100009	01.4921	21.67	100102	01.0245	18.11	100210	01.6031	18.18
050699	00.6236	20.97	060075	01.3102	24.34	100010	01.5263	24.50	100103	00.9830	16.14	100211	01.3282	20.20
050700	01.5678	31.31	060076	01.3829	19.28	100012	01.6950	16.74	100105	01.4360	21.03	100212	01.6623	20.46
050701	01.3360	30.27	060085	00.9348	12.76	100014	01.4918	21.94	100106	01.0823	16.69	100213	01.5199	18.60
050704	01.1294	15.23	060087	01.6777	21.08	100015	01.4344	17.47	100107	01.3253	18.60	100217	01.3379	18.88
050707	01.0702	27.09	060088	00.9931	23.16	100017	01.4976	17.71	100108	01.0633	14.31	100220	01.7265	26.34
050708	01.2629	22.59	060090	00.9777	13.54	100018	01.5086	21.03	100109	01.3838	18.97	100221	01.7374	25.21
050709	01.3280	18.88	060096	01.0685	21.94	100019	01.5290	19.50	100110	01.4040	20.80	100222	01.4127	20.13
050710	01.3480	26.13	060100	01.5060	.....	100020	01.3336	23.86	100112	00.9244	12.57	100223	01.4858	18.81
050713	00.8060	.....	060103	01.2902	23.16	100022	01.9055	24.49	100113	02.1161	19.93	100224	01.4049	20.57
050714	01.3480	.....	060104	01.2502	21.91	100023	01.4358	17.35	100114	01.4078	18.20	100225	01.4014	20.59
050715	01.7138	.....	060107	01.1286	.....	100024	01.3638	19.67	100117	01.3161	19.37	100226	01.4003	18.53
050716	03.8652	.....	070001	01.7599	25.86	100025	01.8449	18.06	100118	01.2409	19.51	100228	01.3287	20.31
050717	00.8003	.....	070002	01.8086	24.34	100026	01.5872	18.06	100121	01.2121	16.03	100229	01.3032	18.10
050718	00.9336	.....	070003	01.1454	25.30	100027	00.9920	15.86	100122	01.3058	16.67	100230	01.3648	22.35
050899	00.5288	.....	070004	01.2352	24.34	100028	01.2339	18.03	100124	01.3284	14.64	100231	01.7051	16.97
060001	01.6504	20.31	070005	01.4131	24.84	100029	01.4199	19.56	100125	01.3273	18.00	100232	01.3660	19.83
060003	01.3293	18.91	070006	01.4122	27.20	100030	01.3066	19.01	100126	01.4408	18.89	100234	01.5349	18.94
060004	01.2793	20.57	070007	01.3912	24.35	100032	01.8893	17.78	100127	01.6387	19.58	100235	01.5525	17.92
060006	01.1829	18.36	070008	01.2534	22.94	100034	01.7634	19.44	100128	02.1517	21.53	100236	01.4246	19.87
060007	01.1389	15.33	070009	01.2944	24.56	100035	01.6050	17.98	100129	01.2696	17.72	100237	02.2024	23.28
060008	01.1684	15.83	070010	01.6774	20.35	100038	01.5798	18.23	100130	01.2454	18.62	100238	01.5894	13.88
060009	01.4660	21.35	070011	01.4579	23.69	100039	01.5397	21.36	100131	01.3794	20.96	100239	01.4442	19.35
060010	01.5585	22.31	070012	01.2488	23.36	100040	01.7626	17.97	100132	01.3098	19.53	100240	00.7775	15.37
060011	01.3645	22.12	070015	01.4162	24.05	100043	01.3643	15.33	100134	00.9935	13.03	100241	00.9329	13.90
060012	01.4391	18.62	070016	01.3810	23.00	100044	01.4082	21.18	100135	01.6123	17.62	100242	01.4132	16.91
060013	01.3221	16.29	070017	01.3702	24.60	100045	01.4052	19.25	100137	01.3170	18.60	100243	01.4048	24.16
060014	01.7402	.....	070018	01.4229	28.54	100046	01.4822	20.36	100138	01.0153	10.76	100244	01.4078	19.39
060015	01.5816	21.13	070019	01.2953	24.83	100047	01.7725	18.92	100139	01.1145	15.04	100246	01.4106	17.86
060016	01.2616	17.07	070020	01.3139	24.55	100048	00.9695	13.58	100140	01.2249	17.48	100248	01.6271	18.75
060018	01.2400	17.15	070021	01.2930	24.85	100049	01.3276	17.97	100142	01.2594	18.68	100249	01.3503	18.84
060020	01.6773	17.56	070022	01.8192	23.48	100050	01.1456	15.90	100144	01.2818	19.61	100252	01.2846	21.94
060022	01.6160	19.49	070024	01.3153	23.84	100051	01.2118	19.11	100146	01.0877	16.15	100253	01.5082	20.97
060023	01.6591	17.02	070025	01.8600	19.43	100052	01.4303	16.90	100147	01.0605	14.54	100254	01.5827	18.66
060024	01.7966	22.84	070026	01.1616	18.55	100053	01.2198	18.09	100150	01.3984	19.96	100255	01.2900	24.34
060027	01.6866	21.24	070027	01.2854	23.11	100054	01.3283	17.76	100151	01.7240	18.08	100256	02.0081	18.90
060028	01.4966	21.55	070028	01.5443	24.77	100055	01.3757	17.93	100154	01.5955	19.74	100258	01.6280	21.07
060029	00.9005	15.35	070029	01.3587	21.95	100056	01.4068	19.38	100156	01.2007	19.92	100259	01.4194	18.73
060030	01.3241	19.00	070030	01.2292	25.18	100057	01.4184	18.63	100157	01.5860	21.06	100260	01.4513	21.73
060031	01.6355	19.53	070031	01.2535	23.12	100060	01.7365	21.02	100159	00.9550	11.69	100262	01.3943	21.16
060032	01.4770	20.78	070033	01.4122	26.38	100061	01.4813	21.68	100160	01.2495	18.43	100263	01.2482	18.64
060033	01.0722	13.41	070034	01.3825	29.05	100062	01.7465	18.11	100161	01.7073	21.30	100264	01.4012	17.62
060034	01.5666	.....	070035	01.4072	22.69	100063	01.2890	18.31	100162	01.4540	19.83	100265	01.3352	15.01
060036	01.1694	15.76	070036	01.5709	27.95	100067	01.4095	16.81	100165	01.1337	13.18	100266	01.3566	18.10
060037	01.0286	13.56	070038	01.0707	.....	100068	01.3733	17.72	100166	01.4808	19.75	100267	01.3379	19.83
060038	01.0310	13.78	070039	00.9302	23.64	100069	01.3153	15.88	100167	01.4454	20.58	100268	01.2241	22.61
060041	00.9383	14.14	080001	01.7025	27.32	100070	01.4966	18.19	100168	01.3650	19.91	100269	01.4247	20.37
060042	01.0363	14.73	080002	01.2023	15.33	100071	01.2953	16.97	100169	01.8710	20.54	100270	00.8682	20.06
060043	00.9025	12.99	080003	01.3849	20.16	100072	01.2360	23.32	100170	01.4100	15.49	100271	01.7428	20.02
060044	01.1085	16.07	080004	01.3094	19.45	100073	01.7511	20.04	100172	01.3995	14.68	100275	01.4146	20.36
060046	01.0901	18.50	080006	01.4184	21.83	100075	01.6523	18.22	100173	01.6957	17.25	100276	01.2702	22.13
060047	00.9872	13.98	080007	01.4486	16.75	100076	01.3180	17.07	100174	01.3787	17.95	100277	01.0519	15.24
060049	01.3479	20.25	090001	01.5888	27.79	100077	01.3753	16.82	100175	01.2198	15.49	100279	01.3775	12.47
060050	01.2593	16.03	090002	01.3122	19.74	100078	01.1969	16.33	100176	02.0937	23.45	100280	01.3550	16.99
060052	01.0840	13.49	090003	01.3697	25.82	100079	01.6561	19.15	100177	01.3473	18.58	100281	01.3003	22.78
060053	01.1047	14.93	090004	01.7397	24.43	100080	01.6318	22.70	100179	01.7319	19.47	100282	01.1124	17.70
060054	01.3319	18.61	090005	01.3450	23.71	100081	01.0539	14.21	100180	01.4631	19.43	110001	01.3047	15.63
060056	00.9946	15.37	090006	01.3214	20.39	100082	01.4614	18.91	100181	01.2111	21.61	110002	01.3058	16.54
060057	01.0133	23.55	090007	01.3635	19.38	100084	01.4186	20.77	100183	01.2830	18.48	110003	01.3845	15.24
060058	00.9506	15.60	090008	01.4969	20.72	100085	01.3915	21.33	100187	01.4150	19.92	110004	01.3881	18.05
060060	00.9769	14.53	090010	01.0223	17.93	100086	01.2392	21.23	100189	01.3952	24.14	110005	01.1802	17.38
060062	00.9096	16.53	090011	02.0090	25.70	100087	01.8553	21.28	100191	01.2949	20.19	110006	01.4001	19.78
060064	01.4880	21.56	100001	01.4825	16.62	100088	01.6726	21.08	100199	01.3616	19.76	110007	01.6056	16.12
060065	01.3260	22.85	100002	01.4763	19.92	100090	01.3888	17.89	100200	01.3456	21.55	110008	01.2651	18.30
060066	01.0226	15.09	100004	01.0119	13.82	100092	01.5281	19.47	100204	01.6026	19.37	110009	01.1532	15.80
060068	01.0475	18.74	100006	01.6406	20.10	100093	01.5080	15.93	100206	01.3988	19.96	110010	02.1459	24.74
060070	01.1221	17.17	100007	01.8866	20.87	100098	01.1552	19.33	100208	01.5848	22.72	110011	01.2262	16.24
060071	01.2194	16.52	100008	01.7096	20.20	100099	01.2922	13.50	100209	01.5855	17.58	110013	01.1130	16.61