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Department of Health and Human Services

Health Care Financing Administration

42 CFR Parts 412, 413, 483, and 485

Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2000 Rates; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 412, 413, 483, and 485

[HCFA–1053–P]

RIN 0938–AJ50

Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2000 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 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, 1999. We also are setting forth proposed rate-of-increase limits as well as proposed policy changes for hospitals and hospital units excluded from the prospective payment systems. Finally, we are proposing changes to the policies governing payment to hospitals for the direct costs of graduate medical education.

DATES: Comments will be considered if received at the appropriate address, as provided below, no later than 5 p.m. on July 6, 1999.

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–1053–P P.O. Box 7517, Baltimore, MD 21207.

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

Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW, Washington, DC 20201, or

Room C5–11–03, Central Building, 7500 Security Boulevard, Baltimore, MD 21244–1850

FOR FURTHER INFORMATION CONTACT:

Steve Phillips, (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:

Comments, Procedures, Availability of Copies, and Electronic Access

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code HCFA–1053–P. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room 445–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

Health Care Financing Administration, Office of Information Services, Security Standards Group, Division of HCFA Enterprise Standards, Room N2–14–26, 7500 Security Boulevard, Baltimore, Maryland 21244–1850. Attn: John Burke HCFA–1053–P.

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I. Background

A. Summary

Section 1886(d) of the Social Security Act (the Act) sets 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 hospital units are excluded from the prospective payment system: 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 hospital's number of 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 and hospital units are located in parts 412 and 413, and the GME regulations are located in part 413.

On July 31, 1998, we published a final rule in the **Federal Register** (63 FR 40954) that implemented both statutory requirements and other changes to the Medicare hospital inpatient prospective

payment systems for both operating costs and capital-related costs, as well as changes addressing payment for excluded hospitals and payments for GME costs. Generally, these changes were effective for discharges occurring on or after October 1, 1998.

In addition, on February 25, 1999, we published in the **Federal Register** (64 FR 9378) a final rule that implemented revised wage index values, geographic adjustment factors, operating standardized amounts, and capital Federal rates for hospitals subject to the inpatient hospital prospective payment system. These changes are effective for discharges occurring on or after March 1, 1999.

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. We also are proposing changes concerning GME costs and excluded hospitals and units, including critical access hospitals (CAHs). This proposed rule would be effective for discharges occurring on or after October 1, 1999.

We note that the efforts that we are undertaking to make the Medicare computer systems compliant on January 1, 2000, will not delay our ability to make timely and updated payments to hospitals under the FY 2000 prospective payment system final rule that will follow this proposed rule. The following is a summary of the major changes that we are proposing to make.

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

Section 1886(d)(4)(C) of the Act requires us to adjust the DRG classifications and relative weights at least annually. In order to avoid compromising our ability to process and pay hospital claims during the period leading up to and immediately following January 1, 2000, we are not implementing any revisions to the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD–9–CM) coding system. The changes that we are proposing to make relating to DRG reclassifications and recalibrations for FY 2000 are set forth in section II of is preamble.

2. Proposed 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:

- The FY 2000 wage index update, using FY 1996 wage data.
- The exclusion from the wage index of Part A physician wage costs that are teaching-related, as well as resident and Part A certified registered nurse anesthetist (CRNA) costs.
- Revisions to the wage index based on hospital redesignations.

3. Other Decisions and Proposed 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 proposed changes concerning the following:

- Sole community hospitals.
- Rural referral centers.
- Indirect medical education adjustment.
- Medicare Geographic Classification Review Board (MGCRB) decisions.
- Direct GME programs.

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

In section V of this preamble, we discuss the special exceptions process for certain eligible hospitals to receive additional payments for major construction or renovation projects that began soon after the start of the capital prospective payment system.

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

In section VI of this preamble, we discuss the following proposals concerning excluded hospital and hospital units and CAHs:

- Limits on and adjustments to the proposed target amounts for FY 2000.
- Changes in bed size or status of excluded hospitals or hospital units.
- Payment for services furnished at satellite hospital locations.
- Responsibility for care of patients in hospitals within hospitals.
- The allowable emergency response time for CAHs located in frontier or other specifically defined remote areas.
- Compliance with minimum data set requirements by CAHs with swing bed approval.

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 2000 prospective payment rates for operating costs and capital-related costs. We also address update factors for determining the rate-of-increase limits for cost reporting periods beginning in FY 2000 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 2000 capital cost model.

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

Section 1886(e)(3)(B) of the Act requires the Secretary to report to Congress on our initial estimate of a recommended update factor for FY 2000 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 2000 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

Under section 1805(b) of the Act, the Medicare Payment Advisory Commission (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, 1999 report made several recommendations concerning hospital inpatient payment policies. These recommendations, and the action we are proposing to take with regard to them

(when an action is recommended) are discussed in detail in this document. See section VII of this preamble for specific information. For further information relating specifically to the MedPAC March 1 report or to obtain a copy of the report, contact MedPAC at (202) 653–7220.

II. Proposed Changes to DRG Reclassifications and Recalibrations of 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 at least 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.

As discussed in more detail in section II.B.8 of this preamble, we are not implementing any revisions to the ICD–9–CM codes. We have undertaken, and continue to undertake, major efforts to ensure that all of the Medicare computer systems are ready to function on January 1, 2000. If we were to implement changes to the ICD–9–CM codes on October 1, 1999, we would endanger the functioning of the Medicare computer systems, and, specifically, we might compromise our ability to process hospital bills. We can, however, reclassify existing codes into different DRGs, if appropriate. The proposed changes to the DRG classification system, and the proposed recalibration of the DRG weights for discharges occurring on or after October 1, 1999, 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 ICD–9–CM codes. The Medicare fiscal intermediary enters the information into its claims processing 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 499 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 transplants (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 (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 2000 and other decisions concerning DRGs are set forth below.

2. MDC 15 (Newborns and Other Neonates with Conditions Originating in the Perinatal Period)

Based on inquiries we have received, we reviewed the appropriateness of including diagnosis codes V29.2 (Newborn observation for suspected respiratory condition) and V29.3 (Newborn observation for other genetic problem) in the list of allowable secondary diagnoses under DRG 391 (Normal Newborn). Currently, when one of these codes is the only secondary diagnosis for an otherwise healthy newborn, the case is assigned to DRG 390 (Neonate with Other Significant Problems).

Diagnosis codes V29.2 and V29.3 are used to indicate that the newborn was observed for a suspected condition but none was found. Other newborn observation codes in this series (V29.0, V29.1, V29.8, and V29.9) are included in the allowable secondary diagnoses under DRG 391. We believe that the presence of diagnosis code V29.2 or V29.3 should not exclude a newborn from being classified as normal. Therefore, we are proposing to include diagnosis codes V29.2 and V29.3 in the list of allowable secondary diagnosis under DRG 391.

3. MDC 19 (Mental Diseases and Disorders)

We have received correspondence about the title of DRG 425, ''Acute Adjustment Reaction and Disturbances of Psychosocial Dysfunction'' under MDC 19. The correspondents state that the use of the terms ''disturbances'' and ''dysfunction'' is redundant since the terms have similar meanings. They suggested that we remove the term ''disturbances.''

We agree with the correspondents and are proposing to revise the title of DRG 425 to read ''Acute Adjustment Reaction and Psychological Dysfunction.''

4. MDC 22 (Burns)

In the FY 1999 final prospective payment system rule that was effective October 1, 1998 (63 FR 40957), we implemented an extensive redesign of the DRGs for burns to more appropriately capture the variation in resource use associated with different classes of burn patients. The redesigned DRGs, 504 through 511, are split on such factors as whether there is an extensive burn, a full-thickness burn, or an inhalation injury, as well as other factors such as skin graft, trauma, or presence of a CC. DRGs 504 and 505 are assigned to cases with extensive third degree burns; that is, cases in which the burns cover at least 20 percent of body surface area combined with a third degree burn covering at least 10 percent of body surface area. DRGs 506 through 509 are assigned to all other cases with full-thickness burns (that is, a third degree burn). Finally, DRGs 510 and 511 are assigned to cases with nonextensive burns (that is, only first and second degree burns).

After these DRGs went into effect on October 1, 1998, we were contacted by several hospitals about our inclusion of the following codes as full-thickness burns:

948.00 Body burn involving less than 10 percent of body surface, third degree less than 10 percent or unspecified
948.10 Body burn involving 10 to 19 percent of body surface, third degree less than 10 percent or unspecified
948.20 Body burn involving 20 to 29 percent of body surface, third degree less than 10 percent or unspecified
948.30 Body burn involving 30 to 39 percent of body surface, third degree less than 10 percent or unspecified
948.40 Body burn involving 40 to 49 percent of body surface, third degree less than 10 percent or unspecified
948.50 Body burn involving 50 to 59 percent of body surface, third degree less than 10 percent or unspecified
948.60 Body burn involving 60 to 69 percent of body surface, third degree less than 10 percent or unspecified
948.70 Body burn involving 70 to 79 percent of body surface, third degree less than 10 percent or unspecified
948.80 Body burn involving 80 to 89 percent of body surface, third degree less than 10 percent or unspecified
948.90 Body burn involving 90 percent or more of body surface, third degree less than 10 percent or unspecified

The hospitals are concerned that the use of the fifth digit ''0'' on codes 948.10 through 948.90 can capture cases in which there actually is no third degree burn. The hospitals requested that we consider removing from the full-thickness burn DRGs 506 through 509 all codes in the 948 category with a fifth digit of ''0''.

We agree that the codes in category 948 with a fifth digit of ''0'' should not be assigned to DRGs 506 through 509 as full-thickness burns since not all of these cases will have a third degree burn. Therefore, we are proposing to remove these codes from DRGs 506 through 509 and to add them to DRG 510 (Nonextensive Burns with CC or Significant Trauma) and DRG 511 (Nonextensive Burns without CC or Significant Trauma).

If a case with a code of 948.10 is a full-thickness burn, this information would be captured in the burn code for the site of the burn (for example, 943.35 (Third degree burn of shoulder)) and the case would be correctly assigned to a full-thickness burn DRG. Hospitals have been instructed in *Coding Clinic for ICD–9–CM*, Fourth Quarter, 1994 (pages 22 through 28) to code the site of the burn first (940 through 947), when known. Codes from category 948 may be used as a principal diagnosis only when the site of the burn is not specified. Category 948 is used as an additional code to provide information on the percentage of total body that is burned or to show the percentage of burn that was third degree. When hospitals report codes properly, full-thickness burns will be assigned to a code for burn of the specific site (940 through 947). This site code also shows the degree of the burn. Furthermore, for those rare cases where the site is not provided, but it is known that 10 percent or more of the body has a third degree burn, hospitals may report this information through the use of category 948 with a fifth digit of ''1'' through ''9''. All of these cases will be classified as full-thickness burns in DRGs 506 through 509. Therefore, our proposal to remove codes 948.1 through 948.9 with a fifth digit of ''0'' will not prevent cases from being assigned to one of the full-thickness DRGs when there is a third degree burn and the case is correctly coded.

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 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 the 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 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 propose to revise the surgical hierarchy for the Pre-MDC DRGs and MDC 3 (Diseases and Disorders of the Ear, Nose, Mouth and Throat) as follows:

- In the Pre-MDC DRGs, we would reorder Lung Transplant (DRG 495) above Bone Marrow Transplant (DRG 481).
- In MDC 3, we would reorder Tonsil and Adenoid Procedure Except Tonsillectomy and/or Adenoidectomy Only (DRGs 57 and 58) above Cleft Lip and Palate Repair (DRG 52).

6. Refinement of Complications and Comorbidities (CC) 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); the August 29, 1997 final rule for the FY 1998 revisions (62 FR 45966); and the July 31, 1998 final rule for the FY 1999 revisions (63 FR 40954)). We are not proposing to add or delete any codes from the CC list.

In addition, as discussed in detail in section II.B.8 of this preamble, because we are not making changes to the ICD–9–CM codes for FY 2000, we do not need to modify the current list for new or deleted codes. Therefore, there are no proposed revisions to the CC Exclusions List for FY 2000.

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, and 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.) No procedures were moved in FY 1999, as noted in the July 31, 1998 final rule (63 FR 40962).

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 identified several procedures that we are proposing to move from DRG 468 to one of the surgical DRGs. We did not identify any necessary changes in procedures under DRG 477 and are, therefore, not proposing to move any procedures from DRG 477 to one of the surgical DRGs.

First, we are proposing to move three codes from DRG 468 to MDC 1 (Diseases and Disorders of the Nervous System), all of which would be assigned to DRGs 7 and 8 (Peripheral and Cranial Nerve and Other Nervous System Procedure).[1] Procedure code 38.7 (Interruption of the vena cava) is sometimes performed in conjunction with treatment for the principal diagnosis 434.11 (Cerebral embolism with infarction), which is assigned to MDC 1. Under the current configuration, procedure code 38.7 is not assigned to MDC 1. Therefore when this procedure is performed by a neurological condition, such as a cerebral embolism with infarction, the discharge does not group to one of the surgical DRGs within MDC 1. It is assigned instead to DRG 468 as an unrelated procedure. Since our medical advisors tell us that procedure code 38.7 is appropriately performed for neurological conditions, we are proposing to add it to DRGs 7 and 8.

Second, we are also proposing that procedure codes 83.92 (Insertion or replacement of skeletal muscle stimulator) and 83.93 (Removal of skeletal muscle stimulator) both be categorized with other procedures on the nervous system. These procedures can be performed on patients with a principal diagnosis in MDC 1, such as 344.00 (Quadriplegia unspecified) or 344.31 (Monoplegia of lower limb, affecting dominant side). Therefore, these two codes would also be assigned to DRGs 7 and 8.

Third, procedure code 39.50 (Angioplasty or atherectomy of noncoronary vessel) is not currently assigned to MDC 4 (Diseases and Disorders of the Respiratory System). This procedure can be performed for patients who develop pulmonary embolism. The principal diagnosis for pulmonary embolism is in MDC 4, and, to increase clinical coherence, we propose to add procedure code 39.50 to that MDC in DRGs 76 and 77 (Other Respiratory System OR Procedures).

Fourth, insertion of totally implantable infusion pump (procedure code 86.06) is not assigned to MDC 5 (Diseases and Disorders of the Circulatory System) in the current DRG configuration. Infusion pumps should be assigned to all MDCs where subcutaneous insertion of the pump is appropriate. Procedure code 86.06 may be performed on patients with a principal diagnosis in MDC 5 such as 451.83 (Phlebitis and thrombophlebitis of the deep veins of other extremities). Therefore, we are proposing to add procedure code 86.06 to DRG 120 (Other Circulatory System OR Procedures) in MDC 5.

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 described 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, co-chaired by the National Center for Health Statistics (NCHS) and HCFA, that is charged with the mission of maintaining and updating the ICD–9–CM system. 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 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 field, 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

[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.

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 for FY 2000 at public meetings held on June 14 and November 2, 1998. Even though the Committee conducted public meetings and considered approval of coding changes for FY 2000 implementation, we are not implementing any changes to ICD–9–CM codes for FY 2000. We have undertaken, and continue to undertake, major efforts to ensure that all of the Medicare computer systems are ready to function on January 1, 2000. If we were to make system changes to capture additions, deletions, and modifications to ICD–9–CM codes for FY 2000, we would endanger the functioning of the Medicare computer systems, and, specifically, we might compromise our ability to process hospital bills. Therefore, the code proposals presented at the public meetings held on June 14 and November 2, 1998, that (if approved) ordinarily would have been included as new codes for October 1, 1999, will not be included in this proposed rule. These code changes to ICD–9–CM will be considered for inclusion in the next annual update for FY 2001. The initial meeting for consideration of coding changes for implementation in FY 2001 will be held on May 13, 1999.

Copies of the minutes of the 1998 meetings can be obtained from the HCFA Home Page at 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; C4–07–07; 7500 Security Boulevard; Baltimore, Maryland 21244–1850. Comments may be sent by E-mail to: pbrooks@hcfa.gov.

9. Other Issue: Implantation of Muscle Stimulator

In the July 31, 1998 final rule, we responded to a comment on the DRG assignment for implantation of a muscle stimulator (63 FR 40964). In that document, we stated that we would readdress this issue after reviewing the FY 1998 MedPAR file.

There is concern in the manufacturing industry that the current DRG assignment for the implantation of a muscle stimulator and the associated tendon transfer for quadriplegics is inappropriate. When the procedures are performed during two separate admissions, the tendon transfer (procedure code 82.56 (Other hand tendon transfer or transplantation)) is assigned to DRGs 7 and 8 and the insertion of the muscle stimulator (procedure code 83.92 (Insertion or replacement of skeletal muscle stimulator)) is assigned to DRG 468. However, when both procedures are performed in the same admission, the case is assigned to DRGs 7 and 8.

As discussed in section II.B.7.a of this preamble, we are proposing to assign code 83.92 to DRGs 7 and 8 in MDC 1. Therefore, if a case involves either procedure code 82.56 or 83.92, or both procedure codes, the case would be assigned to DRGs 7 and 8.

A presentation on one type of muscle stimulator was made by a device manufacturer before the ICD–9–CM Coordination and Maintenance Committee on November 2, 1998. The manufacturer strongly suggested that a new code assignment be made for the procedure for insertion of this stimulator and that it be placed in category 04.9 (Other operations on cranial and peripheral nerves). However, based on comments received by the Committee, there was an overwhelming response from the coding community that a new code should not be created. The commenters believe that these codes (82.56 and 83.92) adequately described the procedures since the patient receives a tendon transfer in addition to the skeletal muscle stimulator insertion. This is done so that the quadriplegic patient can achieve some hand grasping ability where there was none before. Some quadriplegic patients receive the tendon transfer on one admission and the stimulator insertion on a subsequent admission. Others have both procedures performed on the same admission. Since the tendon transfer and stimulator insertion are being performed on quadriplegic patients, a condition found in MDC 1, we propose to add procedure codes 82.56 and 83.92 to DRGs 7 and 8.

C. Recalibration of DRG Weights

We are proposing to use the same basic methodology for the FY 2000 recalibration as we did for FY 1999. (See the July 31, 1998 final rule (63 FR 40965).) That is, we would recalibrate the weights based on charge data for Medicare discharges. However, we propose to use the most current charge information available, the FY 1998 MedPAR file. (For the FY 1999 recalibration, we used the FY 1997 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 1998 MedPAR data, based on bills received by HCFA through December 1998, from all hospitals subject to the prospective payment system and short-term acute care hospitals in waiver States. The FY 1998 MedPAR file includes data for approximately 11.2 million Medicare discharges.

The methodology used to calculate the proposed DRG relative weights from the FY 1998 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 and 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 1998 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 2000. Using the FY 1998 MedPAR data set, there are 39 DRGs that contain fewer than 10 cases. We computed the weights for the 39 low-volume DRGs by adjusting the FY 1999 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.

D. Use of Non-MedPAR Data for Reclassification and Recalibration of the DRGs

1. Introduction

As in past years, in the DRG reclassification and recalibration process for the FY 2000 proposed rule, we used the MedPAR file, which consists of data for approximately 11 million Medicare discharges. In the FY 1999 rulemaking process, we used the FY 1997 MedPAR file to recalibrate DRGs and evaluate possible changes to DRG classifications; for this FY 2000 proposed rule, we used the FY 1998 MedPAR file. The Conference Report that accompanied the Balanced Budget Act of 1997 stated 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 Medicare Provider Analysis and Review (MedPAR) data in annually recalibrating and reclassifying the DRGs.'' (H. R. Conf. Rep. No. 105–217 at 734 (1997)).

Consistent with that language, we considered non-MedPAR data both in the rulemaking process for FY 1999 and in developing this proposed rule. We received non-MedPAR data from entities on behalf of the manufacturer of a specific drug, platelet inhibitors; the manufacturer is seeking to obtain a new DRG assignment for cases involving platelet inhibitors. The non-MedPAR data purported to show cases involving platelet inhibitors. As discussed further below, we concluded it was not feasible to use the non-MedPAR data submitted to us because, among other things, we did not have information to verify that the cases actually involved the drug, nor did we have information to verify that the cases reflected a representative sample (and did not simply reflect high cost cases).

Effective October 1, 1998, we implemented a code for platelet inhibitors, but until we receive bills for Medicare discharges occurring during FY 1999, the MedPAR data do not enable us to distinguish between cases with platelet inhibitors and cases without platelet inhibitors (63 FR 40963). Representatives of the pharmaceutical company first presented us with non-MedPAR data during the rulemaking process for FY 1999. The data was compiled by a health information company, and purported to show, for cases from a sample of hospitals, the average standardized charges (as calculated by the health information company) for different classes of patients.

In the FY 1999 final rule, we stated a number of reasons why we rejected the non-MedPAR data we had received. First, we could not validate whether the data reflected Medicare beneficiaries. Second, the data came from a limited number of hospitals (83) having an information sharing contract with the health information company that compiled the database; the company failed to provide us with information that would enable us to verify whether the data reflected a representative sample of hospitals or claims. Third, for over 90 percent of the cases, the company failed to provide us with information on which hospital furnished the treatment. This means that we could not validate the data on standardized charges nor could we use the data to determine an appropriate DRG weight for the DRG *from which* the cases would be reclassified. For these reasons (and others), we concluded in the July 31, 1998 final rule that we could not use the data to change the DRG assignment of cases involving platelet inhibitor drug therapy from DRG 112 (Percutaneous Cardiovascular Pacemaker Procedures) to DRG 116 (Other Permanent Cardiac Pacemaker Implant or PTCA with Coronary Artery Stent Implant).

After publication of the July 31, 1998 final rule, we met and corresponded on several occasions with the manufacturers, vendors, and legal representatives of the pharmaceutical company in an effort to resolve data issues. We reiterated that, among other things, we needed to know for each case

the hospital that furnished the services. We have not received information necessary to validate the data itself or its representativeness.

We remain open to considering non-MedPAR data in the DRG reclassification and recalibration process, but, consistent with the Conference Report, as well as our longstanding policies, the data must be ''reliable'' and ''validated.'' The July 31, 1998 final rule reflects the major factors that we consider in evaluating whether data are feasible, reliable, and validated, but we believe it might be useful to discuss these issues in greater detail.

2. The DRG Reclassification and Recalibration Process

In order to understand whether it is feasible to use non-MedPAR data, and whether the data are reliable and validated, it is critical to understand the DRG recalibration and reclassification process. As described earlier, one of the first steps in the annual DRG recalibration is that the Medicare hospital inpatient claims (in the MedPAR file) from the preceding Federal fiscal year are classified using the DRG classification system (proposed or final) for the upcoming year. Cases are classified into DRGs 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. Each case is classified into one and only one DRG.

As the term suggests, the relative weight for each DRG reflects *relative* resource use. The recalibration process requires data that enable us to compare resource use across DRGs. As explained earlier, as part of the recalibration process, we standardize the charges reflected on each Medicare claim to remove the effects of area wage differences, the IME adjustment, and the DSH adjustment; in order to standardize charges, we need to know which hospital furnished the service. For each DRG, we calculate the average of the standardized charges for the cases classified to the DRG. To calculate DRG relative weights, we compare average standardized charges across DRGs.

In evaluating whether it is appropriate to reclassify cases from one DRG to another, we examine the average standardized charges for those cases. The recalibration process and the reclassification process are integrally related; to evaluate whether cases involving a certain procedure should be reclassified, we need to have information that (1) enables us to identify cases that involve the procedure and cases that do not involve the procedure, and (2) enables us to determine appropriate DRG relative weights if certain cases are reclassified.

3. Feasible, Reliable, Validated Data

As indicated earlier, the Conference Report reflected the conferees' belief that, ''to the extent feasible,'' HCFA should consider ''reliable, validated data'' in recalibrating and reclassifying DRGs. The concepts of reliability and validation are closely related. In order for us to use non-MedPAR data, the non-MedPAR data must be reliable in and of itself in that the data must be independently validated. When an entity submits non-MedPAR data, we must be able to independently review the medical records and verify that a particular procedure was performed for each of the cases that purportedly involved the procedure. This verification requires the identification of a particular Medicare beneficiary and the hospital where the beneficiary was treated, as well as the dates involved. Although it is unlikely that we would review 100 percent of thousands of cases submitted for review, at a minimum, we must be able to validate data through a random sampling methodology. We must also be able to verify the charges that are reflected in the data.

Independent validation is particularly critical in part because the non-MedPAR data might be submitted by (or on behalf of) entities that have a financial interest in obtaining a new DRG assignment and in obtaining the highest possible DRG relative weight. If we receive non-MedPAR data that purport to reflect cases involving a certain procedure and a certain level of charges, we must have some way to verify the data.

Even if non-MedPAR data are reliable and verifiable, that does not mean it is necessarily ''feasible'' to use the data for purposes of recalibration and reclassification. In order to be feasible for these purposes, the non-MedPAR data must enable us to appropriately measure relative resource use across DRGs. It is critical that cases are classified into one *and only one* DRG in the recalibration process, and that we have information that enables us to standardize charges for each case and determine appropriate DRG relative weights. Moreover, the data must reflect a complete set of cases or, at a minimum, a representative sample of hospitals and claims.

If cases are classified into more than one DRG (or into the incorrect DRG) in the recalibration process, or if the non-MedPAR data reflect an unrepresentative sample of cases, the measure of relative resource would be distorted. For example, cases of percutaneous transluminal coronary angioplasty (PTCA) treated with GPIIb/IIIa platelet inhibitors (procedure code 99.20) are currently classified to DRG 112. The drug manufacturer has provided us with information on the average charges for a sample of cases that purportedly involve PTCA, for the purpose of evaluating whether these cases should be moved to the higher-weighted DRG 116. However, without adequate identification of the cases to allow us to specifically identify all of the cases treated with platelet inhibitors, the relative weight for DRG 112 would reflect the costs of platelet inhibitor cases. This distortion would result in excessive payments under DRG 112, and thus undermine the integrity of the recalibration process.

Therefore, in order for the use of non-MedPAR data to be feasible, generally we must be able to accurately and completely identify all of the cases to be reclassified from one DRG to another. At a minimum, we must have some mechanism for ensuring that DRG weights are not inappropriately inflated (or deflated) to the extent that a DRG weight reflects cases that would be reclassified to a different DRG.

In short, then, for use of non-MedPAR data to be feasible for purposes of DRG recalibration and reclassification, the data must, among other things (1) be independently verifiable, (2) reflect a complete set of cases (or a representative sample of cases), and (3) enable us to calculate appropriate DRG relative weights and ensure that cases are classified to the ''correct'' DRG, and to one DRG only, in the recalibration process.

Applying this analysis, the non-MEDPAR data we have received with respect to platelet inhibitors are unreliable and its use is not feasible. The health information company, on behalf of the pharmaceutical company, has provided us with a sample of cases that purported to reflect platelet inhibitors, and also purported to reflect the standardized charges for those cases, but the company has failed to provide us with information that would enable us to verify that the cases actually involved platelet inhibitors or verify the level of charges.

Moreover, the data are not useful for purposes of measuring relative resource use. We have not received sufficient information to verify whether the hospitals are representative of all hospitals in the country and whether the non-MedPAR data reflects a representative sample of all cases involving platelet inhibitors. Also, we have not received sufficient information

to use the non-MedPAR data to calculate appropriate DRG relative weights.

4. Submission of Data

Finally, in order for use of non-MEDPAR data to be feasible, we must have sufficient time to evaluate and test the data. The time necessary to do so depends upon the nature and quality of the data submitted. Generally, however, a significant sample of the data should be submitted by August 1, approximately 8 months prior to the publication of the proposed rule, so that we can test the data and make a preliminary assessment as to the feasibility of its use. Subsequently, a complete database should be submitted no later than December 1 for consideration in conjunction with the next year's proposed rule.

5. How the Prospective Payment System Ensures Access to New Technologies

As noted at the outset of this discussion, the Conference Report that accompanied the BBA indicated that we should consider non-MEDPAR data, to the extent feasible, ''in order to ensure that Medicare beneficiaries have access to innovative new drug therapies.'' (H. R. Conf. Rep. No. 105–217 at 734 (1997)) There seems to be a concern that, if a new technology is introduced, and if the new technology is costly, then Medicare would not make adequate payment if the new technology is not immediately placed in a new DRG. This concern is unfounded. As explained below, the Medicare hospital inpatient prospective payment does ensure access to new drug therapies, and new technologies in general.

First, to the extent a case involving a new technology is extremely costly relative to the cases reflected in the DRG relative weight, the hospital might qualify for outlier payments, additional payments over and above the standard PPS payment.

Second, Medicare promotes access to new technologies by making payments under the propsective payment system that are designed to ensure that Medicare payments for a hospital's cases *as a whole* are adequate. We establish DRGs based on factors such as clinical coherence and resource utilization. Each diagnosis-related group encompasses a variety of cases, reflecting a range of services and a range of resources. Generally, then, each DRG reflects some higher cost cases and some lower cost cases.

For some cases, the hospital's costs might be higher than the payment under the propsective payment system; this does not mean that the DRG classifications are ''inappropriate.'' For other cases, the hospital's costs will be lower than the payment under the prospective payment system. We believe that Medicare makes appropriate payments for a hospital's cases as a whole.

Each year we examine the best data available to assess whether DRG changes are appropriate and to recalibrate DRG relative weights. As we have indicated on numerous occasions, it usually takes 2 years from the time a procedure is assigned a code to collect the appropriate MedPAR data and then make an assessment as to whether a DRG change is appropriate. This timetable applies to reclassifications that would lead to decreased payment as well as those that would increase payment. In fact, the introduction of new technologies itself might lead to either higher than average costs or *lower* costs.

Our ability to evaluate and implement potential DRG changes depends on the availability of validated, representative data. We believe that our policies ensure access to new technologies and are critical to the integrity of the recalibration process. As explained above, we remain open to using non-MedPAR data if the data are reliable and validated and enable us to appropriately measure relative resource use.

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.

Beginning October 1, 1993, section 1886(d)(3)(E) of the Act requires that we update the wage index annually. 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. As discussed below in section III.F of this preamble, we also take into account the geographic reclassification of hospitals in accordance with sections 1886(d)(8)(B) and 1886(d)(10) of the Act when calculating the wage index.

B. FY 2000 Wage Index Update

The proposed FY 2000 wage index values in section VI of the Addendum to this proposed rule (effective for hospital discharges occurring on or after October 1, 1999 and before October 1, 2000) are based on the data collected from the Medicare cost reports submitted by hospitals for cost reporting periods beginning in FY 1996 (the FY 1999 wage index was based on FY 1995 wage data).

We note that the FY 1999 wage index published in the July 31, 1998 final rule was further revised on February 25, 1999 (64 FR 9378) to reflect approved revisions to the hospital wage data used to compute the wage index. In that final rule, we implemented revised wage index values, geographic adjustment factors, operating standardized amounts, and capital Federal rates for hospitals subject to the inpatient hospital prospective payment system. These changes are effective for discharges occurring on or after March 1, 1999.

The proposed FY 2000 wage index includes the following categories of data associated with costs paid under the

hospital inpatient prospective payment system (as well as outpatient costs), which were also included in the FY 1999 wage index:

- Salaries and hours from short-term, acute care hospitals.
- Home office costs and hours.
- Certain contract labor costs and hours.
- Wage-related costs.

Consistent with the wage index methodology for FY 1999, the proposed wage index for FY 2000 also continues to exclude the direct and overhead salaries and hours for services not paid through the inpatient prospective payment system such as skilled nursing facility services, home health services, or other subprovider components that are not subject to the prospective payment system.

We 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. Finally, section 4410 of the BBA 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.

C. FY 2000 Wage Index Proposals

In the July 31, 1998 final rule, we reiterated our position that, to the greatest degree possible, the hospital wage index should reflect the wage costs associated with the areas of the hospital included under the hospital inpatient prospective payment system (63 FR 40970). That final rule contained a detailed discussion concerning the costs related to teaching physicians, residents, and CRNAs, all of which are paid by Medicare separately from the prospective payment system. For reasons outlined in detail in that final rule, we decided not to remove those costs from the calculation of the FY 1999 wage index, but to review updated data and consider removing them in developing the FY 2000 wage index.

In response to concerns within the hospital industry related to the removal of these costs from the wage index calculation, the American Hospital Association (AHA) convened a workgroup to develop a consensus recommendation. The workgroup, which consisted of representatives from national and state hospital associations, recommended that costs related to teaching physicians, residents, and CRNAs should be phased out of the wage index calculation over a 5-year period. As discussed in more detail below, based upon our analysis of hospitals' FY 1996 wage data, and consistent with the AHA workgroup's recommendation, we are proposing to phase out these costs from the calculation of the wage index over a 5-year period. The proposed FY 2000 wage index is based on a blend of 80 percent of an average hourly wage including these costs, and 20 percent of an average hourly wage excluding these costs.

1. Teaching Physician Costs

Before FY 1999, we included direct physician Part A costs and excluded contract physician Part A costs from the wage index calculation. Since some States prohibit hospitals from directly employing physicians, hospitals in these States were unable to include physician Part A costs because they were incurred under contract rather than directly. Therefore, for cost reporting periods beginning in 1995, we began separately collecting physician Part A costs (both direct and contract) so we could evaluate how to best handle these costs in the wage index calculation. Based on our analysis of the 1995 wage data, we decided to include the contract physician salaries in the wage index beginning with FY 1999.

In the July 31, 1998 final rule, in response to comments regarding the inclusion in physician Part A costs of teaching physician costs for which teaching hospitals are already compensated through the Medicare GME payment, we stated that we would collect teaching physician data ''as expeditiously as possible in order to analyze whether it is feasible to separate teaching physician costs from other physician Part A costs'' (63 FR 40968). Excluding teaching physician costs from the wage index calculation is consistent with our general policy to exclude from that calculation those costs that are paid separately from the prospective payment system.

Because the FY 1996 cost reports did not identify teaching physician salaries and hours separately from physician Part A costs, we instructed our fiscal intermediaries to collect, through a survey, teaching physician costs and hours from the teaching hospitals they service. Specifically, we requested collection of data on the costs and hours related to teaching physicians that were included in Line 4 (salaried), Line 10 (contracted), Line 12 (home office and related organizations), and Line 18 (wage-related costs) of the Worksheet S–3, Part II. In our instructions accompanying the survey, we indicated that these teaching-related costs are those payable under the per resident amounts (§ 413.86) and reported on Worksheet A, Line 23 of the hospital's cost report.

The survey data collected as of the last week of January 1999 are included in the preliminary public use file made available on the Internet on February 5, 1999. At that time, we had received completed surveys for over one-half of teaching hospitals reporting physician Part A costs on their Worksheet S–3, Part II (372 out of 700). In early February 1999, we instructed intermediaries to review the survey data for consistency with the Supplemental Worksheet A–8–2 of the hospitals' cost reports. Supplemental Worksheet A–8–2 is used to apply the reasonable compensation equivalency limits to the costs of provider-based physicians, itemizing these costs by the corresponding line number on Worksheet A.

When we notified the fiscal intermediaries (and the fiscal intermediaries notified the hospitals) of the availability to review the survey data on the Internet, we also established deadlines of March 5, 1999 for hospitals to request changes to the teaching survey data, and April 5, 1999, for the fiscal intermediaries to submit the data to HCRIS. The additional data collected from the hospitals through the fiscal intermediaries by April 5 will be included in the final wage data file released in May 1999.

Due to the extraordinary effort needed to collect these data and the importance of accurately removing teaching physician costs, we will consider requests from a hospital to revise its teaching survey data as reflected on the final wage data file released in May 1999. (We are not extending the deadline for requests for revisions to cost report data.) Requests must be received by HCFA and the hospital's fiscal intermediary no later than June 7, 1999, and must include all necessary supporting documentation. As described above, these data were not originally collected on the FY 1996 cost report. The deadlines established under our annual process for editing and verifying the wage data reflect the fact that hospitals prepare and submit their cost reports at least 1 year, and generally more than 1 year, before the deadline for requesting changes. Because the timeframe in which the survey data were collected was considerably shorter, we have extended the deadline for revising those data.

Since we published the July 31, 1998 final rule, we have received a recommendation from the hospital industry concerning the methodology that could be used to exclude physician

teaching-related costs from the wage index. The industry recommended that we implement a 5-year phase-out of all physician Part A wage costs that are teaching-related, as well as all resident and Part A CRNA costs. In FY 2000, the first year of the phase-out, the applicable wage index would be based on a blend of 80 percent of the current policy, which would include all physician Part A costs, and 20 percent of the new policy, which would exclude teaching physician Part A, resident, and CRNA costs. The percentages would be adjusted 20 percent each year until FY 2004, when all teaching physician, resident, and CRNA costs would be eliminated from the wage index calculation.

The workgroup also recommended that if the teaching data collected by the intermediaries are not accurate or reliable, HCFA would include only 20 percent of reported physician Part A costs in the calculation, based on the assumption that 80 percent of total physician Part A costs are related to teaching physicians.

We appreciate the industry's willingness to work with us on this issue and recommend a reasonable and practical solution. In developing our proposed FY 2000 wage index, we have adopted most of the components of this recommendation.

In developing the proposed FY 2000 wage index, we calculated the teaching costs to be removed from the wage index as follow. If we had complete survey data for a hospital, that amount was subtracted from the amount reported on the Worksheet S–3 for physician Part A costs. However, relying solely on the survey data would have resulted in the removal of no teaching physician costs for many hospitals.

As noted above, the hospital industry recommended that if HCFA believes the survey data are not reliable or accurate, it should remove 80 percent of the total physician Part A costs and hours. Although we considered this option, we believe that removing 80 percent of the total physician Part A costs and hours across the board would not recognize the variations among hospitals in terms of the percentage of their physician Part A costs consisting of teaching physician costs. Of the hospitals for which we have survey data, teaching physician costs, as reflected on the survey, amount to, on average, approximately 68 percent. If we adopted the recommended methodology, we would not only negate the efforts of those hospitals and their fiscal intermediaries that did complete the teaching physician survey, we would also actually penalize hospitals that cooperated in completing the survey by removing an amount in excess of actual teaching physician Part A costs they reported.

Therefore, under our proposal, for any hospital that completed the survey, we removed from the wage data the physician Part A teaching costs and hours reported on the survey form. These data had been verified by the fiscal intermediary before submission to HCFA. If we did not have survey data for a teaching hospital as of February 22, 1999, we removed 80 percent of the hospital's reported total physician Part A costs and hours for the proposed wage index. Based upon our communications with fiscal intermediaries, we believe we will have a substantially higher response rate for the survey data by the time we calculate the final FY 2000 wage index values. As discussed above, we have instructed the fiscal intermediaries to undertake a further attempt to collect these data for those hospitals that initially did not report survey data. We believe that since the average percentage of teaching costs compared to total physician Part A costs is less than 80 percent, it would be an advantage to a hospital to complete the survey.

Although removing 80 percent from the amount reported on the Worksheet S–3 for physician Part A costs allows an estimate of teaching physician costs to be removed in the majority of cases in which survey data are not available, there are instances in which a teaching hospital did not report either survey data or any physician Part A costs on its Worksheet S–3. We have identified 72 such teaching hospitals in our database. For purposes of calculating the proposed FY 2000 wage index for these 72 hospitals, we subtracted the costs reported on Line 23 of the Worksheet A, Column 1 (Resident and Other Program Costs) from Line 1 of the Worksheet S–3. These costs (from Line 23, Column 1 of Worksheet A) are included in Line 1 of the Worksheet S–3, which is the sum of Column 1, Worksheet A. They also represent costs for which the hospital is paid through the per resident amount under the direct GME payment. Therefore, we believe it is appropriate to remove these costs from the wage index calculation in situations in which hospitals have failed to otherwise identify their teaching physician costs. To determine the hours to be removed, we divided the costs reported on Line 23 of the Worksheet A, Column 1 by the national average hourly wage for physician Part A costs based upon Line 4 of the Worksheet S–3 (the national average hourly wage is $54.48). We have indicated these 72 hospitals by an asterisk in Table 3C of this proposed rule.

We invite comments as to whether the proposed method we have used to remove teaching-related costs based on the amount included in Line 23, Column 1 of Worksheet A would be an appropriate method for removing GME costs in the future (and perhaps other excluded area costs as well). We are especially concerned that the earliest cost report on which we will be able to make the necessary changes to capture the separate reporting of teaching physician Part A costs would be cost reports that would be submitted for cost reporting periods beginning during FY 1998. Therefore, we are considering the potential for subtracting the costs in Lines 20, 22, and 23 of Worksheet A from Line 1 of Worksheet S–3, Part II, in calculating the FY 2001 wage index. The current Worksheet S–3 is not designed to net out of Line 1 costs that are otherwise included in Column 1 of Worksheet A, but it would be possible to use data from the Worksheet A in a manner similar to that described above.

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 (§ 412.113(c)). Because 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. However, because these costs were not separately identifiable before the FY 1995 wage data, we could not remove them.

We began collecting the resident and CRNA wage data separately on the FY 1995 cost report. However, there were data reporting problems associated with these costs. For example, the original FY 1995 cost report instructions for reporting resident costs on Line 6 of Worksheet S–3, Part III, erroneously included teaching physician salaries and other teaching program costs. Also, the FY 1995 Worksheet S–3 did not provide for separate reporting of CRNA wage-related costs. These problems were corrected in the reporting instructions for the FY 1996 cost report, and we are now proposing to remove CRNA and resident costs over a 5-year period.

3. Transition Period

The proposed FY 2000 wage index is based on a blend of 80 percent of

hospitals' average hourly wages without removing the costs and hours associated with teaching physician Part A, residents, and CRNAs, and 20 percent of the average hourly wage after removing these costs and hours from the wage index calculation. This methodology is consistent with the recommendation of the industry workgroup for a 5-year phase-out of these costs. The transition methodology is discussed in detail in section III.E of this preamble.

D. Verification of Wage Data From the Medicare Cost Report

The data for the proposed FY 2000 wage index were obtained from Worksheet S–3, Parts II and III of the FY 1996 Medicare cost reports. The data file used to construct the proposed wage index includes FY 1996 data submitted to the Health Care Provider Cost Report Information System (HCRIS) as of early February 1999. As in past years, we performed an intensive review of the wage data, mostly through the use of edits designed to identify aberrant data.

From mid-January to mid-February 1999, we asked our fiscal intermediaries to revise or verify data elements that resulted in specific edit failures. Some unresolved data elements are included in the calculation of the proposed FY 2000 wage index pending their resolution before calculation of the final FY 2000 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 5, 1999. 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 removed data for eight hospitals that failed edits. For four 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. Two hospitals had negative average hourly wages after allocating overhead to their excluded areas, and were therefore removed from the calculation. The data from the remaining two hospitals were removed because inclusion of their data would have significantly distorted the wage index values. The data for these hospitals will be included in the final wage index if we receive corrected data that pass our edits. As a result, the proposed FY 2000 wage index is calculated based on FY 1996 wage data for 5,035 hospitals.

E. Computation of the Wage Index

The method used to compute the proposed FY 2000 wage index is as follows:

Step 1—As noted above, we are proposing to base the FY 2000 wage index on wage data reported on the FY 1996 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 II and III of the Medicare cost report for the hospital's cost reporting period beginning on or after October 1, 1995 and before October 1, 1996. In addition, we included data from a few hospitals that had cost reporting periods beginning in September 1995 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 because particular labor market areas might be affected due to the omission of these hospitals. However, we generally describe these wage data as FY 1996 data.

Step 2—Salaries—The method used to compute a hospital's average hourly wage is a blend of 80 percent of the hospital's average hourly wage including all teaching physician Part A, resident, and CRNA costs, and 20 percent of the hospital's average hourly wage after eliminating all teaching physician, resident, and CRNA costs.

In calculating a hospital's average salaries plus wage-related costs, including all teaching physician Part A, resident, and CRNA costs, we subtracted from Line 1 (total salaries) the Part B salaries reported on Lines 3 and 5, home office salaries reported on Line 7, and excluded salaries reported on Lines 8 and 8.01 (that is, direct salaries attributable to skilled nursing facility services, home health services, and other subprovider components not subject to the prospective payment system). We also subtracted from Line 1 the salaries for which no hours were reported on Lines 2, 4, and 6. To determine total salaries plus wage-related costs, we added to the net hospital salaries the costs of contract labor for direct patient care, certain top management, and physician Part A services (Lines 9 and 10), home office salaries and wage-related costs reported by the hospital on Lines 11 and 12, and nonexcluded area wage-related costs (Lines 13, 14, 16, 18, and 20). We note that contract labor and home office salaries for which no corresponding hours are reported were not included.

We then calculated a hospital's salaries plus wage-related costs by subtracting from total salaries the salaries plus wage-related costs for teaching physicians (see section III.C.1 of this preamble for a detail discussion of this policy), Part A CRNAs (Lines 2 and 16), and residents (Lines 6 and 20).

Step 3—Hours—With the exception of wage-related costs, for which there are no associated hours, we computed total hours using the same methods as described for salaries in Step 2.

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 (sum of Lines 8 and 8.01 of Worksheet S–3, Part II) to revised total hours (Line 1 minus Lines 3, 5, and 7 of Worksheet S–3, Part II). We then 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 13 of Worksheet S–3, Part III. 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 adjustment, we estimated the percentage change in the employment cost index (ECI) for compensation for each 30-day increment from October 14, 1995 through April 15, 1997 for private industry hospital workers from the Bureau of Labor Statistics' Compensation and Working Conditions. We use the ECI because it reflects the price increase associated with total compensation (salaries plus fringes) rather than just the increase in salaries. In addition, the ECI includes managers as well as other hospital workers. This methodology to compute the monthly update factors uses actual quarterly ECI data and assures that the update factors match the actual quarterly and annual percent changes. The factors used to adjust 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
10/14/95	11/15/95	1.023163
11/14/95	12/15/95	1.021153
12/14/95	01/15/96	1.019151
01/14/96	02/15/96	1.017157
02/14/96	03/15/96	1.015246
03/14/96	04/15/96	1.013489

MIDPOINT OF COST REPORTING PERIOD—Continued

After	Before	Adjustment factor
04/14/96	05/15/96	1.011888
05/14/96	06/15/96	1.010428
06/14/96	07/15/96	1.009099
07/14/96	08/15/96	1.007900
08/14/96	09/15/96	1.006788
09/14/96	10/15/96	1.005719
10/14/96	11/15/96	1.004695
11/14/96	12/15/96	1.003653
12/14/96	01/15/97	1.002529
01/14/97	02/15/97	1.001325
02/14/97	03/15/97	1.000000
03/14/97	04/15/97	0.998514

For example, the midpoint of a cost reporting period beginning January 1, 1996 and ending December 31, 1996 is June 30, 1996. An adjustment factor of 1.009099 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 1996 and covers a period of less than 360 days or more 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 before 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 under both methods in Step 6 by the sum of the corresponding total hours (from Step 4) for all hospitals in each labor market area to determine an average hourly wage for the area.

Because the proposed FY 2000 wage index is based on a blend of average hourly wages, we then added 80 percent of the average hourly wage calculated without removing teaching physician Part A, residents, and CRNA costs, and 20 percent of the average hourly wage calculated with these costs removed.

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 same blending methodology described in Step 7). Using the data as described above, the national average hourly wage is $20.9675.

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. (The national Puerto Rico standardized amount is adjusted by a wage index calculated for all Puerto Rico labor market areas based on the national average hourly wage as described above.) 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 $9.96607 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 the BBA 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 that would have been made in the year if this section did not apply. For FY 2000, this change affects 185 hospitals in 39 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 in which 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 2000 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, before the redesignation of hospitals, based on the FY 1996 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 preliminary FY 1996 data as of February 22, 1999. The MGCRB will use the average hourly wage published in the final rule to evaluate a hospital's application for reclassification for FY 2001, 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. We note that in adjudicating these wage index reclassification requests during FY 2000, the MGCRB will use the average hourly wages for each hospital and labor market area that are reflected in the final FY 2000 wage index.

At the time this proposed wage index was constructed, the MGCRB had completed its review of FY 2000 reclassification requests. The proposed FY 2000 wage index values incorporate all 441 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 2000. 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 following this proposed rule. The changes may affect not only the wage index value for specific geographic areas, but also the wage index value redesignated hospitals receive, that is, whether they 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 2000 must be received by the MGCRB by June 21, 1999. A hospital that requests to withdraw its application may not later request that the MGCRB decision be reinstated.

G. Requests for Wage Data Corrections

To allow hospitals time to evaluate the wage data used to construct the proposed FY 2000 hospital wage index, we made available to the public a data file containing the FY 1996 hospital wage data. As stated in section II.D of this preamble, the data file used to construct the proposed wage index includes FY 1996 data submitted to HCRIS as of early February 1999. In a memorandum dated February 1, 1999, 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 5, 1999 through the Internet at HCFA's home page (http://www.hcfa.gov). We also instructed the intermediaries to advise hospitals of the availability of these data either 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. It should be noted that the hospital average hourly wages shown in Table 3C do not reflect any changes made to a hospital's data after February 22, 1999. Changes approved by a hospital's fiscal intermediary and forwarded to HCRIS by April 5, 1999 will be reflected on the final public use wage data file scheduled to be made available May 7, 1999.

We believe hospitals have had ample time to ensure the accuracy of their FY 1996 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 5, 1999, a hospital believed that its FY 1996 wage data were incorrectly reported, the hospital was to submit corrections along with complete, detailed supporting documentation to its intermediary by March 5, 1999. Hospitals were notified of this deadline, and of all other possible deadlines and requirements, through written communications from their fiscal intermediaries in early February 1999.

Any wage data corrections to be reflected in the final wage index must have been reviewed and verified by the intermediary and transmitted to HCFA on or before April 5, 1999. (The deadline for hospitals to request changes from their fiscal intermediaries was March 5, 1999.) 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, 1999. We cannot guarantee that corrections transmitted to HCFA after April 5, 1999 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 II and III to the hospitals. In addition, fiscal intermediaries were to notify hospitals of the changes or the reasons that 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 5 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 2000 payment rates. Accordingly, hospitals that do not meet the procedural deadlines set forth above will not be afforded a later opportunity to submit wage data corrections or to dispute the intermediary's decision with respect to requested changes.

The final wage data public use file will be released by May 7, 1999. Hospitals should examine both Table 3C of this proposed rule and the May 7 final public use wage data file (which reflects revisions to the data used to calculate the values in Table 3C) to verify the data HCFA is using to calculate the wage index. Hospitals will have until June 7, 1999 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 at that time will be limited to errors in the entry or tabulation of the final wage data that the hospital could not have known about before the release of the final wage data public use file.

The final wage data file released on May 7, 1999 will contain the wage data that will be used to construct the wage index values in the final rule. As noted above in section III.C of this preamble, this file will include hospitals' teaching survey data as well as cost report data. As with the file made available in February 1999, HCFA will make the final wage data file released in May 1999 available to hospital associations and the public (on the Internet). However, with the exception of the teaching survey data, this file 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 5 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 7, 1999. 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; C4–07–07; 7500 Security Boulevard; Baltimore, MD 21244–1850. Each request must also 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 point in the process, 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. (As noted above, however, we are also allowing hospitals to request changes to their teaching survey data. These requests must comply with all of the documentation and deadline requirements as otherwise specified in this proposed rule.) 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 5, 1999.
- Requests for correction of errors that were not, but could have been, identified during the hospital's review of the February 1999 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 7, 1999) will be incorporated into the final wage index to be published by July 30, 1999 and effective October 1, 1999.

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 1999, 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 2000 wage index by July 30, 1999 and the implementation of the FY 2000 wage index on October 1, 1999. If hospitals avail themselves of this opportunity, the wage index implemented on October 1 should be free of these 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 in which 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 2000 (that is, by the June 7, 1999 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.

In the September 1, 1994 **Federal Register**, we stated that we did not believe that a ''formal appeals process'' regarding intermediary decisions denying hospital requests for wage data revisions was necessary, given the numerous opportunities provided to hospitals to verify and revise their data (59 FR 45351). We continue to believe that the process described above provides hospitals more than adequate opportunity to ensure that their data are correct. Nevertheless, we wish to clarify that, while there is no formal appeals process that culminates before the publication of the final rule and that is described above, hospitals may later seek formal review of denials of requests for wage data revisions made as a result of that process.

Once the final wage index values are calculated and published in the **Federal Register**, the last opportunity for a hospital to seek to have its wage data revised is under the limited circumstances described in § 412.63(w)(2). As we noted in the September 1, 1995 **Federal Register**, however, hospitals are entitled to appeal any denial of a request for a wage data revision made as a result of HCFA's wage data correction process to the Provider Reimbursement Review Board (PRRB), consistent with the rules for PRRB appeals found at 42 CFR part 405, Subpart R (60 FR 45795). As we also stated in the 1995 **Federal Register**, and as the regulation at § 412.63(w)(5) provides, any subsequent reversal of a denial of a wage revision request that

results from a hospital's appeal to the PRRB or beyond will be given effect by paying the hospital under a revised wage index that reflects the revised wage data at issue. The revised wage data will not, however, be used for purposes of revisiting past adjudications of requests for geographic reclassification.

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

A. Sole Community Hospitals (SCHs)(§ 412.92)

If a hospital is classified as a SCH because, by reason of certain factors, it is the sole source of inpatient hospital services reasonably available to Medicare beneficiaries in a geographic area, the hospital is paid based on the highest of the following: the applicable adjusted Federal rate; the updated hospital-specific rate based on a 1982 base period; or the updated hospital-specific rate based on a 1987 base period. Under our existing rules, urban hospitals within 35 miles of another hospital cannot qualify as SCHs. Since 1983, we have consistently defined an ''urban'' area for purposes of determining if a hospital qualifies for SCH status as a MSA or NECMA as defined by OMB.

In the past, we have considered and rejected two alternatives to the MSA definitions of an urban area for SCH purposes. These alternatives were the urbanized areas as defined by the Census Bureau and the health facility planning areas (HFPAs) as used by the Health Resource Services Administration. We have concluded that the MSA definition continues to be the most appropriate geographic delimiter available at this time. Therefore, we propose to continue to apply the MSA definition of an urban area for SCH status purposes.

We propose to continue our current policy for several reasons. First, as we have previously noted, since OMB considers local commuting patterns in establishing urban definitions, we believe that residents in urban areas have access to hospital services either by living in close proximity to a hospital or by establishing a heavy commuting pattern to an area in which a hospital is located (48 FR 39780, September 1, 1983). We do not believe that either Census Bureau urbanized areas or HFPAs take commuting patterns into account in the way that OMB's MSAs do. We believe commuting patterns serve as an important indicia of whether a hospital is the sole hospital reasonably accessible by Medicare beneficiaries in an area.

In addition, we note that our use of MSAs to define urban areas for SCH status purposes has direct statutory support. Section 1886(d)(2)(D) of the Act specifically authorizes us to use OMB's MSA definition of urban areas for purposes of calculating the prospective payment system standardized amounts. SCH status represents an adjustment to the usual prospective payment that a hospital would receive, and since that prospective payment is based on the standardized amount, among other factors, we believe it would be anomalous to employ one definition of urban area for purposes of calculating the standardized amount and another for purposes of determining if the hospital qualified as a SCH. To do so would be to use one set of geographic delimiters in applying the general rule (payment under the prospective payment system based on the standardized amount) but a different set in determining exceptions to the rule (payment under the prospective payment system adjusted to take into account SCH status). We do not think this would be appropriate. For this reason, also, we propose to continue to define ''urban'' for SCH purposes as meaning MSAs as defined by OMB, not as meaning either Census Bureau urbanized areas or HFPAs.

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 (DSH) 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 1998 (October 1, 1997 through September 30, 1998) and include bills posted to HCFA's records through December 1998. Therefore, we are proposing that, in addition to meeting other criteria, hospitals with fewer than 275 beds, if they are to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 1999, must have a case-mix index value for FY 1998 that is at least—

- 1.3438; or
- 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 following table:

Region	Case-mix index value
1. New England (CT, ME, MA, NH, RI, VT)	1.2480
2. Middle Atlantic (PA, NJ, NY)	1.2504

Region	Case-mix index value
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.3269
4. East North Central (IL, IN, MI, OH, WI)	1.2593
5. East South Central (AL, KY, MS, TN)	1.2772
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.1871
7. West South Central (AR, LA, OK, TX)	1.3003
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.3280
9. Pacific (AK, CA, HI, OR, WA)	1.3277

The preceding numbers will be revised in the final rule to the extent required to reflect the updated FY 1998 MedPAR file, which will contain data from additional bills received through March 31, 1999.

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 1998 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. 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 1997 (that is, October 1, 1996 through September 30, 1997). That is the latest year for which we have complete discharge data available.

Therefore, we are proposing that, in addition to meeting other criteria, a hospital, if it is to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 1999, must have as the number of discharges for its cost reporting period that began during FY 1998 a figure that is at least—

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

Region	Number of discharges
1. New England (CT, ME, MA, NH, RI, VT)	6672
2. Middle Atlantic (PA, NJ, NY)	8635
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	7753
4. East North Central (IL, IN, MI, OH, WI)	7390
5. East South Central (AL, KY, MS, TN)	6741
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	5662
7. West South Central (AR, LA, OK, TX)	5344
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	7993
9. Pacific (AK, CA, HI, OR, WA)	5993

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 criterion for all hospitals. These numbers will be revised in the final rule based on the latest FY 1997 cost report data.

We reiterate that an osteopathic hospital, if it is to qualify for rural referral center status for cost reporting periods beginning on or after October 1, 1999, must have at least 3,000 discharges for its cost reporting period that began during FY 1997.

C. Changes to the Indirect Medical Education Adjustment (§ 412.105)

Section 1886(d)(5)(B) of the Act provides that prospective payment hospitals that have residents in an approved graduate medical education (GME) program receive an additional payment to reflect the higher indirect operating costs associated with GME. The regulations regarding the calculation of this additional payment, known as the indirect medical education (IME) adjustment, are located at § 412.105.

In the August 29, 1997 final rule (62 FR 46029), we redesignated the previous § 412.105(g) as § 412.105(f), and added a new paragraph (g) to implement section 1886(d)(5)(B) of the Act as revised by section 4621 of the Balanced Budget Act of 1997. However, when we redesignated paragraph (g) as paragraph (f), we inadvertently did not revise all of the relevant cross-references to reflect this redesignation. Specifically, at § 412.105(f)(1)(iii), there are three cross-references to paragraph (g)(1)(ii). These cross-references are incorrect in light of the redesignation of previous paragraph (g) as paragraph (f). We are proposing to revise § 412.105(f)(1)(iii) to correct these cross-references.

D. Medicare Geographic Classification Review Board: Conforming Changes §§ 412.256 and 412.276

In the May 12, 1998 final rule (63 FR 26321), we revised the regulations governing the timeframes for submittal of applications by hospitals to the MGCRB for geographic reclassifications and for MGCRB decisions to take into consideration the revised statutory publication schedule for the annual prospective payment policies and rates (that is, August 1 instead of September 1) implemented by the BBA. In making those changes, we inadvertently omitted conforming changes to two other sections of the regulations that also specify timeframes that are affected by the change to an August 1 publication date—§§ 412.256 and 412.276. We propose to revise § 412.256(c)(2) to specify that at the request of the hospital, the MGCRB may, for good cause, grant a hospital that has submitted an application by September 1 (instead of October 1) an extension beyond September 1 (instead of October 1) to complete its application. In addition, we propose to revise § 412.276(a) to specify that the MGCRB notifies the parties in writing, with a copy to HCFA, and issues a decision within 180 days after the ''first day of the 13-month period preceding the Federal fiscal year for which the hospital had filed a completed application'' for reclassification, to make the language consistent with the statute and the May 1998 changes made to the application deadline in § 412.256(a)(2).

E. Payment for Direct Costs of Graduate Medical Education (§ 413.86)

Under section 1886(h) of the Act, Medicare pays hospitals for the direct costs of graduate medical education (GME). The payments are based on the number of residents trained by the hospital. The BBA revised section 1886(h) of the Act to cap the number of residents that hospitals may count for direct GME. We have issued rules to implement the caps for GME (62 FR 46002, August 29, 1997; 63 FR 26327, May 12, 1998; and 63 FR 40986, July 31, 1998). Since the publication of these rules we have received a number of questions relating to GME. In addition, we have received information related to other aspects of our GME policies. In response to these questions and information, we are clarifying certain GME policies and also making some technical changes to the regulations text. In addition, we are proposing certain changes in GME policy.

1. Approved Geriatric Programs

Under sections 1886(h)(5)(F) and (G) of the Act and § 413.86(g), Medicare counts each resident within an initial residency period as a 1.0 full-time equivalent (FTE) for purposes of determining GME payments. Each resident beyond the initial residency period is counted as 0.5 full-time equivalent. Section 1886(h)(5)(F) of the Act extends the initial residency period by up to 2 years if an individual is in a geriatric or preventive medicine residency or fellowship. At § 413.86(b), we specify that an ''approved geriatric program'' is ''a fellowship program of one or more years in length that is approved by the Accreditation Council for Graduate Medical Education (ACGME) under the ACGME's criteria for geriatric fellowship programs.'' In recent years, geriatric programs have been approved by other national organizations. Consistent with the statute, we are proposing to clarify the definition of approved geriatric programs at § 413.86(b) to include fellowship programs approved by the American Osteopathic Association, the Commission on Dental Accreditation, and the Council on Podiatric Medical Education. These organizations, in addition to ACGME, are recognized by HCFA as the accrediting bodies for determining approved educational activities. We also would make a conforming change to § 413.86(g)(1)(iii) to recognize approved geriatric programs accredited by all national approving organizations.

2. Hospital Payment for Resident Training in Nonhospital Settings

Under sections 1886(d)(5)(B)(iv) and 1886(h)(4)(E) of the Act, hospitals may count residents working in nonhospital sites for indirect and direct medical education respectively if the hospital incurs ''all or substantially all'' of these education costs. The requirements for counting the time residents spend training in nonhospital settings are addressed at § 413.86(f)(4). Currently, the requirements for hospital payment under this provision are that the resident spend his or her time in patient care activities and that a written agreement exist between the hospital and the nonhospital site. This written agreement must indicate that the hospital will incur the cost of the residents' salaries and fringe benefits while the residents are training in the nonhospital site and that the hospital is providing reasonable compensation to the nonhospital site for supervisory teaching activities. In addition, the written agreement must indicate the compensation the hospital is providing to the nonhospital site for supervisory teaching activities.

Under the statute, the time residents spend at nonhospital sites may be counted ''if the hospital incurs all, or substantially all, of the costs of the training program in that setting.'' The existing regulations text, however, is framed in terms of the hospital having an agreement that it ''will incur'' the costs in the nonhospital setting. We are proposing to make a technical change to the regulations text by adding a new § 413.86(f)(4)(iii), to clarify that in order to count residents at a nonhospital site, the hospital must actually incur all or substantially all of the costs for the training program, as defined in § 413.86(b), in the nonhospital site. This definition of all or substantially all requires the hospital to incur the expenses of 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 attributable to direct GME.

3. New Residency Programs

In the regulations we published on August 29, 1997 and May 12, 1998, we established special rules for adjusting the full-time equivalent (FTE) resident caps for indirect and direct GME for new medical residency programs. In general, the special rules allow for adjustments to the caps based on a number of residents participating in the program in its third year of existence. In §§ 413.86(g)(6)(i) and 413.86(g)(6)(ii), we set forth a methodology for adjusting hospital FTE caps for new medical residency training programs established on or after January 1, 1995. We are proposing the following clarifications, technical changes, and policy changes:

a. In § 413.86(g)(6)(i), we specify that, if a hospital had no residents before January 1, 1995, the adjustments for new programs are based on the highest number of residents in any program year during the third year of the newly established program. However, § 413.86(g)(6)(ii) does not explicitly state the methodology for adjusting caps for hospitals that did have residents in the most recent cost reporting period ending before January 1, 1995. The adjustments of the caps for programs established on or after January 1, 1995 and on or before August 5, 1997, also are made based on the number of residents in the third year of the new program. We are proposing to revise § 413.86(g)(6)(ii) to clarify that, for a hospital that did have residents in the most recent cost reporting period ending on or before December 31, 1996 (the proposed revised date described in section IV.E.3.d. of this preamble), the adjustment is based on the highest number of residents in any program year in the third year of the new program.

b. Sections 413.86(g)(6)(i) and 413.86(g)(6)(ii) specify that the adjustment to the cap is also based on the number of years in which residents are expected to complete each program based on the minimum accredited length for the type of program. We are proposing to add language to clarify how to account for situations in which the residents spend an entire program year (or years) at one hospital and the remaining year (or years) of the program at another hospital. In this situation, the adjustment to the FTE cap is based on the number of years the residents are training at each hospital, not the minimum accredited length for the type of program. If we were to use the minimum accredited length for the program in this case, the total adjustment to the cap might exceed the total accredited slots available to the hospitals participating in the program. In the May 12, 1998 final rule (63 FR 26334), we specified that the adjustment to the FTE cap may not exceed the number of accredited resident slots available.

c. It was brought to our attention that the regulations do not explicitly address how to apply the cap during the first 3 years of a new program before the adjustments to the cap are established. We are proposing to clarify our policy on new residency programs by adding language in §§ 413.86(g)(6)(i) and 413.86(g)(6)(ii) to specify how to determine the hospital's cap in the first 3 years of a new residency program, before the implementation of the hospital's permanent adjustment to its FTE cap effective beginning with the fourth year of the program. We are proposing to specify that the cap may be adjusted during each year of the first 3 years of the hospital's new residency program, using the actual number of residents participating in the new program. The adjustment may not exceed the number of accredited slots available to the hospital for each program year.

d. As discussed above, on August 29, 1997, we implemented the hospital-specific caps on the number of residents that a hospital can count for purposes of GME payments in a final rule with comment period (62 FR 46002). In both the May 12, 1998 and July 31, 1998 final rules (63 FR 26327 and 63 FR 40954), we responded to comments we received on this provision. We did not receive any comments about hospitals that participated in residency training in the

past, had terminated their participation prior to the hospitals' cost reporting period ending in calendar year 1996, and have now again begun a new residency program. After publication of the July 31, 1998 final rule, we were contacted by representatives of some hospitals that had a resident cap of zero because they had temporarily terminated their GME programs in the past and had no residents training during the cost reporting period ending in 1996. Based on the existing regulations, these hospitals have FTE caps of zero. There is no provision in the existing regulations for making adjustments to the cap to allow these hospitals to receive payment for indirect and direct GME for allopathic and osteopathic residents.

To address this issue, we are proposing to revise § 413.86(g)(6)(i) to allow for an adjustment to a hospital's FTE cap if the hospital had no allopathic and osteopathic residents in its cost reporting period ending during calendar year 1996. This change would allow all hospitals that did not participate in allopathic and osteopathic resident training in the cost reporting period ending in calendar year 1996 to receive adjustments to the indirect and direct GME FTE caps for new residency programs. We believe it is appropriate to revise the regulations to allow for payment during the first 3 years of the new program and for an adjustment to the FTE cap 3 years after these hospitals restart participation in residency training, similar to the existing adjustment for hospitals that never participated in residency training. We propose to revise § 413.86(g)(6)(i) to allow a hospital that has zero residents for the cost reporting period ending during the calendar year 1996 to receive an adjustment. This change would be effective for discharges occurring on or after October 1, 1999, for purposes of the IME adjustment and for cost reporting periods beginning on or after October 1, 1999, for purposes of direct GME.

In addition, we are proposing to make a change in § 413.86(g)(6)(ii) to make the language similar to that in § 413.86(g)(6)(i) to specify that hospitals that did have residents in the cost reporting period ending on or before December 31, 1996, are allowed adjustments to the cap for new programs begun on or after January 1, 1995, and on or before August 5, 1997. Currently, § 413.86(g)(6)(ii) refers to a hospital that did have residents in its most recent cost reporting period ending on or before January 1, 1995. The regulation states that these hospitals also may qualify for an adjustment to the caps, but only for medical residency programs created on or after January 1, 1995, and on or before August 5, 1997. Since we are proposing to revise § 413.86(g)(6)(i) to indicate that a hospital may qualify for an adjustment to the cap under that paragraph if it did not have residents in the cost reporting period ending during calendar year 1996, we are proposing to make a similar change in § 413.86(g)(6)(ii) to indicate that this paragraph provides for an adjustment to the cap for hospitals that did have residents in its most recent reporting period ending on or before December 31, 1996. We are proposing this revision to make the language of these two paragraphs consistent. Hospitals may qualify either under § 413.86(g)(6)(i) or § 413.86(g)(6)(ii). For hospitals that qualify under § 413.86(g)(6)(i), the FTE caps are established 3 years after the hospital either begins or restarts participation in residency training for programs that began on or after January 1, 1995. However, for hospitals that qualify under § 413.86(g)(6)(ii), adjustments to the cap are limited to those programs that began on or after January 1, 1995 and on or before August 5, 1997.

e. We are proposing to make technical changes to §§ 413.86(g)(6)(i) and 413.86(g)(6)(ii), which refer to whether a hospital had residents in its most recent cost reporting period on or before December 31, 1996. Instead of simply specifying ''residents,'' we are proposing to reference ''allopathic and osteopathic residents,'' because the FTE cap applies only to allopathic and osteopathy residents. There is no FTE cap on the number of podiatry and dentistry residents. Therefore, we are proposing to add the words ''allopathic and osteopathic'' in §§ 413.86(g)(6)(i) and 413.86(g)(6)(ii) before the word ''resident''.

4. Adjustment to GME Caps for Certain Hospitals To Account for Residents in New Medical Residency Training Programs

Section 4623 of the BBA amended section 1886(h) of the Act to provide for ''special rules'' in applying FTE caps for medical residency training programs established on or after January 1, 1995. In the August 29, 1997 and May 12, 1998 final rules (62 FR 46002 and 63 FR 26327), we implemented special rules to account for residents in new medical residency training programs. We are proposing to implement another special rule to permit an adjustment to the FTE cap for a hospital if the entire facility was under construction prior to August 5, 1997 (the date of enactment of the BBA) and if the hospital sponsored a new medical residency training program but the residents temporarily trained at another hospital.

Under current policies, if a new medical residency training was established on or after January 1, 1995, a hospital may receive an adjustment to its FTE cap to account for residents in the new program. If the residents in the new program begin training in one hospital and are subsequently ''transferred'' to another hospital, the second hospital does *not* receive an adjustment to its FTE cap; if we made an adjustment for the second hospital, then two hospitals would receive an adjustment for the same resident.

We believe, however, that an adjustment for the second hospital might be appropriate in certain limited circumstances. If the second hospital sponsored a new medical residency training program but the residents in the new program temporarily trained at the first hospital because the second hospital was still being built, then we believe it might be appropriate to permit an adjustment for the second hospital. Otherwise, the second hospital's FTE cap would be zero, and the hospital would not receive any GME or IME payments.

We are proposing to permit an adjustment under this policy only if the second hospital (the sponsor of the new program) began construction of its entire facility prior to the date of enactment of the BBA. Prior to August 5, 1997, a hospital would not have had knowledge of the provisions of the BBA and thus would not have known that a decision to temporarily train residents at another hospital might have resulted in the hospital being unable to receive GME and IME payments in the future. In contrast, a hospital that began construction of an entirely new facility on or after August 5, 1997 would have had notice of changes in the law prior to making a decision to temporarily train residents at another hospital.

Thus, we are proposing to add a new § 413.86(g)(7) (existing § 413.86(g)(7) would be redesignated as § 413.86(g)(9)) to address application of the FTE caps with regard to a hospital that began construction of an entire facility prior to August 5, 1997, sponsored medical residency training programs, and temporarily trained those residents at another hospital(s) until the new facility was completed. For hospitals that meet these criteria, we propose that the FTE caps will be determined in a manner similar to those hospitals that qualify for an adjustment to the FTE cap under § 413.86(g)(6)(i). That is, the hospital's cap would equal the lesser of (a) the product of the highest number of

residents in any program year during the third year of the first program's existence for all new residency training programs at either the newly constructed facility or the temporary training site and the number of years in which residents are expected to complete the programs based on the minimum accredited length for each type of program; or (b) the number of accredited slots available for each year of the program. If the medical residency training programs sponsored by the newly constructed hospital have been in existence for 3 years or more by the time the residents begin training at the newly constructed hospital, the newly constructed hospital's cap would be the number of residents training in the third year of the first of those programs begun at the a temporary training site. If the medical residency training programs sponsored by the newly constructed hospital have been in existence for less than 3 years when the residents begin training at the newly constructed hospital, the hospital's cap would be based on the number of residents training at the newly constructed hospital in the third year of the first of those programs (including the years at the temporary training site). This provision would be effective for portions of cost reporting periods occurring on or after October 1, 1999.

5. Temporary Adjustments to FTE Cap To Reflect Residents Affected by Hospital Closure

In the May 12, 1998 prospective payment system final rule (63 FR 26330), we indicated that we would allow a temporary adjustment to a hospital's resident cap under limited circumstances and if certain criteria are met when a hospital assumes the training of additional residents because of another hospital's closure. The temporary adjustment to the FTE cap is available to the hospital only for the period of time necessary to train those displaced residents. Once the residents leave the hospital or complete their programs, the hospital cap would be based solely on the statutory base year (with any applicable adjustments for new medical residency training programs or affiliated group arrangements).

Under current policies, we permit a temporary adjustment to the FTE cap for a hospital only if it assumed additional medical residents from a hospital that closed in the July 1996–June 1997 residency training year. We are proposing to allow adjustments to address hospital closures after this period. Thus, we would allow an adjustment for a hospital if it takes on additional residents from a hospital that closes at any time on or after July 1, 1996. This adjustment is intended to account for residents who may have partially completed a medical residency training program and would be unable to complete their training without a residency position at another hospital.

We are proposing this change because hospitals have indicated a reluctance to accept additional residents from a closed hospital without a temporary adjustment to their caps. Therefore, we are proposing to add a new § 413.86(g)(8) to allow a temporary adjustment to a hospital's FTE cap to reflect residents added because of a hospital's closure at any time on or after July 1, 1996. We would allow an adjustment to a hospital's FTE cap if the hospital meets the following criteria: (a) the hospital is training additional residents from a hospital that closed on or after July 1, 1996; and (b) the hospital that is training the additional residents who are assumed from the closed hospital submits a request to its fiscal intermediary at least 60 days before the beginning of training of the residents for a temporary adjustment to its FTE cap, documents that the hospital is eligible for this temporary adjustment to its FTE cap by identifying the residents who have come from the closed hospital and have caused the hospital to exceed its cap, and specifies the length of time that the adjustment is needed. After the displaced residents leave the hospital's training program or complete their residency program, the hospital's cap would be based solely on the statutory base year (with any applicable adjustments for new medical residency training programs or affiliated group arrangements).

6. Determining the Weighted Number of FTE Residents

Section 413.86(g)(1)(ii) states that for residency programs in osteopathy, dentistry, and podiatry, the minimum requirement for certification in a specialty or subspecialty is the minimum number of years of formal training necessary to satisfy the requirements of the appropriate approving body listed in § 415.200(a). This reference is incorrect. The correct section in which approving bodies for residency programs are listed is § 415.152. We propose to make this correction.

Section 413.86(g)(1)(i) specifies that the initial residency period is the minimum number of years of formal training necessary to satisfy board eligibility in the particular specialty for which the resident is training, as specified in the 1985–1986 Directory of Residency Training Programs. Section 1886(h)(5)(G)(iii) of the Act allows the Secretary to increase or decrease the initial residency period if the minimum number of years of formal training specified in a later edition of the directory is different from the period specified in the 1985–1986 Directory of Residency Training Programs. We are proposing to revise the regulations text to state that the initial residency period is determined using the most recently published edition of the Graduate Medical Education Directory, not the 1985–1986 Directory.

7. Clarification of a Statement in the Preamble of the May 12, 1998 Final Rule Relating to Affiliated Groups

In the May 12, 1998 final rule (63 FR 26341), in the third column of page 26341, in the sentence prior to section ''O. Payment to Managed Care Plans for Graduate Medical Education,'' we stated, ''If the combined FTE counts for the individual hospitals that are members of the same affiliated group do not exceed the aggregate cap, we will pay each hospital based on its FTE cap as adjusted per agreements.'' The phrase ''do not exceed'' should have read ''exceed.'' Thus, the sentence should have read, ''If the combined FTE counts for individual hospitals that are members of the same affiliated group exceed the aggregate cap, we will pay each hospital based on its FTE cap as adjusted per agreements.'' We regret any confusion that resulted from this misstatement.

V. Proposed Changes to the Prospective Payment System for Capital-Related Costs: Special Exceptions Process

Section 1886(g) of the Act requires the Secretary to pay for hospital capital-related costs ''in accordance with a prospective payment system established by the Secretary.'' Under the statute, the Secretary has broad authority in establishing and implementing the capital prospective payment system. We initially implemented the capital prospective payment system in an August 30, 1991 final rule (56 FR 43409), in which we established a 10-year transition period to change the payment methodology for Medicare inpatient capital-related costs from a reasonable cost-based methodology to a prospective methodology (based fully on the Federal rate).

Generally, during the transition period, inpatient capital-related costs will be paid on a per discharge basis, and the amount of payment depends on the relationship between the hospital-specific rate and the Federal rate during the hospital's base year. A hospital with

a base year hospital-specific rate less than the Federal rate will be paid under the fully prospective payment methodology during the transition period. This method is based on a dynamic blend percentage of the hospital's hospital-specific rate and the applicable Federal rate for each year during the transition period. A hospital with a base period hospital-specific rate greater than the Federal rate will be paid under the hold harmless payment methodology during the transition period. A hospital paid under the hold harmless payment methodology receives the higher of (1) a blended payment of 85 percent of reasonable cost for old capital plus an amount for new capital based on a portion of the Federal rate or (2) a payment based on 100 percent of the adjusted Federal rate. The amount recognized as old capital is generally limited to the allowable Medicare capital-related costs that were in use for patient care as of December 31, 1990. Under limited circumstances, capital-related costs for assets obligated prior to December 31, 1990, but put in use for patient care after December 31, 1990 may also be recognized as old capital if certain conditions are met. These costs are known as obligated capital costs. New capital costs are generally defined as allowable Medicare capital-related costs for assets put in use for patient care after December 31, 1990. Beginning in FY 2001, at the conclusion of the transition period for the capital prospective payment system, capital payments will be based solely on the Federal rate for most hospitals.

In the August 30, 1991 final rule, we also established a capital exceptions policy, which provides for exceptions payments during the transition period (§ 412.348). We also indicated that we would carefully monitor the impact of the capital prospective payment system in order to determine whether some type of permanent exceptions process was necessary and the circumstances under which additional payments would be made.

In the Conference Report that accompanied the Omnibus Budget Reconciliation Act (OBRA) of 1993 (Pub. L. 103–66), Congress addressed obligated capital criteria for hospitals in States with a lengthy certificate of need (CON) process. The language states, ''The conferees note that in the proposed rule for fiscal year 1994 changes to the hospital inpatient prospective payment system that was published in the **Federal Register** on May 26, 1993, the Secretary indicated that insufficient information was available to complete a systematic evaluation of the obligated capital criteria for hospitals in states with a lengthy Certificate-of-Need process in time to consider appropriate changes during the fiscal year 1994 rulemaking process. The conferees expect the Secretary to complete the assessment in time for consideration in the fiscal year 1995 rulemaking process and that appropriate changes in payment policy will be made to address the problems of hospitals subject to a lengthy Certificate-of-Need review process or subject to other circumstances which are not fully addressed in the current rules. In addition, the conferees believe the Secretary should evaluate whether current policies provide adequate protection to sole community hospitals and hospitals that serve a disproportionate share of low income patients.'' (H.R. Conf. Rep. No. 103–66, at 744 (1993)).

In the May 27, 1994 proposed hospital inpatient prospective payment rule (59 FR 27744), we described our analysis of provisions related to obligated capital for hospitals subject to lengthy CON processes and proposed a change to the deadline for putting an asset into use for patient care (§ 412.302(c)(2)(i)(D)). We proposed changing the deadline from ''the earlier of'' September 30, 1996, or 4 years from the date of CON approval to ''the later of'' September 30, 1996, or 4 years from the date of CON approval.

In addition, in the May 27, 1994 proposed rule, we noted that the same hospitals that had asked for changes in the obligated capital provisions had also recommended changes to the capital exceptions policy, which would provide exceptions payments after the conclusion of the capital prospective payment transition period. These hospitals had asked that the minimum payment level for urban hospitals with at least 100 beds and a DSH percentage of at least 20.2 percent be guaranteed through the rest of the transition and extended for at least 10 years after the transition. We noted that we had tried to address the concerns of these hospitals in developing the proposed special exceptions process that was discussed in the same proposed rule.

In the September 1, 1994 final rule (59 FR 45376), we adopted the proposed change to the deadline for putting an asset into use in the obligated capital regulations (§ 412.348). We also implemented the capital special exceptions process and adopted qualifying criteria for the classes of eligible hospitals. The classes of eligible hospitals include urban hospitals with a DSH percentage of 20.2 percent and at least 100 beds and sole community hospitals.

Under the special exceptions provision at § 412.348(g), an additional payment may be made for up to 10 years beyond the end of the capital prospective payment system transition period for eligible hospitals that meet (1) a project need requirement, (2) a project size requirement, and (3) in the case of certain urban hospitals, an excess capacity test. In the September 1, 1994 final rule, we described the special exceptions process as ''* * * narrowly defined, focusing on a small group of hospitals who found themselves in a disadvantaged position. The target hospitals were those who had an immediate and imperative need to begin major renovations or replacements just after the beginning of the capital prospective payment system. These hospitals would not be eligible for protection under the old capital and obligated capital provisions, and would not have been allowed any time to accrue excess capital prospective payments to fund these projects.'' (59 FR 45385)

In addition to sole community hospitals and urban hospitals with at least 100 beds that have a DSH percentage of at least 20.2 percent, hospitals eligible for special exceptions include urban hospitals with at least 100 beds that receive at least 30 percent of their revenue from State or local funds for indigent care, and hospitals with a combined inpatient Medicare and Medicaid utilization of at least 70 percent.

To qualify for a special exceptions payment, a hospital must satisfy a project need requirement as described at § 412.348(g)(2) and a project size requirement as described at § 412.348(g)(5). For hospitals in States with CON requirements, the project need requirement is satisfied by obtaining a CON approval. For other hospitals, the project need requirement is satisfied by meeting an age of assets test. The project size requirement is satisfied if the hospital completes the qualifying project between the period beginning on or after its first cost reporting period beginning on or after October 1, 1991, and the end of its last cost reporting period beginning before October 1, 2001, and the project costs are (1) at least $200 million or (2) at least 100 percent of the hospital's operating cost during the first 12-month cost reporting period beginning on or after October 1, 1991. The minimum payment level under special exceptions for all qualifying hospitals is 70 percent of allowable capital-related costs. Special exception payments are offset against positive Medicare capital and operating margins.

When we established the special exceptions process, we selected the hospital's cost reporting period beginning before October 1, 2001, as the project completion date in order to limit cost-based exceptions payments to a period of not more than 10 years beyond the end of the transition to the fully Federal capital prospective payment system. Because hospitals are eligible to receive special exceptions payments for up to 10 years from the year in which they complete their project (but for not more than 10 years after September 30, 2001, the end of the capital prospective payment transition), if a project is completed by September 30, 2001, exceptions payments could continue up to September 30, 2011. In addition, we believed that for projects completed after the September 30, 2001, hospitals would have had the opportunity to reserve their prior years' capital prospective payment system payments for financing projects.

In the July 31, 1998 final rule (63 FR 40999), we stated that a few hospitals had expressed concern with the required completion date of October 1, 2001, and other qualifying criteria for the special exceptions payment. Therefore, we solicited certain information from hospitals on major capital construction projects that might qualify for the capital special exceptions payments so we could determine if any changes in the special exceptions criteria or process were necessary.

Four hospitals responded timely with information on their major capital construction projects. The hospitals submitted information about their location, the cost of the project, the date that the certificate of need approval was received, the start date of the project, and the anticipated completion date.

Some hospitals suggested that we change the existing project completion date criterion, that is, the criterion that the qualifying projects must be completed between the hospital's first cost reporting period beginning on or after October 1, 1991, and the end of its last cost reporting period beginning before October 1, 2001. They proposed that, as an alternative, a hospital be eligible for the special exceptions payment if the hospital had received its CON approval for the qualifying project by September 1, 1995, and had spent $750,000 or 10 percent of total project cost by that date, and that the project completion date be changed to December 31, 2005 (which would be well beyond the 10 years we have established for the capital prospective payment system transition). However, other hospitals recommended that we not institute a date by which a hospital must have received its CON approval.

In addition, some hospitals have suggested other ways in which the special exceptions process could be revised. Some of these hospitals expressed concern about the project size requirement and stated that small community-based institutions were unlikely to be able to support debt in the range of $200 million.

We understand that a few hospitals may not meet the DSH percentage requirement of at least 20.2 percent. Some of these hospitals suggested lowering the qualifying percentage to 15 percent. They also suggested changing the payment level for special exceptions from 70 percent to 85 percent and changing the requirement at § 412.348(g)(8)(ii)(B) that special exception payments be offset against positive Medicare operating and capital margins. They suggested limiting the offset provision to capital margins. In addition, some of these hospitals suggested capping special exceptions payments that result from changes to the current special exceptions process at $40 million annually.

While we have no specific proposal at this time to revise the special exceptions process, we specifically invite comments from hospitals and other interested parties on the suggestions and recommendations discussed above. We note that, since the capital special exceptions process is budget neutral, any liberalization of the policy would require a commensurate reduction in the capital rate paid to all hospitals. Even after the end of the capital prospective payment system transition, we will continue to make an adjustment to the capital Federal rate in a budget neutral manner to pay for exceptions, as long as an exceptions policy is in force. Currently, the limited special exceptions policy will allow for exceptions payments through September 30, 2011.

We have little information about the impact of any of the recommended changes, since no hospitals are currently being paid under the special exceptions process. Until FY 2001, the special exceptions provision pays either the same as the regular exceptions process or less for high DSH and sole community hospitals. We will attempt to obtain information on projects that may qualify for special exceptions payments through our fiscal intermediaries during the comment period. However, we are reluctant to place a significant data gathering burden on fiscal intermediaries at this time because of their current workload resulting from the major efforts to make the Medicare computer systems compliant on January 1, 2000. Based on comments that we receive from hospitals and any data received from the fiscal intermediaries, we may address changes to the special exceptions criteria in the final rule, or we may propose changes in the criteria in the FY 2001 hospital inpatient prospective payment system proposed rule.

VI. Proposed Changes for Hospitals and Hospital Units Excluded From the Prospective Payment System

A. Limits on and Adjustments to the Target Amounts for Excluded Hospitals and Units (§§ 413.40(b)(4) and (g))

1. Updated Caps

Section 1886(b)(3) of the Act (as amended by section 4414 of the BBA) establishes caps on the target amounts for certain 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); the May 12, 1998 final rule (63 FR 26344); and the July 31, 1998 final rule (64 FR 41000). For purposes of calculating the caps, 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 current estimate of the market basket increase for excluded hospitals and units for FY 2000 is 2.6 percent. Accordingly, the proposed caps on target amounts for cost reporting periods beginning in FY 2000 are as follows:

- Psychiatric hospitals and units: $11,067
- Rehabilitation hospitals and units: $20,071
- Long-term care hospitals: $39,596

2. New Excluded Hospitals and Units (§ 413.40(f))

a. Updated Caps for New Hospitals and Units. Section 1886(b)(7) of the Act establishes a payment methodology for new psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals. Under the statutory methodology, for a hospital that is within a class of hospitals specified in the statute and that first

receives payments as a hospital or unit excluded from the prospective payment system on or after October 1, 1997, the amount of payment will be determined as follows. For the first two 12-month cost reporting periods, the amount of payment is the lesser of (1) the operating costs per case, or (2) 110 percent of the national median of target amounts for the same class of hospitals for cost reporting periods ending during FY 1996, updated to the first cost reporting period in which the hospital receives payments and adjusted for differences in area wage levels.

The proposed amounts included in the following table reflect the updated 110 percent of the wage neutral national median target amounts for each class of excluded hospitals and units for cost reporting periods beginning during FY 2000. These figures are updates to the final FY 1999 figures by the estimated market basket increase of 2.6 percent. For a new provider, the labor-related share of the target amount is multiplied by the appropriate geographic area wage index and added to the nonlabor-related share in order to determine the per case limit on payment under the statutory payment methodology for new providers.

Class of excluded hospital or unit	Labor-related share	Nonlabor-related share
Psychiatric	$6,376	$2,536
Rehabilitation	12,537	4,984
Long-Term Care	16,158	6,424

b. Multicampus Excluded Hospitals. Section 1886(b) of the Act, as amended by the BBA, provides for caps on target amounts for certain classes of excluded hospitals, and also provides a statutory payment methodology for new excluded hospitals. A question has arisen regarding the appropriate target amount to be used for an excluded hospital or unit that was part of a multicampus hospital but alters its organizational structure so that it is no longer part of that multicampus hospital. The question was raised by long-term care hospitals that are seeking alternate structures due to the application of the cap on hospital-specific target amounts specified in § 413.40(c)(4)(iii).

In these cases, to determine the appropriate target amount, we must determine whether the excluded hospital or unit established under the organizational restructure is a new provider. Under § 413.40(f)(1), a new excluded hospital or unit is a provider of hospital inpatient services that (1) has operated as the type of hospital or unit for which HCFA granted it approval to participate in the Medicare program, under present or previous ownership (or both), for less than 1 full year; and (2) has provided the type of hospital inpatient services for which HCFA granted it approval to participate for less than 2 full years. For a new children's hospital, a 2-year exemption from the application of the target amount is permitted (§ 413.40(f)(2)(i)). For the first two 12-month cost reporting periods, a new psychiatric or rehabilitation hospital or unit or a long-term care hospital receives the lower of its new inpatient operating cost per case or 110 percent of a national median of target amounts for the class of hospital, updated and adjusted for area wages (§ 413.40(f)(2)(ii)).

If the entity that separated itself from the multicampus hospital provides inpatient services of a different type than it had when it was part of the multicampus hospital so that it qualifies as a different class of excluded hospital or unit (for example, from long-term care to rehabilitation), we would calculate a new target amount per discharge for the newly created hospital or unit. However, if the entity does not operate as a different class of hospital or unit, it does not meet the criteria at § 413.40(f)(1) to qualify as a new provider. Instead, if the entity replaces a hospital or unit that had been excluded from the prospective payment system (for example, the entity had previously been a long-term care hospital before becoming part of the multicampus hospital), the previously established hospital-specific target amount for the hospital prior to becoming part of the multicampus hospital would again be applicable. This is consistent with our current policy for a hospital or unit excluded from the prospective payment system that has periods in which the hospital or unit is not subject to the target amount, as specified at § 413.40(b)(1)(i). The target amount established earlier for the hospital or unit is again applicable despite intervening cost reporting periods during which the hospital or unit was not subject to that target amount due to other provisions of the law or regulations that applied while it was part of the multicampus hospital. In contrast, we propose to revise § 413.40(b)(1)(iii) to specify that if the entity continues to operate as the same class of hospital that is excluded from the prospective payment system, but does not replace a provider that existed prior to being part of a multicampus hospital (for example, a newly created long-term care hospital became part of a multicampus hospital and subsequently separates from the multicampus hospital to operate separately), the base period for calculating a hospital-specific target amount for the newly separated hospital is the first cost reporting period of at least 12 months effective with the revised Medicare certification.

3. Exceptions

The August 29, 1997 final rule with comment period (62 FR 46018) specified that a hospital that has a hospital-specific target amount that is capped at the 75th percentile of target amounts for hospitals in the same class (psychiatric, rehabilitation, or long-term care) would not be granted an adjustment payment (also referred to as an exception payment) 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.

In addition, the July 31, 1998 final rule (63 FR 41001) revised § 413.40(g)(1) to specify, under paragraph (g)(1)(iv), that in the case of a psychiatric hospital or unit, rehabilitation hospital or unit, or long-term care hospital, the amount of the adjustment payment may not exceed the applicable limit amounts for hospitals of the same class.

Similarly, for hospitals and units with a FY 1998 hospital-specific revised target amount established under the rebasing provision at § 413.40(b)(1)(iv), in determining whether the hospital qualifies for an adjustment and the amount of the adjustment, we compare the hospital's operating costs to the average costs and statistics for the cost reporting periods used to determine the FY 1998 revised target amount. Since the rebased FY 1998 target amount is an average of three cost reporting periods, as described in § 413.40(b)(1)(iv), comparisons of costs from the cost year to the FY 1998 cost period would be inaccurate. Therefore, as specified in the August 29, 1997 final rule with comment period (62 FR 46018), a determination of whether the hospital qualifies for an adjustment and the amount of an adjustment is based on a comparison of the hospital's operating costs and its costs used to calculate the FY 1998 rebased target amount.

The conditions that must be met to qualify for an adjustment remain unchanged, as specified in Chapter 30 of the Provider Reimbursement Manual. Making comparisons between the base year and the cost year requires that each particular inpatient service be

compared. For example, to determine whether the hospital qualifies for an adjustment and the amount of an adjustment for increased routine services or an increase in a particular ancillary service, we compare the costs incurred by the hospital in the cost year to the hospital's routine services or ancillary services in the base year. Therefore, for hospitals that have been rebased under the provisions of § 413.40(b)(1)(iv) and qualify for an adjustment under the provisions of § 413.40(g), the base year figures used for costs, utilization, length-of-stay, etc., are determined based on the average of the costs and utilization statistics from the same 3 cost reporting years used in calculating the FY 1998 rebased target amount. While we recognize that additional calculations are necessary to prepare an adjustment payment request in this manner, we believe it is the most equitable means of determining an adjustment payment. We also point out that the averaging calculation for the various cost centers and utilization statistics must only be performed the first year a provider requests an adjustment after FY 1998, and thereafter those averaged calculations may be utilized for subsequent years' adjustment requests.

Therefore, once these averages are calculated, the same values will be used for determining the amount of any subsequent year adjustments.

We propose to revise § 413.40(g)(1) to clarify these limitations on the adjustment payments.

4. Development of Case-Mix Adjusted Prospective Payment System for Rehabilitation Hospitals and Units

Section 4421 of the BBA added a new section 1886(j) to the Act which mandates the phase-in of a case-mix adjusted prospective payment system for inpatient rehabilitation services (freestanding hospitals and units) for cost reporting periods beginning on or after October 1, 2000 and before October 1, 2002. The prospective payment system will be fully implemented for cost reporting periods beginning on or after October 1, 2002.

As provided in section 1886(j)(3)(A) of the Act, the prospective payment rates will be based on the inpatient operating and capital costs of rehabilitation facilities. Payments will be adjusted for case-mix using patient classification groups, area wages, inflation, and outlier and any other factors the Secretary determines necessary. We will set prospective payment amounts so that total payments under the system during FY 2001 and FY 2002 are projected to equal 98 percent of the amount of payments that would have been made under the current payment system. Outlier payments in a fiscal year may not be projected or estimated to exceed 5 percent of the total payments based on the rates for that fiscal year.

B. Changes in Bed Size or Status of Hospital Units Excluded Under the Prospective Payment System

Existing regulations (§§ 412.25(b) and (c)) specify that, for purposes of payment to a psychiatric or rehabilitation unit that is excluded from the prospective payment system, changes in the bed size or the status of excluded hospital units will be recognized only at the beginning of a cost reporting period. These regulations have been in effect since the inception of the inpatient hospital prospective payment system and were intended to simplify administration of the exclusion provisions of the prospective payment systems by establishing clear rules for the timing of changes in these excluded units.

Recently, a number of hospitals have suggested that we consider a change in our policy to recognize, for purposes of exclusion from the prospective payment system, reductions in number of beds in, or entire closure of, units at any time during a cost reporting period. They indicated that the bed capacity made available as a result of these changes could be used, as they need them, to provide additional services to meet patient needs in the acute care part of the hospital that is paid under the prospective payment system.

We have evaluated the concerns of the hospitals and the effect on the administration of the Medicare program and the health care of beneficiaries of making these payment changes. As a result of this evaluation, we believe it is reasonable to adopt a more flexible policy on recognition of hospitals' changes in the use of their facilities. However, we note that whenever a hospital establishes an excluded unit within the hospital, our Medicare fiscal intermediary must be able to determine costs of the unit separately from costs of the part of the hospital paid under the prospective payment system. The proper determination of costs ensures that the hospital is paid the correct amount for services in each part of the facility, and that payments under the prospective payment system do not duplicate payments made under the rules applicable to excluded hospitals and units, or vice versa. For this reason, we do not believe it would be appropriate to recognize, for purposes of exclusion from the prospective payment system, changes in the bed size or status of an excluded unit that are so frequent that they interfere with the ability of the intermediary to accurately determine costs.

Moreover, section 1886(d)(1)(B) of the Act authorizes exclusion from the prospective payment system of specific types of hospitals and units, but not of specific admissions or stays, such as admissions for rehabilitation or psychiatric care, in a hospital paid under the prospective payment system. Without limits on the frequency of changes in excluded units for purposes of proper Medicare payment, there is the potential for some hospitals to adjust the status or size of their excluded units so frequently that the units would no longer be distinct entities and the exclusion would effectively apply only to certain types of care.

To provide more flexibility to hospitals while not recognizing changes that undermine statutory requirements and principles, we propose to revise §§ 412.25(b) and (c) to provide that, for purposes of exclusion from the prospective payment system, the number of beds and square footage of an excluded unit may be decreased, or an excluded unit may be closed in its entirety, at any time during a cost reporting period under certain conditions. The hospital would be required to give the fiscal intermediary and the HCFA Regional Office a 30-day advance written notice of the intended change and to maintain all information needed to accurately determine costs attributable to the excluded unit and proper payments. However, any unit that is closed during a cost reporting period could not be paid again as a unit excluded from the prospective payment system until the start of the next cost reporting period. If the number of beds or square footage of a unit excluded from the prospective payment system is decreased during a cost reporting period, that decrease would remain in effect for the remainder of that period.

We note that the number of beds and square footage of the part of the hospital paid under the prospective payment system may also be affected by a change in the size or status of a unit that is excluded from the prospective payment system. If the bed capacity and square footage were previously part of the excluded unit and are then included in the part of the hospital paid under the prospective payment system and are used to treat acute patients rather than excluded unit patients, the additional bed capacity and square footage would, starting with the effective date of the change, be counted as part of the

hospital paid under the prospective payment system. We would count the bed capacity and square footage for purposes of calculating available bed-days and the number of beds under §§ 412.105 and 412.106, relating to payments for the indirect costs of GME and service to a disproportionate share of low-income patients. On the other hand, if the bed capacity and square footage are taken out of service or added to another Medicare provider, such as a distinct-part SNF, they would not be counted as part of the hospital paid under the prospective payment system.

C. Payment for Services Furnished at Satellite Hospital Locations

Under Medicare, each hospital is treated, for purposes of certification, coverage, and payment, as a single institution. That is, each entity that is approved to participate in Medicare as a ''hospital'' must separately comply with applicable health and safety requirements as a condition of participation under regulations at Part 482, with provider agreement requirements specified in regulations at Part 489, and with requirements relating to the scope of benefits under Medicare Part A and B specified in parts 409 and 410. Our policies that involve the movement of patients from one hospital to another, or from outpatient to inpatient status at a same hospital, are premised on the assumption that each hospital is organized and operated as a separate institution.

Section 412.22(e) of the regulations permits an entity that is located in the same building or in separate buildings on the same campus as another hospital to be treated, for purposes of exclusion under the prospective payment systems, as a ''hospital within a hospital.'' This status is available, however, only when the entity meets specific, stringent criteria designed to ensure that the hospital-within-a-hospital is organized as a separate entity and operates as a separate entity.

Recently, we have received several requests for approval of ''satellite'' arrangements, under which an existing hospital that is excluded under the prospective payment system, and that is either a freestanding hospital or a hospital-within-a-hospital under § 412.22(e), wishes to lease space in a building or on a campus occupied by another hospital, and, in some cases, to have most or all services to patients furnished by the other hospital under contractual agreements, including arrangements permitted under section 1861(w)(1) of the Act. In most cases, a hospital intends to have several of these satellite locations so that the hospital would not exist at any single location, but only as an aggregation of beds located at several sites. Generally, the excluded hospital seeks to have the satellite facility treated as if the satellite facility were ''part of'' the excluded hospital.

The fundamental problem with satellite arrangements is that the satellite facility might be ''part of'' the excluded hospital only on a nominal basis (that is, only on paper). The satellite facility might not operate as part of the excluded hospital, but instead might effectively be a ''part of'' the hospital within which it is located, or might effectively be its own separate entity. From a payment perspective, if the satellite facility is effectively *not* part of the excluded hospital, then Medicare would make inappropriately high payments if Medicare treats the satellite facility as part of the excluded hospital.

Perhaps most significantly, if Medicare treated the satellite facility as part of the excluded hospital, the services in the satellite facility might inappropriately be paid by Medicare on the basis of reasonable costs (subject to limits) when they should be paid on the basis of prospective payment. If the satellite facility operates as ''part of'' the prospective payment system hospital in which it is located, and not as part of the excluded hospital with which it is affiliated, then the considerations underlying exclusion from the prospective payment system do not apply to the services furnished in satellite facilities. Thus, if the satellite facility is effectively part of the prospective payment system hospital, then the services should be paid under the prospective payment system.

Satellite arrangements can lead to inappropriate Medicare payments in a number of ways. For example, an excluded long-term care hospital might set up a satellite facility within an acute care hospital paid under the prospective payment system. Such a configuration could make it relatively easy for the prospective payment hospital to discharge a patient prematurely to the excluded long-term care hospital satellite location that is in its building or on its campus. The result could be inappropriate duplication of payment, in that the prospective payment system hospital would receive full payment under the DRG system even if it did not complete the acute treatment of the patient, and the hospital excluded under the prospective payment systems would receive payment for some services that should have been furnished in the prospective payment system hospital and paid under the prospective payment system. While the discharge and transfer regulations at § 412.4 provide disincentives to these inappropriate transfers in some 10 DRGs, there are many other cases not assigned to these DRGs in which such transfers could occur.

Another potential abuse related to duplication of Medicare payment could occur with respect to the preadmission payment window provisions of section 1886(a)(4) of the Act (implemented under regulations at §§ 412.2(c)(5) and 413.40(c)(2)). Under the regulations, services provided by the hospital or by an entity wholly owned or operated by the hospital within the 3 calendar days before admission to a prospective payment system hospital, or within 1 calendar day before admission to a hospital excluded from the prospective payment system, are treated for payment purposes as if they had been furnished during the inpatient stay. For prospective payment system hospitals, the provision is designed to prevent services historically furnished by hospitals during the early parts of inpatient stays from being ''unbundled'' and furnished just prior to admission and billed on an outpatient basis. If this situation were to occur, the result would be that outpatient payment under Medicare Part B would be made for services for which Part A payment is provided under the prospective payment system, that is, duplication of payments for outpatient and inpatient services. For hospitals excluded from the prospective payment system, the payment window provision is intended to minimize beneficiary liability for Part B deductible and coinsurance amounts while encouraging use of outpatient facilities rather than inpatient facilities when appropriate.

If excluded hospitals were able to set up satellite facilities within hospitals paid under the prospective payment system and obtain exclusion from the prospective payment system for the satellite facilities, the two hospitals could easily circumvent the preadmission payment window requirements by setting up outpatient departments of both hospitals at each site where both have inpatient facilities, and scheduling patients who are to be admitted to one hospital to receive preadmission care at the outpatient department of the other hospital. Thus, exclusion of satellite facilities could result in payments that are inconsistent with the purpose of the payment window. (We note that this abuse could also occur, at least theoretically, if the satellite facilities were not excluded from the prospective payment system. However, allowing exclusion from the

prospective payment system of satellites increases the likelihood that such arrangements will actually be set up.)

There also is a potential for satellite facilities to be used as a means to avoid the effects of section 4416 of the BBA, which is implemented in regulations at § 413.40(f)(2)(ii). This section limits the target amounts for psychiatric and rehabilitation hospitals and units and long-term care hospitals that are first paid as hospitals excluded from the prospective payment system on or after October 1, 1997, to 110 percent of the national median of the target amounts of similarly classified hospitals. This limitation applies to the hospital's first two 12-month cost reporting periods. Section 413.40(c)(4)(iii), which implements provisions of section 4414 of the BBA, sets the 75th percentile of the target amounts of similarly classified hospitals as a limit on costs for psychiatric and rehabilitation hospitals and units and long-term care hospitals excluded from the prospective payment system before October 1, 1997. If we permitted exclusion of satellite facilities, a hospital chain could set up new locations and avoid the limits applicable to new providers by characterizing the new locations as satellites of existing hospitals. This result would effectively nullify the anticipated budgetary savings of section 4416 of the BBA in such situations.

While many hospitals furnish care to cancer patients, exclusion from the prospective payment system as a cancer hospital is not available to a facility unless it was classified as such on or before December 31, 1991 (section 1886(d)(10)(B)(v) of the act and regulations at § 412.23(f)). The statute effectively prohibits recognition of newly established hospitals as cancer hospitals. If we were to permit satellite locations of excluded hospitals to be set up within prospective payment system hospitals and to be excluded from the prospective payment system, existing cancer hospitals might set up satellite locations in prospective payment hospitals, thus avoiding the prohibition on new cancer hospitals. This practice would be inconsistent with section 1886(d)(10)(B)(v) and its implementing regulations. It also could potentially allow a hospital under the prospective payment system to admit or transfer all high-cost cancer patients to the ''cancer hospital satellite'' while making a profit on the low-cost cancer patients remaining at the prospective payment system hospital.

Finally, we note that rehabilitation units that are excluded from the prospective payment system are required to have a medical director of rehabilitation who furnishes services to the unit or its patients at least 20 hours per week (§ 412.29(f)(1)). However, this requirement presumably would not apply if the facility is described not as a unit of the hospital in which it is based, but as a satellite of an existing rehabilitation hospital, since that hospital would already have its medical director. The existence of a high level of physician oversight of rehabilitation is a key identifier of the kind of unit that provides inpatient hospital-level rehabilitation care as its primary activity, not merely as an adjunct or extension of acute care. We believe allowing satellites of rehabilitation hospitals to be set up in prospective payment system hospitals and excluded from the prospective payment system would undermine the requirement for that level of physician oversight, and limit our ability to exclude only those units providing the appropriate level of rehabilitation services.

We believe that a number of excluded hospitals are seeking satellite arrangements so that the services furnished in the satellite facility are inappropriately paid on an excluded basis when they should be paid on a prospective basis. We also believe that a number of excluded hospitals are seeking satellite arrangements in order to avoid the effect of the payment caps that apply to new hospitals and would apply to the satellite facility if the satellite facility received separate certification. And, as discussed above, satellite arrangements can lead to other problems. To prevent inappropriate Medicare payment for services furnished in satellite facilities, we propose to revise §§ 412.22 and 412.25 to provide for payment to satellite facilities of hospitals and units that are excluded from the prospective payment system under specific rules. With respect to both hospitals and units, we would define ''satellite facility'' as a part of a hospital that provides inpatient services in a building also used by another hospital, or in one or more buildings on the same campus as buildings also used by another hospital, but is not a ''hospital-within-a-hospital,'' since it is also part of another hospital. If the satellite facility is located in a hospital that is paid under the prospective payment system, Medicare would pay for services furnished at the satellite facility by using the same rates that apply to the prospective payment hospital within which the satellite is located. As explained earlier, we believe that, if the satellite facility is effectively ''part of'' the prospective payment system hospital, then it should be paid under the prospective payment system.

If the satellite facility is located in a hospital excluded from the prospective payment system, then Medicare would pay for the services furnished in the satellite facility as follows: we would examine the discharges of the satellite facility and we would apply the target amount for the excluded hospital *in which the hospital is located,* subject to the applicable cap for the hospital *of which the satellite is a part.* Also, when the satellite facility is established, we would treat the satellite facility as a new hospital for payment purposes. That is, for the satellite's first two 12-month cost reporting periods, the satellite would be subject to the cap that applies to new hospitals of the same class as the hospital of which the satellite is a part. We believe that application of the cap for new hospitals is appropriate because we believe that a number of hospitals are attempting to avoid the new hospital caps by characterizing entities as satellites rather than new hospitals.

Under our proposal, satellite facilities excluded from the prospective payment system prior to the effective date of the revised regulations (October 1, 1999) would not be subject to those new regulations as long as they operate under the same terms and conditions in effect on September 30, 1999. We would make this exception available only to those facilities that can document to the HCFA regional offices that they are operating as satellite facilities excluded from the prospective payment system as of that date, not to facilities that might be excluded from the prospective payment system as of that date and at some later time enter into satellite arrangements. The proposed rules for payments to satellite facilities would not apply to multicampus arrangements, that is, those in which a hospital has several locations but does not share a building or a campus with any other hospital at any location.

We also solicit comment on a possible further exception. In section 4417 of the BBA, Congress extended the long-term care hospital exclusion to a hospital ''that first received payment under this subsection [subsection 1886(d)(1)(B)(iv) of the Act] in 1986 which has an average inpatient length of stay (as determined by the Secretary) of greater than 20 days and that has 80 percent or more of its annual Medicare inpatient discharges with a principal diagnosis of neoplastic disease in the 12-month cost reporting period ending in fiscal year 1997.'' In view of the specific provision made for a hospital meeting these requirements, we are considering whether a satellite facility opened by such a hospital

should be exempt from the proposed rules on satellites on this preamble. We welcome comment on this issue and on whether such an exclusion could be implemented without compromising the effectiveness of the proposed changes.

We recognize that there may be some operational difficulties differentiating services, costs, and discharges of the satellite facilities from those of the existing hospital that is excluded from the prospective payment system. If these operational problems cannot be overcome, we might, in the final rule, revise §§ 412.22 and 412.25 to prohibit exclusion of any hospital or hospital unit from the prospective payment system that is structured, entirely or in part, as a satellite facility in a hospital paid under the prospective payment system. The effect of this change would be that all Medicare payments to such a hospital or hospital unit with a satellite facility would be made under the prospective payment system.

Before deciding to propose these changes, we considered whether the hospital-within-a-hospital rules in § 412.22(e) provide adequate protection against abuses of the prospective payment system exclusion by satellite facilities. For the reasons described below, we concluded that they do not.

The current hospital-within-a-hospital criteria were issued through proposed rules published in the **Federal Register** on May 27, 1994 (59 FR 27708) and final rules published on September 1, 1994 (59 FR 45330). In those documents, we explained that the DRG system is based on an averaging concept that provides appropriate payment for the type and mix of cases treated by acute care hospitals, but that the averaging concept underlying the DRG system does not apply to long-stay hospitals, which have few short-stay or low-cost cases and might be systematically underpaid if the prospective payment system were applied to them. We explained that it would not be appropriate to make prospective payment system exclusion available to long-stay units of acute hospitals, since those units account for only part of the hospital's patient load and the principles underlying the prospective payment system do apply to the larger hospital. We also stated that the hospital-within-a-hospital criteria, now codified at § 412.22(e), ensure that facilities structured as hospitals-within-hospitals are sufficiently separate from the host hospitals to warrant exclusion from the prospective payment system as separate hospitals.

The considerations that make it inappropriate to exclude long-stay units of general hospitals from the prospective payment system also make it inappropriate, in our view, to allow exclusion from prospective payment system of facilities that treat only a part of the patient load of the larger prospective payment system hospitals in which they are located, but are presented as satellites of another facility. In responding to a comment in the September 1, 1994 final rule, we stated that we believe that the hospital-within-a-hospital criteria should have application in all cases involving joint occupancy of a building or campus by an applicant long-term hospital and another hospital (59 FR 45330). After further review of the issue, however, we have now concluded that while the hospital-within-a-hospital criteria are designed to prevent potential abuses similar to those posed by satellites, the criteria themselves cannot be effectively applied to satellite arrangements. This is because the criteria are designed to apply to hospitals that exist only in one location. For example, under § 412.22(e)(5)(ii), one criterion for showing separate operation of a hospital-within-a-hospital is that the hospital's costs of services obtained under contracts or other arrangements from the host hospital (or from a controlling third entity) be no more than 15 percent of the hospital's total inpatient operating cost. Because a satellite facility would integrate its costs with those of the hospital with which it is affiliated, it is possible that the entire hospital could meet this test even though all costs of the satellite facility were incurred under contracts or arrangements. Likewise, the criterion regarding the source of inpatient referrals (§ 412.22(e)(5)(iii)) could be met by an entire hospital, even though most or all patients treated at a satellite facility were referred from the hospital in which the satellite is located. Thus, existing hospital-within-a-hospital criteria are not adequate to deal with satellite issues.

D. Responsibility for Care of Patients in Hospitals Within Hospitals

Normally, hospitals that admit patients, including hospitals subject to the prospective payment system and ''hospitals-within-hospitals'' that are excluded from the prospective payment system, accept overall responsibility for the patients' care and furnish all services they require. In accordance with section 1886(d)(5)(I) of the Act and implementing regulations at § 412.4, for payment purposes, the prospective payment system distinguishes between ''discharges'' (situations in which a patient leaves an acute care hospital paid under the prospective payment system after receiving complete acute care treatment) and ''transfers'' (situations in which acute care treatment is not completed at the first hospital and the patient is transferred to another acute care hospital for continued, related care). The payment rules at § 413.30, which apply to hospitals excluded from the prospective payment system, also are premised on the assumption that discharges occur only when the excluded hospital's care of the patient is complete.

It has come to our attention that, given the co-location of prospective payment system facilities and facilities excluded from the prospective payment system in a hospital-within-a-hospital, and the absence of clinical constraints on the movement of patients, there may be situations where, in such settings, patients appear to have been moved from one facility to another for financial rather than clinical reasons. The excluded hospital-within-a-hospital might have incentives to inappropriately discharge patients early (to the prospective payment system hospital within which it is located) in order to minimize its overall costs and in turn to minimize its cost per discharge. If the excluded hospital-within-a-hospital inappropriately discharges patients to the prospective payment system hospital without providing a complete episode of the type of care furnished by the excluded hospital, then Medicare would make inappropriate payments to the hospital-within-a-hospital. This is the case because payments made to an excluded hospital are made on a per-stay basis, up to the hospital's per discharge target amount, and any artificial decrease in the hospital's cost per stay could lead to the hospital inappropriately avoiding its target amount cap mandated by section 4414 of the BBA and receiving inappropriate bonus and relief payments under section 4415 of the BBA.

For example, if a long-term care hospital has an average length of stay of 30 days and incurs a cost per patient-day of $1,500, its average cost per stay is $45,000 ($1,500 × 30). If that hospital discharged 20 percent of its patients to a prospective payment system hospital before the 30th day of their stay at the long-term care hospital, the patients might still stay, on average, a total of 30 days at the two hospitals. However, by transferring an increased number of patients early during the period, the long-term care hospital would be able to reduce its cost per discharge.

If the hospital's cap on its target amount is $38,593 and the hospital's cost per discharge is $45,000, then the hospital's payments would be based on

a target amount of $38,593. If, as a result of the inappropriate discharges, the cost per stay is $37,500, Medicare payment to the hospital would be based on a target amount of $37,500, plus an additional amount under the bonus provisions of § 413.40(d)(2). In addition, a separate DRG payment would be made to the prospective payment system hospital that completed the treatment at the satellite location. Thus, Medicare payments for a 30-day period of inpatient care would increase without any additional quality of care or benefit to the patient. The additional payment would merely be a result of artificially decreasing the long-term care hospital's cost per discharge and adding a second payment to the prospective payment system hospital.

We believe it is important to address possible financial incentives for inappropriate early discharges from excluded hospitals-within-hospitals to prospective payment system hospitals. Therefore, we considered several approaches for preventing inappropriate Medicare payments to an excluded hospital-within-a-hospital for inappropriate discharges to the prospective payment system hospital in which it is located. One approach would be to provide that, if an excluded hospital-within-a-hospital transfers patients from its beds to beds of the prospective payment system hospital with which it is located, the hospital-within-a-hospital would not qualify for exclusion in the next cost reporting period. We recognize that this approach might ''penalize'' hospitals for transfers that are medically appropriate. However, we need to balance (1) our concern with preventing inappropriate Medicare payment and (2) our need to have a rule that is administratively feasible.

A second possible approach would be to provide that the hospital-within-a-hospital would qualify for exclusion only if it transfers patients to the prospective payment system hospital only when the services the patients require cannot be furnished by the hospital-within-a-hospital. This approach has the advantage of specifically targeting inappropriate early discharges, but it has the significant disadvantage of being difficult if not impossible to administer because of the extent of case review that would be required to implement it.

After considering these options, we have decided to propose a third approach. Under this approach, we would deny exclusion to a hospital-within-a-hospital for a cost reporting period if, during the most recent cost reporting period for which information is available, the excluded hospital-within-a-hospital transferred more than 5 percent of its inpatients to the prospective payment system hospital in which it is located. We believe that a 5-percent allowance of transfers under this approach would (1) avoid the need for administratively burdensome case review, (2) provide adequate flexibility for transfers in those cases where the hospital-within-a-hospital is not equipped or staffed to provide the services required by the patient, and (3) limit the extent to which patients may be transferred inappropriately.

We welcome comments on our proposed approach as well as suggestions on other ways to address the possible incentives for inappropriate transfers in a manner that is administratively feasible.

E. Critical Access Hospitals (CAHS)

1. Emergency Response Time Requirements for CAHs in Frontier and Remote Areas

Because of the high cost of staffing rural hospital emergency rooms and the low volume of services in those facilities, we do not require CAHs to have emergency personnel on site at all times. Thus, for CAHs, the regulations at § 485.618(d) require a doctor of medicine or a doctor of osteopathy, a physician assistant, or a nurse practitioner with training and experience in emergency care to be on call and immediately available by telephone or radio contact, and available on site within 30 minutes, on a 24-hour basis. We included this requirement because we recognize the need of rural residents to have reasonable access to emergency care in their local communities.

Section 1820(h) of the Act, as added by section 4201 of the BBA, states that any medical assistance facility (MAF) in Montana shall be deemed to have been certified by the Secretary as a CAH if that facility is otherwise eligible to be designated by the State as a CAH. However, under the current requirements, following the initial transition of a MAF to CAH status, the former MAF would be subject to the CAH requirements during any subsequent review, one of which is the 30-minute emergency response time for emergency services currently required under § 485.518(d).

Recently, some facilities have suggested that in many ''frontier'' areas (that is, those having fewer than six residents per square mile), the requirement of a 30-minute response might be too restrictive for CAHs, especially those MAFs transitioning to CAH status.

We are aware it is costly and difficult to recruit and train the personnel needed to operate emergency rooms in the most remote, sparsely populated rural areas. On the other hand, in contemplating any changes to the emergency response timeframe for CAHs, we must ensure that the response time is not extended to the point that patient health and safety are jeopardized.

In order to recognize the special needs of sparsely populated rural areas in meeting beneficiaries' health needs, and at the same time to protect patients' health and safety, we are proposing to revise § 485.618(d) to allow a response time of up to 60 minutes for a CAH if (1) it is located in an area of the State that is defined as a frontier area (that is, having fewer than six residents per square mile based on the latest population data published by the Bureau of the Census) or meets other criteria for a remote location adopted by the State and approved by HCFA under criteria specified in its rural health care plan under section 1820(b) of the Act; (2) the State determines that, under its rural health care plan, allowing the longer emergency response time is the only feasible method of providing emergency care to residents of the area; and (3) the State maintains documentation showing that a response time up to 60 minutes at a particular CAH it designates is justified because other available alternatives would increase the time required to stabilize the patient in an emergency. The criteria for remote location would, like other parts of the rural health care plan, be subject to review and approval by the HCFA Regional Office, as would the State's documentation regarding the emergency response time.

We note that, under the terms of the Montana State Code applicable to MAFs, at times when no emergency response person is available to come to the facility, a MAF's director of nursing is permitted to come to the facility and authorize the transfer of a patient seeking emergency services to another facility. Under one possible reading of the State requirement, this activity could be seen as an alternative way of complying with the emergency services requirement and the MAF's (and CAH's) responsibilities under section 1867 of the Act (the Emergency Medical Treatment and Active Labor Amendments Provision) to provide emergency medical screening and stabilization services to patients who come to the hospital seeking emergency treatment. We request comments on

whether the Medicare regulations in §§ 485.618(d) and 489.24 should be further revised to explicitly permit this practice to continue following the transition of a MAF to CAH status. We are particularly interested in obtaining comment from practitioners on the risks and benefits involved in adoption of this practice.

2. Compliance With Minimum Data Set (MDS) Requirements by CAHs With Swing-Bed Approval

Existing regulations allow CAHs to obtain approval from HCFA to use their inpatient beds to provide posthospital SNF care (§ 485.645). To obtain such approval, however, the CAH must agree to meet specific requirements that also apply to SNFs, including the comprehensive assessment requirements at § 483.20(b) of the SNF conditions of participation.

Section 483.20(b)(1) specifies that a SNF must make a comprehensive assessment of a resident's needs, using the resident assessment instrument specified by the State. Section 483.20(b)(2) further specifies that, subject to the timeframes in § 413.343(b), the assessments must be conducted within 14 calendar days after the patient is admitted; within 14 days after the facility determines, or should have determined, that there is a significant change in the patient's physical or mental condition; and at least once every 12 months. Section 413.343(b) specifies that in accordance with the methodology in § 413.337(c) related to the adjustment of the Federal rates for case-mix (the SNF prospective payment system), patient assessments must be performed on the 5th, 14th, 30th, 60th, and 90th days following admission.

It is clear that the timeframes for patient assessments required under § 413.343(b) are linked to the prospective payment system for SNFs. The methodology specifically referenced in § 413.337(c) refers to the SNF prospective payment system. Therefore, it is apparent that the patient assessments and concomitant timeframes for performing such assessments are inextricably intertwined with the case-mix adjustment under the SNF prospective payment system. CAHs with swing-bed approval are not paid for their services to SNF-level patients under that SNF prospective payment system but are paid under the payment method described in § 413.114, which does not include a case-mix adjustment. Therefore, the timeframes for patient assessments as dictated by § 413.343(b) are not applicable to CAHs and are not required to be met by CAHs. Nevertheless, to make it explicit that the patient assessment timeframes required under § 413.343(b) do not apply, we propose to revise § 485.645 to state that the requirements in § 413.343(b), and the timeframes specified in § 483.20, do not apply to CAHs.

VII. MedPAC Recommendations

We have reviewed the March 1, 1999 report submitted by MedPAC to Congress and have given its recommendations careful consideration in conjunction with the proposals set forth in this document. Recommendations 3A and 3B concerning the update factors for inpatient hospital 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. Other recommendations are discussed below.

A. Excluded Hospitals and Hospital Units (Recommendations 4B and 4C)

Recommendation: The Congress should adjust the wage-related portion of the excluded hospital target amount caps (the 75th percentile of target amounts for hospitals in the same class (psychiatric hospital or unit, rehabilitation hospital or unit, or long-term care hospitals)) to account for geographic differences in labor costs. The Commission presumes legislation would be necessary to adjust the caps for wages.

Response: We previously addressed this issue in the May 12, 1998 final rule (63 FR 26345). In that discussion, we explain why we believe the statutory language, the statutory scheme, and the legislative history, viewed together, strongly argue against making a wage adjustment in applying the target amount caps under the current statute.

Recommendation: Additional research in case-mix classification systems for psychiatric patients should be encouraged, with the aim of developing a case-mix adjusted prospective payment system for psychiatric patients in the future.

Response: As MedPAC indicated in its recommendation discussion, prior research has indicated substantial difficulties in developing a psychiatric case-mix classification system. Another issue is the adequate identification of a system that reflects the unique characteristics of psychiatric care for the Medicare population, primarily the elderly. During the past year, we have met with industry representatives to discuss further research efforts on this issue as well as understand the initial impacts of the recent legislative changes to excluded hospital payment system on psychiatric hospitals and units. We will continue these efforts in FY 2000.

B. Disproportionate Share Hospitals (DSH) (Recommendations 3C, 3D, and 3E)

Recommendations: The Congress should require that disproportionate share payments be distributed according to each hospital's share of low-income patient costs, defined broadly to include all care to the poor. The measure of low-income costs should reflect: (1) Medicare patients eligible for Supplemental Security Income, Medicaid patients, patients sponsored by other indigent care programs, and uninsured and underinsured patients as represented by uncompensated care (both charity and bad debts); and (2) services provided in both inpatient and outpatient settings.

As under current policy, disproportionate share payment should be made in the form of an adjustment to the per-case payment rate. In this way, the total payment each hospital receives will reflect its volume of Medicare patients.

Through a minimum threshold for low-income share, the formula for distributing disproportionate share payments should concentrate payments among hospitals with the highest shares of poor patients. A reasonable range for this threshold would be levels that make between 50 percent and 60 percent of hospitals eligible for a payment. The size of the payment adjustment, however, should increase gradually from zero at the threshold. The same distribution formula should apply to all hospitals covered by prospective payment.

The Secretary should collect the data necessary to revise the disproportionate share payment system from all hospitals paid under prospective payment system.

Response: We continue to give careful consideration to MedPAC's recommendations concerning the DSH adjustment made to operating payments under the prospective payment system.

We are in the process of preparing a report to Congress on the Medicare DSH adjustment that includes several options for amending the statutory disproportionate share adjustment formula. We believe that any adjustment to the DSH formula or data sources should be directed and supported by the Congress.

The MedPAC option involves collecting data on uncompensated care, that is, charity and bad debts. Ideally, this would be a direct measure of a hospital's indigent care burden. However, there are problems associated with verification of such data and

consistency of reporting nationally. We appreciate the Commission's recommendations about and assistance with the Medicare DSH adjustment as we formulate our legislative proposal and await Congressional action.

VIII. 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**. This file, scheduled to be available by the end of April, 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**. The FY 1998 MedPAR file used for the FY 2000 final rule will be cutoff 6 months after the end of the fiscal year (March file) and is scheduled to be available by the end of April.

Media: Tape/Cartridge
File Cost: $3,655.00 per fiscal year
Periods Available: FY 1988 through FY 1998

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**. This file, scheduled to be available by the end of April, 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**. The FY 1998 MedPAR file used for the FY 2000 final rule will be cutoff 6 months after the end of the fiscal year (March file) and is scheduled to be available by the end of April.

Media: Tape/Cartridge
File Cost: $1,130.00 per State per year
Periods Available: FY 1988 through FY 1998

3. HCFA Wage Data

This file contains the hospital hours and salaries for 1996 used to create the proposed FY 2000 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
1999	1996	2000
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**.
- Final Rule published in the **Federal Register**.

Media: Diskette/most recent year on the Internet
File Cost: $165.00 per year
Periods Available: FY 2000 PPS Update

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

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

Media: Diskette/most recent year on the Internet
File Cost: $165.00 per year
Periods Available: FY 2000 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: $165.00 per year
Periods Available: FY 2000 PPS Update

6. Reclassified Hospitals New Wage Index (Formerly: Reclassified Hospitals by Provider Only)

This file contains a list of hospitals that were reclassified for the purpose of assigning a new wage index. Two versions of these files are created each year. They support the following:

- NPRM published in the **Federal Register**.
- Final Rule published in the **Federal Register**.

Media: Diskette/Internet
File Cost: $165.00 per year
Periods Available: FY 2000 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 and PPS–XIV Minimum Data Sets are part of the PPS–XIII and PPS–XIV Hospital Data Set Files.)

File Cost: $770.00 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 and PPS–XIV Capital Data Sets are part of the PPS–XIII and PPS–XIV Hospital Data Set Files.)

File Cost: $770.00 per year

9. PPS–XIII and PPS–XIV Hospital Data Set

The file contains cost, statistical, financial, and other data from the Medicare Hospital Cost Report. The data set includes only the most current cost (as submitted, final settled, or reopened) submitted for a Medicare Certified Hospital by the Medicare Fiscal Intermediary to HCFA. The data set are updated at the end of each calendar quarter and is available on the last day of the following month.

Media: Diskette/Internet
File Cost: $2,500.00

	Periods beginning on or after	and before
PPS–XIII	10/01/95	10/01/96
PPS–XIV	10/01/96	10/01/97

10. 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 2000 PPS Update

11. 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**.
- Final rule published in the **Federal Register**.

Media: Diskette/most recent year on Internet
Price: $165.00 per year/per file
Periods Available: FY 1985 through FY 1998

12. 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:**

- NPRM.
- Final rule.

Media: Diskette/Internet
File Cost: $165.00
Periods Available: FY 2000 PPS Update

13. 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: $165.00
Periods Available: FY 2000 PPS Update

14. 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**.
- Final rule published in the **Federal Register**.

Media: Diskette/Internet
File Cost: $165.00
Periods Available: FY 2000 PPS Update

For further information concerning these data tapes, contact The HCFA Public Use Files Hotline at (410) 786–3691.

Commenters interested in obtaining or discussing any other data used in constructing this rule should contact Stephen Phillips at (410) 786–4531.

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 2000 be published by August 1, 1999, we will consider only those

comments that deal specifically with the matters discussed in this proposed rule.

List of Subjects

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 Part 483

Grant programs-health, Health facilities, Health professions, Health records, Medicaid, Medicare, Nursing homes, Nutrition, Reporting and recordkeeping requirements, Safety.

42 CFR Part 485

Grant programs-health, Health facilities, Medicaid, Medicare, Reporting and recordkeeping requirements.

42 CFR Chapter IV is amended as set forth below:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

A. Part 412 is amended as follows:

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 1395hh).

2. Section 412.22 is amended by adding new paragraphs (e)(6) and (h) to read as follows:

§ 412.22 Excluded hospitals and hospital units: General rules.

* * * * *

(e) *Hospitals-within-hospitals.* * * *

(6) *Responsibility for care of patients.* During the most recent cost reporting period for which information is available, the hospital transferred no more than 5 percent of its inpatients to the prospective payment system hospital within which it is located.

* * * * *

(h) *Satellite facilities.* (1) For purposes of paragraphs (h)(2) through (h)(5) of this section, a satellite facility is a part of a hospital that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital.

(2) Effective for cost reporting periods beginning on or after October 1, 1999, payment for services furnished in satellite facilities of hospitals excluded from the prospective payment systems is made in accordance with the rules specified in paragraphs (h)(3) and (h)(4) of this section.

(3) If the satellite facility occupies space in the same building or on the same campus as a hospital paid under the prospective payment system, payment for services furnished at the satellite facility is based on the same rates that apply to the prospective payment system hospital within which the satellite is located.

(4) If the satellite facility occupies space in the same building or on the same campus as a hospital excluded from the prospective payment systems, payment for services furnished at the satellite facility is made as follows:

(i) For the first two 12-month cost reporting periods during which the satellite facility treats patients, payment for services furnished at the satellite facility is made in accordance with the provisions of § 413.40(f)(2) of this subchapter.

(ii) For subsequent cost reporting periods, payment for services furnished at the satellite facility is made based on the target amount of the excluded hospital in which the satellite is located, but is subject to the cap at the hospital of which the satellite is a part.

(5) The provisions of paragraphs (h)(2) through (h)(4) of this section do not apply to any hospital or entity structured as a satellite facility on September 30, 1999, and excluded from the prospective payment systems on that date, to the extent the hospital continues operating under the same terms and conditions, including the number of beds and square footage considered, for purposes of Medicare participation and payment, to be part of the hospital, in effect on September 30, 1999.

3. Section 412.25 is amended by revising paragraphs (b) and (c) and adding a new paragraph (e) to read as follows:

§ 412.25 Excluded hospital units: common requirements.

* * * * *

(b) *Changes in the size of excluded units.* For purposes of exclusions from the prospective payment systems under this section, changes in the number of beds and square footage considered to be part of each excluded unit are allowed as specified in paragraphs (b)(1) and (b)(2) of this section.

(1) *Increase in size.* The number of beds and square footage of an excluded unit may be increased only at the start of a cost reporting period.

(2) *Decrease in size.* The number of beds and square footage of an excluded unit may be decreased at any time during a cost reporting period if the hospital notifies the fiscal intermediary and the HCFA Regional Office in writing of the planned decrease at least 30 days before the date of the decrease, and maintains the information needed to accurately determine costs that are attributable to the excluded unit. Any decrease in the number of beds or square footage considered to be part of an excluded unit made during a cost reporting period continues in effect for the remainder of that period.

(c) *Changes in the status of hospital units.* For purposes of exclusions from the prospective payment systems under this section, the status of each hospital unit (excluded or not excluded) is determined as specified in paragraphs (c)(1) and (c)(2) of this section.

(1) The status of a hospital unit may be changed from not excluded to excluded only at the start of a cost reporting period. If a unit is added to a hospital after the start of a cost reporting period, it cannot be excluded from the prospective payment systems before the start of a hospital's next cost reporting period.

(2) The status of a hospital unit may be changed from excluded to not excluded at any time during a cost reporting period, but only if the hospital notifies the fiscal intermediary and the HCFA Regional Office in writing of the change at least 30 days before the date of the change, and maintains the information needed to accurately determine costs that are or are not attributable to the excluded unit. A change in the status of a unit from excluded to not excluded that is made during a cost reporting period continues in effect for the remainder of that period.

* * * * *

(e) *Satellite facilities.* (1) For purposes of paragraphs (e)(2) through (e)(5) of this section, a satellite facility is a part of a hospital that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital.

(2) Effective for cost reporting periods beginning on or after October 1, 1999, payment for services furnished in psychiatric or rehabilitation units that are structured, entirely or in part, as satellite facilities are made in accordance with the rules specified in paragraphs (e)(3) and (e)(4) of this section.

(3) If the satellite facility occupies space in the same building or on the same campus as a hospital paid under the prospective payment systems,

payment for services furnished at the satellite facility is based on same rates that apply to the prospective payment system hospital within which the satellite is located.

(4) If the satellite facility occupies space in the same building or on the same campus as a hospital excluded from the prospective payment systems, payment for services furnished at the satellite facility is made as follows:

(i) For the first two 12-month cost reporting periods during which the satellite facility treats patients, payment for services furnished at the satellite facility is made in accordance with the provisions of § 413.40(f)(2) of this subchapter.

(ii) For subsequent cost reporting periods, payment for services furnished at the satellite facility is made based on the target amount of the excluded hospital in which the satellite is located, but is subject to the cap of the hospital of which the satellite is a part.

(5) The provisions of paragraph (e)(2) through (e)(4) of this section do not apply to any unit structured as a satellite facility on September 30, 1999, and excluded from the prospective payment systems on that date, to the extent the unit continues operating under the same terms and conditions, including the number of beds and square footage considered to be part of the unit, in effect on September 30, 1999.

§ 412.105 [Amended]

4. Section 412.105 is amended by revising the cross reference ''paragraph (g)(1)(ii) of this section'' in paragraphs (f)(1)(iii) (three times) and (f)(2)(v) to read ''paragraph (f)(1)(ii) of this section''.

§ 412.256 [Amended]

5. In § 412.256, paragraph (c)(2), the date ''October 1'', appearing in two places, is revised to read ''September 1''.

6. Section 412.276 is amended by revising paragraph (a) to read as follows:

§ 412.276 Timing of MGCRB decision and its appeal.

(a) *Timing.* The MGCRB notifies the parties in writing, with a copy to HCFA, and issues a decision within 180 days after the first day of the 13-month period preceding the Federal fiscal year for which a hospital has filed a complete application. The hospital has 15 days from the date of the decision to request Administrator review.

* * * * *

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

B. Part 413 is amended as follows:

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), 1871, 1881, 1883, and 1886 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).

2. Section 413.40 is amended by revising paragraphs (b)(1)(iii) and (g)(1) to read as follows:

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

* * * * *

(b) *Cost reporting periods subject to the rate-of-increase ceiling.* (1) *Base period.* * * *

(iii) When the operational structure of a hospital or unit changes (that is, a freestanding hospital becomes a unit or vice versa, or an entity of a multicampus hospital becomes a newly created hospital or unit or vice versa), the base period for the hospital or unit that changed its operational structure is the first cost reporting period of at least 12 months effective with the revised Medicare certification classification.

* * * * *

(g) *Adjustment.* (1) *General rules.* (i) 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 in paragraphs (g)(2), (g)(3), and (g)(4) of this section.

(ii) 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.

(iii) When an adjustment is requested by the hospital, HCFA makes an adjustment only if the hospital's operating costs exceed the rate-of-increase ceiling imposed under this section.

(iv) In the case of a psychiatric hospital or unit, rehabilitation hospital or unit, or long-term care hospital, the amount of payment under paragraph (g)(3) of this section may not exceed the payment amount based on the target amount determined under paragraph (c)(4)(iii) of this section.

(v) In the case of a hospital or unit that received a revised FY 1998 target amount under the rebasing provisions of paragraph (b)(1)(iv) of this section, the amount of an adjustment payment for a cost reporting period is based on a comparison of the hospital's operating costs for the cost reporting period to the average costs and statistics for the cost reporting periods used to determine the FY 1998 rebased target amount.

* * * * *

§ 413.86 [Amended]

3. Section 413.86 is amended as follows:

a. In paragraph (b), the definition of ''approved geriatric program'' is revised to read: ''*Approved geriatric program* means a fellowship program of one or more years in length that is approved by one of the national organizations listed in § 415.152 of this chapter under that respective organization's criteria for geriatric fellowship programs.''

b. In paragraph (b), under paragraph (1) of the definition of ''approved medical residency program'', the reference ''§ 415.200(a) of this chapter'' is revised to read ''§ 415.152 of this chapter''.

c. In paragraph (e)(1)(ii)(C), the reference ''paragraph (j)(2) of this section'' is revised to read ''paragraph (k)(1) of this section''.

d. In paragraph (e)(1)(iv), the reference, ''paragraph (j)(1) of this section'', is revised to read ''paragraph (k)(1) of this section''.

e. A new paragraph (f)(4)(iii) is added, paragraphs (g)(1) (i), (ii), and (iii), (g)(6) introductory text and (g)(6) (i) and (ii) are revised, paragraph (g)(7) is redesignated as paragraph (g)(9), and new paragraphs (g)(7) and (g)(8) are added to read as follows:

§ 413.86 Direct graduate medical education payments.

* * * * *

(f) *Determining the total number of FTE residents.* * * *

(4) * * *

(iii) The hospital must incur all or substantially all of the costs for the training program in the nonhospital setting in accordance with the definition in paragraph (b) of this section.

(g) *Determining the weighted number of FTE residents.* * * *

(1) * * *

(i) For residency programs other than those specified in paragraphs (g)(1)(ii) and (g)(1)(iii) of this section, the initial residency period is the minimum

number of years of formal training necessary to satisfy the requirements for initial board eligibility in the particular specialty for which the resident is training, as specified in the most recently published edition of the Graduate Medical Education Directory.

(ii) For residency programs in osteopathy, dentistry, and podiatry, the minimum requirement for certification in a specialty or subspecialty is the minimum number of years of formal training necessary to satisfy the requirements of the appropriate approving body listed in § 415.152 of this chapter.

(iii) For residency programs in geriatric medicine accredited by the appropriate approving body listed in § 415.152 of this chapter, these programs are considered approved programs on the later of—

(A) The starting date of the program within a hospital; or

(B) The hospital's cost reporting periods beginning on or after July 1, 1985.

* * * * *

(6) If a hospital establishes a new medical residency training program as defined in paragraph (g)(9) of this section on or after January 1, 1995, the hospital's FTE cap described under paragraph (g)(4) of this section may be adjusted as follows:

(i) If a hospital had no allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, and it establishes a new medical residency training program on or after January 1, 1995, the hospital's unweighted FTE resident cap under paragraph (g)(4) of this section may be adjusted based on the product of the highest number of residents in any program year during the third year of the first program's existence for all new residency training programs and the number of years in which residents are expected to complete the program based on the minimum accredited length for the type of program. The adjustment to the cap may not exceed the number of accredited slots available to the hospital for the new program.

(A) If the residents are spending an entire program year (or years) at one hospital and the remainder of the program at another hospital, the adjustment to each respective hospital's cap is equal to the product of the highest number of residents in any program year during the third year of the first program's existence and the number of years the residents are training at each respective hospital.

(B) Prior to the implementation of the hospital's adjustment to its FTE cap beginning with the fourth year of the hospital's residency program(s), the hospital's cap may be adjusted during each of the first 3 years of the hospital's new residency program using the actual number of residents participating in the new program. The adjustment may not exceed the number of accredited slots available to the hospital for each program year.

(C) Except for rural hospitals, the cap will not be adjusted for new programs established more than 3 years after the first program begins training residents.

(D) Rural hospitals that qualify for an adjustment to its FTE cap under paragraph (g)(6)(i) of this section are permitted to be part of the same affiliated group for purposes of an aggregate FTE limit.

(ii) If a hospital had allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, the hospital's unweighted FTE cap may be adjusted for new medical residency training programs established on or after January 1, 1995 and on or before August 5, 1997. The adjustment to the hospital's FTE resident limit for the new program is based on the product of the highest number of residents in any program year during the third year of the newly established program and the number of years in which residents are expected to complete each program based on the minimum accredited length for the type of program.

(A) If the residents are spending an entire program year (or years) at one hospital and the remainder of the program at another hospital, the adjustment to each respective hospital's cap is equal to the product of the highest number of residents in any program year during the third year of the first program's existence and the number of years the residents are training at each respective hospital.

(B) Prior to the implementation of the hospital's adjustment to its FTE cap beginning with the fourth year of the hospital's residency program, the hospital's cap may be adjusted during each of the first 3 years of the hospital's new residency program, using the actual number of residents in the new programs. The adjustment may not exceed the number of accredited slots available to the hospital for each program year.

* * * * *

(7) A hospital that began construction of its facility prior to August 5, 1997, sponsored new medical residency training programs, and temporarily trained those residents at another hospital(s) until the facility was completed may receive an adjustment to its FTE cap.

(i) The newly constructed hospital's FTE cap is equal to the lesser of:

(A) The product of the highest number of residents in any program year during the third year of the first program's existence for all new residency training programs and the number of years in which residents are expected to complete the programs based on the minimum accredited length for each type of program; or

(B) The number of accredited slots available to the hospital for each year of the programs.

(ii) If the medical residency training programs sponsored by the newly constructed hospital have been in existence for 3 years or more by the time the residents begin training at the newly constructed hospital, the newly constructed hospital's cap will be based on the number of residents training in the third year of the first of those programs begun at the temporary training site.

(iii) If the medical residency training programs sponsored by the newly constructed hospital have been in existence for less than 3 years by the time the residents begin training at the newly constructed hospital, the newly constructed hospital's cap will be based on the number of residents training at the newly constructed hospital in the third year of the first of those programs (including the years at the temporary training site).

(iv) The provisions of this paragraph (g)(7) are applicable during portions of cost reporting periods occurring on or after October 1, 1999.

(8) A hospital may receive a temporary adjustment to its FTE cap to reflect residents added because of another hospital's closure if the hospital meets the following criteria:

(i) The hospital is training additional residents from a hospital that closed on or after July 1, 1996.

(ii) At least 60 days before the hospital begins to train the residents, the hospital submits a request to its fiscal intermediary for a temporary adjustment to its FTE cap, documents that the hospital is eligible for this temporary adjustment by identifying the residents who have come from the closed hospital and have caused the hospital to exceed its cap, and specifies the length of time the adjustment is needed.

* * * * *

PART 483—REQUIREMENTS FOR STATES AND LONG-TERM CARE FACILITIES

C. Part 483 is amended as set forth below:

1. The authority citation for Part 483 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. In § 483.20, the introductory text of paragraph (b)(2) is revised to read as follows:

§ 483.20 Resident assessment.

* * * * *

(b) *Comprehensive assessments.*

* * *

(2) *When required.* Subject to the timeframes prescribed in § 413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii). However, the timeframes prescribed in § 413.343(b) of this chapter do not apply to CAHs.

* * * * *

PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

D. Part 485 is amended as follows:

1. The authority citation for Part 485 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. Section 485.618 is amended by revising paragraph (d) to read as follows:

§ 485.618 Conditions of participation: Emergency services.

* * * * *

(d) *Standard: Personnel.* There must be a doctor of medicine or osteopathy, a physician assistant, or a nurse practitioner with training or experience in emergency care on call and immediately available by telephone or radio contact, and available on site within the following timeframes:

(1) Within 30 minutes, on a 24-hour a day basis, if the CAH is located in an area other than an area described in paragraph (d)(2) of this section; or

(2) Within 60 minutes, on a 24-hour a day basis, if the following requirements are met:

(i) The CAH is located in an area designated as frontier (that is, an area having fewer than six residents per square mile based on the latest population data published by the Bureau of the Census) or in an area that meets criteria for a remote location adopted by the State in its rural health care plan, and approved by HCFA, under section 1820(b) of the Act;

(ii) The State has determined under criteria in its rural health care plan that allowing an emergency response time longer than 30 minutes is the only feasible method of providing emergency care to residents of the area served by the CAH; and

(iii) The State maintains documentation showing that the response time of up to 60 minutes at a particular CAH it designates are justified because other available alternatives would increase the time needed to stabilize a patient in an emergency.

* * * * *

3. In § 485.645, the introductory text of paragraph (d) is republished and paragraph (d)(6) is revised to read as follows:

§ 485.645 Special requirements for CAH providers of long-term care services (“swing beds”).

* * * * *

(d) *SNF services.* CAH is substantially in compliance with the following SNF requirements contained in subpart B of part 483 of this chapter:

* * * * *

(6) Comprehensive assessment, comprehensive care plan, and discharge planning (§ 483.20(b), (d), and (e) of this chapter, except that the CAH is not required to comply with the requirements for frequency, scope and number of assessments prescribed in § 413.343(b)).

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance)

Dated: April 9, 1999.

Nancy Ann DeParle,

Administrator, Health Care Financing Administration.

Dated: April 26, 1999.

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, 1999; Payment Amounts for Blood Clotting Factor Effective for Discharges Occurring On or After October 1, 1999; and Update Factors and Rate-of-Increase Percentages Effective With Cost Reporting Periods Beginning On or After October 1, 1999

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, 1999, 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 yields 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 for FY 2000. The changes, to be applied prospectively, would affect the calculation of the Federal rates. In section III of this addendum, we are proposing updates to the payments per unit for blood clotting factor provided to hospital inpatients who have hemophilia. We also are proposing to add another product (clotting factor, porcine (HCPCS code J7191)) to the list of clotting factors that would be paid under this benefit.

In section IV of this addendum, we discuss our proposed changes for

determining the prospective payment rates for Medicare inpatient capital-related costs for FY 2000. Section V of this addendum sets forth our proposed changes for determining the rate-of-increase limits for hospitals excluded from the prospective payment system for FY 2000. The tables to which we refer in the preamble to the proposed rule are presented at the end of this addendum in section VI.

II. Proposed Changes to Prospective Payment Rates for Inpatient Operating Costs for FY 2000

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, 1999. 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 2000.

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

- Updates of 0.9 percent for all areas (that is, the market basket percentage increase of 2.7 percent minus 1.8 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 1999 budget neutrality factor and applying a revised factor;
- An adjustment to apply the revised outlier offset by removing the FY 1999 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.

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 us to determine the Medicare target amounts 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 us to update base-year per discharge costs for FY 1984 and then standardize the cost data in order to remove the effects of certain sources of variation in cost among hospitals. These effects 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. The average labor share in Puerto Rico is 71.3 percent. We are proposing to revise the discharge-weighted national standardized amount for Puerto Rico to reflect the proportion of discharges in large urban and other areas from the FY 1998 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 1997 population estimates published by the Bureau of the Census, 61 areas meet the criteria to be defined as large urban areas for FY 2000. 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 areas' and the other areas' average standardized amounts for FY 2000 using the applicable percentage increases specified in section 1886(b)(3)(B)(i) of the Act. Section 1886(b)(3)(B)(i)(XV) of the Act specifies that, for hospitals in all areas, the update factor for the standardized amounts for FY 2000 is equal to the market basket percentage increase minus 1.8 percentage points.

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 2000 is 2.7 percent. Thus, for FY 2000,

the proposed update to the average standardized amounts equals 0.9 percent.

As in the past, we are adjusting the FY 1999 standardized amounts to remove the effects of the FY 1999 geographic reclassifications and outlier payments before applying the FY 2000 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 2000.

Although the update factor for FY 2000 is set by law, we are required by section 1886(e)(3) of the Act to report to the Congress on our initial recommendation of update factors for FY 2000 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 requires us to update the hospital wage index on an annual basis beginning October 1, 1993. This provision also requires us to make any updates or adjustments to the wage index 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 1999 relative weights and wage index to aggregate payments using the proposed FY 2000 relative weights and wage index. The same methodology was used for the FY 1999 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 0.997393. We also 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 0.999910. These budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the FY 1999 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 apply these same adjustment factors to the hospital-specific rates that are effective for cost reporting periods beginning on or after October 1, 1999. (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. Based on these simulations, we are applying an adjustment factor of 0.994453 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 1999 budget neutrality adjustment factor. We note that the proposed FY 2000 adjustment reflects wage index and standardized amount reclassifications approved by the MGCRB or the Administrator as of February 26, 1999. The effects of any additional reclassification changes resulting from appeals and reviews of the MGCRB decisions for FY 2000 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 2000.

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 1999, the fixed loss cost outlier threshold is equal to the prospective payment for the DRG plus $11,100 ($10,129 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 1999 standardized amounts of 0.948740 for the large urban and other areas rates and 0.9392 for the capital Federal rate.

In accordance with section 1886(d)(5)(A)(iv) of the Act, we calculated proposed outlier thresholds for FY 2000 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 2000 standardized amounts by the same percentage to account for the projected proportion of payments paid to outliers. To calculate FY 2000 outlier thresholds, we simulated payments by applying FY 2000 rates and policies to the December 1998 update of the FY 1998 MedPAR file and the December 1998 update of the provider-specific file. As we have explained in the past, to calculate outlier thresholds we apply a cost inflation factor to update costs for the cases used to simulate payments. 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, we used a cost inflation factor of minus 1.724 percent. To set the proposed FY 2000 outlier thresholds, we used a cost inflation factor (or cost adjustment factor) of zero percent. This factor reflects our analysis of the best available cost report data as well as calculations (using the best available data) indicating that the percentage of actual outlier payments for FY 1998, is higher than we projected before the beginning of FY 1998, and that the percentage of actual outlier payments for FY 1999 will likely be higher than we projected before the beginning of FY 1999. The calculations of ''actual'' outlier payments are discussed further below. Based on these simulations, we are proposing a fixed loss cost outlier threshold in FY 2000 equal to the prospective payment rate for the DRG plus $14,575 ($13,309 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.

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 2000 will result in outlier payments equal to 5.1 percent of operating DRG payments and 6.0 percent of capital payments based on the Federal rate.

The proposed outlier adjustment factors applied to the standardized amounts for FY 2000 are as follows:

	Operating standardized amounts	Capital Federal rate
National	0.948934	0.9397
Puerto Rico	0.969184	0.9334

We apply the proposed outlier adjustment factors after removing the effects of the FY 1999 outlier adjustment factors on the standardized amounts.

Table 8A in section VI 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 July 31, 1998 final rule (63 FR 41099), effective October 1, 1999. 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 0.212473 greater than 1.280336 and capital cost-to-charge ratios lower than 0.0130310 or greater than 0.17166. 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 2000 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 July 31, 1998 final rule (63 FR 41009), we stated that, based on available data, we estimated that actual FY 1998 outlier payments would be approximately 5.4 percent of actual total DRG payments. This was computed by simulating payments using actual FY 1997 bill data available at the time. That is, the estimate of actual outlier payments did not reflect actual FY 1998 bills but instead reflected the application of FY 1998 rates and policies to available FY 1997 bills. Our current estimate, using available FY 1998 bills, is that actual outlier payments for FY 1998 were approximately 6.5 percent of actual total DRG payments. We note that the MedPAR file for FY 1998 discharges continues to be updated. Thus, the data indicate that, for FY 1998, the percentage of actual outlier payments relative to actual total payments is higher than we projected before FY 1998 (and thus exceeds the percentage by which we reduced the standardized amounts for FY 1998). In fact, the data indicate that the proportion of actual outlier payments for FY 1998 exceeds 6 percent. Nevertheless, consistent with the policy and statutory interpretation we have maintained since the inception of the prospective payment system, we do not plan to recoup money and make retroactive adjustments to outlier payments for FY 1998.

We currently estimate that actual outlier payments for FY 1999 will be approximately 6.2 percent of actual total DRG payments, higher than the 5.1 percent we projected in setting outlier policies for FY 1999. This estimate is based on simulations using the December 1998 update of the provider-specific file and the December 1998 update of the FY 1998 MedPAR file (discharge data for FY 1998 bills). We used these data to calculate an estimate of the actual outlier percentage for FY 1999 by applying FY 1999 rates and policies to available FY 1998 bills.

5. FY 2000 Standardized Amounts

The adjusted standardized amounts are divided into labor and nonlabor portions. Table 1A 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). The labor and nonlabor portions of the national average standardized amounts for Puerto Rico hospitals are set forth in Table 1C. This table also includes the Puerto Rico standardized amounts.

B. Adjustments for Area Wage Levels and Cost of Living

Tables 1A and 1C, 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 requires that we make an adjustment 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 this preamble, we discuss the data and methodology for the proposed wage index. The proposed 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 2000, 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, 1999, we will publish them in the final rule and use them in determining FY 2000 payments.

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

Alaska—All areas	1.25
Hawaii:	
County of Honolulu	1.25
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 VI of this addendum contains the relative weights that we propose to use for discharges occurring in FY 2000. These factors have been recalibrated as explained in section II of the preamble.

D. Calculation of Prospective Payment Rates for FY 2000

General Formula for Calculation of Prospective Payment Rates for FY 2000

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, or, 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, 100 percent of the Federal rate plus 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, 1999 and before October 1, 2000, 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 Table 1A in section VI 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 VI 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 VI 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 2000.* We are proposing to increase the hospital-specific rates by 0.9 percent (the hospital market basket percentage increase of 2.7 percent minus 1.8 percentage points) for sole community hospitals and Medicare-dependent, small rural hospitals located in all areas for FY 2000. 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 2000, is the market basket rate of increase minus 1.8 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 2000, is the market basket rate of increase minus 1.8 percentage points.

b. Calculation of Hospital-Specific Rate. For sole community hospitals and

Medicare-dependent, small rural hospitals, the applicable FY 2000 hospital-specific rate would be calculated by increasing the hospital's hospital-specific rate for the preceding fiscal year by the applicable update factor (0.9 percent), which is the same as the update for all prospective payment hospitals. In addition, the hospital-specific rate would be adjusted by the budget neutrality adjustment factor (that is, 0.997393) 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, 1999, 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, 1999 and Before October 1, 2000.

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 of section VI 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 VI 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 VI 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 of section VI of the addendum) by the appropriate national wage index (see Tables 4A and 4B of section VI 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 VI 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 the Payment Rates for Blood Clotting Factor for Hemophilia Inpatients

As discussed in our August 29, 1997 final rule with comment period (62 FR 46002) and our May 12, 1998 final rule (63 FR 26327), section 4452 of Public Law 105–33 amended section 6011(d) of Public Law 101–239 to reinstate the add-on payment for the costs of administering blood clotting factor to Medicare beneficiaries who have hemophilia and who are hospital inpatients for discharges occurring on or after October 1, 1997.

We are proposing to calculate the add-on payment for FY 2000 using the same methodology we described in the August 29, 1997 and May 12, 1998 final rules. That is, we are proposing to establish a price per unit of clotting factor based on the average wholesale price (AWP). To identify the AWP, we are using the most recent data available from First DataBank, a commercial source of AWPs in electronic format. The add-on payment amount for each clotting factor, as described by HCFA's Common Procedure Coding System (HCPCS), is based on the median AWP of the several products available in that category of factor, discounted by 15 percent.

We also are proposing to add HCPCS code J7191 (clotting factor, porcine) to the list of clotting factors that will be paid under this benefit. This code was recently reestablished in the HCPCS coding system because it represents a unique product that is different from the other clotting factors listed.

Based on the methodology described above, we are proposing the following prices per unit of factor for FY 2000:

J7190 Factor VIII (antihemophilic factor, human)	0.79
J7191 Factor VIII (antihemophilic factor, porcine)	1.87
J7192 Factor VIII (antihemophilic factor, recombinant)	1.03
J7194 Factor IX (complex)	0.45
J7196 Other hemophilia clotting factors (for example, anti-inhibitors)	1.43
Q0160 Factor IX (antihemophilic factor, purified, nonrecombinant)	0.97
Q0161 Factor IX (antihemophilic factor, purified, recombinant)	1.00

These prices for blood clotting factor administered to inpatients who have hemophilia would be effective for discharges beginning on or after October 1, 1999 through September 30, 2000. Payment will be made for blood clotting factor only if there is an ICD–9–CM diagnosis code for hemophilia included on the bill.

IV. Proposed Changes to Payment Rates for Inpatient Capital-Related Costs for FY 2000

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 2000. The rates would be effective for discharges occurring on or after October 1, 1999.

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 that 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 requires that for discharges occurring on or after October 1, 1997, and before October 1, 2002, the unadjusted standard Federal rate is reduced by 17.78 percent. A small part of that reduction will be restored effective October 1, 2002. As a result of the February 25, 1999 final rule (64 FR 9378), the Federal rate changed effective March 1, 1999, because of revisions to the GAF.

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. For discharges occurring on or after October 1, 1997, and before October 1, 2002, the unadjusted hospital-specific rate is reduced by 17.78 percent. A small part of this reduction will 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

In the July 31, 1998 final rule (63 FR 41011) we established a capital Federal rate of $378.05 for FY 1999. As of the March 1, 1999 revision, the Federal rate for FY 1999 is $378.10. As a result of the changes we are proposing to the factors used to establish the Federal rate in this preamble, the proposed FY 2000 Federal rate is $374.31.

In the discussion that follows, we explain the factors that were used to determine the proposed FY 2000 capital Federal rate. In particular, we explain why the proposed FY 2000 Federal rate has decreased 1.00 percent compared to the FY 1999 Federal rate. Even though the proposed FY 2000 Federal capital rate is less than the FY 1999 Federal rate, we estimate aggregate capital payments will increase by 2.66 percent during this same period. This increase is primarily due to the increase in the Federal blend percentage from 80 to 90 percent for fully prospective payment hospitals.

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 2000 compared to FY 1999.

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 2000 under that framework is −0.6 percent. This proposal is based on a projected 0.5 percent increase in the CIPI, a −0.7 percent adjustment for the FY 1998 DRG reclassification and recalibration, and a forecast error correction of −0.4 percent. We explain the basis for the FY 2000 CIPI projection in section II.D of this addendum. Here we describe the policy adjustments that have been applied.

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 1998 DRG reclassification and

recalibration as part of our FY 2000 update recommendation.) We have adopted this case-mix index adjustment in the capital update framework as well.

For FY 2000, we are projecting a 0.5 percent increase in the case-mix index. We estimate that real case-mix increase will equal 0.5 percent in FY 2000. Therefore, the proposed net adjustment for case-mix change in FY 2000 is 0.0 percentage points.

We estimate that FY 1998 DRG reclassification and recalibration resulted in a 0.7 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. Therefore, we are making a −0.7 percent adjustment for DRG reclassification and recalibration in the proposed update for FY 2000.

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 and the forecast used in calculating the update factors. In setting a prospective payment rate under the framework, we make an adjustment for forecast error only if our estimate of the change in the capital input price index 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. A forecast error of −0.4 percentage points was calculated for the FY 1998 update. That is, current historical data indicate that the FY 1998 CIPI used in calculating the forecasted FY 1998 update factor overstated realized price increases by 0.4 percent. Therefore, we are making a −0.4 percent adjustment for forecast error in the proposed update for FY 2000.

Under the capital prospective payment system update 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. Therefore, we have 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 2000, we have developed a Medicare-specific intensity measure based on a 5-year average using FY 1994–1998 data. In determining case-mix constant intensity, we found that observed case-mix increase was 0.8 percent in FY 1994, 1.7 percent in FY 1995, 1.6 percent in FY 1996, 0.3 percent in FY 1997, and −0.4 percent in FY 1998. 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 1994 through FY 1998. Based on this analysis, we believe that all of the observed case-mix increase for FY 1994, FY 1997 and FY 1998 is real. The increases for FY 1995 and FY 1996 were in excess of our estimate of real case mix increase.

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 0.8 percent for FY 1994, 1.0 percent for FY 1995, 1.0 percent for FY 1996, 0.3 percent for FY 1997, and −0.4 for FY 1998, we estimate that case-mix constant intensity declined by an average 1.3 percent during FYs 1994 through 1998, for a cumulative decrease of 6.3 percent. If we assume that real case-mix increase was 0.8 percent for FY 1994, 1.4 percent for FY 1995, 1.4 percent for FY 1996, 0.3 percent for FY 1997, and −0.4 for FY 1998, we estimate that case-mix constant intensity declined by an average 1.5 percent during FYs 1994 through 1998, for a cumulative decrease of 7.1 percent. Since we estimate that intensity has declined during that period, we are recommending a 0.0 percent intensity adjustment for FY 2000.

b. Comparison of HCFA and MedPAC Update Recommendations. MedPAC recommends a −1.1 to 1.8 percent update to the standard capital Federal rate and we are recommending a −0.6 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 that 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 a financing policy 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 0.5 percent, and the percentage change in MedPAC's market basket is 1.9 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. For the FY 2000 update, the Commission is also including a site-of-care substitution adjustment to account for the decline in the average length of Medicare acute inpatient stays. This adjustment is designed to shift funding along with associated costs when Medicare patients are discharged to postacute settings that replace acute impatient days. Other factors, such as technological advances that allow for a decreased need in follow-up care and BBA mandated policy on payment for transfer cases that limits payments within certain DRGs, are reflected in the site-of-care substitution adjustment as well. A negative intensity adjustment would capture the site of care substitution accounted for in MedPAC's update framework. However, we did not make a negative adjustment for intensity this year. We may examine the appropriateness of adopting a negative intensity adjustment at a later date.

MedPAC recommends a −1.8 to a −0.9 adjustment for site-of-care substitutions for FY 2000. For FY 2000, MedPAC recommends a −1.0 to a 0.0 adjustment for productivity. We recommend a 0.0 intensity adjustment. Additionally, since long-term interest rates are low by historical standards, MedPAC recommends a −0.3 to a 0.0 adjustment to the update for FY 2000, to reflect changes in the real interest rates.

We recommend a 0.0 total case mix adjustment since we are projecting a 0.5 percent increase in the case mix index and we estimate that real case-mix increase will equal 0.5 percent in FY 2000. 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 0.0 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 has recommended a −1.1 to 1.8 percent update to the capital Federal rate for FY 2000. MedPAC believes that the annual updates to the capital and operating payments under the prospective payment system should not differ substantially, even though they are determined separately, since they correspond to costs generated by providing the same inpatient hospital services to the same Medicare patients. This range for the capital update is consistent with the prospective payment system operating update range of 0.0 to 2.6 recommended by the Commission. We describe the basis for our proposed −0.6 percent total update in the preceding section. Our recommendation is within the range recommended by MedPAC.

Also, MedPAC argued that the distinction between inpatient operating and capital payment rates is arbitrary and does not foster efficient overall decision making about the allocation of resources. Accordingly, MedPAC recommended that once the transition to fully perspective capital payment is completed, a single PPS payment rate should be developed for hospital inpatient services to Medicare beneficiaries. MedPAC indicated that a single PPS payment rate for both operating and capital PPS costs would be consistent with the way that hospitals purchase a majority of goods and services.

We responded to a similar comment in the July 31, 1998 final rule (63 FR 41013) and in the September 1, 1995 final rule (60 FR 45816). In those rules, we stated that our long-term goal was to develop a single update framework for operating and capital prospective payments and that we would begin development of a unified framework. We indicated that, in the meantime, we would maintain as much consistency as possible between the current operating and capital frameworks in order to facilitate the eventual development of a unified framework. In addition, we stated that because of the similarity of the update frameworks, the update frameworks could be combined without too much difficulty. We maintain our goal of combining the update frameworks at the end of the capital transition period and may examine combining the payment systems after the conclusion of the capital prospective payment transition period.

TABLE 1.—HCFA'S FY 2000 UPDATE FACTOR AND MEDPAC'S RECOMMENDATION

	HCFA's update factor	MedPAC's recommendation
Capital Input Price Index Financing Policy Adjustment	0.5	1.9
Financing Policy Adjustment	.....	−0.3 to 0.0
Policy Adjustment Factors:		
Productivity	.....	−1.0 to 0.0
Intensity	0.0	.....
Science and Technology	.....	0.5 to 1.0
Intensity	.....	(1)
Real within DRG Change	.....	(2)
Site-of-Care Substitution	.....	−1.8 to −0.9
Subtotal	0.0	−2.3 to 0.1
Case-Mix Adjustment Factors:	.....	.....
Projected Case-Mix Change	−0.5	.....
Real Across DRG Change	0.5	.....
Coding Change	.....	0.0
Real within DRG Change	(3)	0.0 to 0.2
Subtotal	0.0	0.0 to 0.2
Effect of FY 1998 Reclassification and Recalibration	0.7	.....
Forecast Error Correction	−0.4	−0.4

TABLE 1.—HCFA'S FY 2000 UPDATE FACTOR AND MEDPAC'S RECOMMENDATION—Continued

	HCFA's update factor	MedPAC's recommendation
Total Update	−0.6	−1.1 to 1.8

[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, 90 percent for cost reporting periods beginning in FY 2000 for hospitals paid under the fully prospective payment 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 July 31, 1998 final rule, we estimated that outlier payments for capital in FY 1999 would equal 6.08 percent of inpatient capital-related payments based on the Federal rate (63 FR 41013). Accordingly, we applied an outlier adjustment factor of 0.9392 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 6.03 percent of inpatient capital-related payments based on the Federal rate in FY 2000. Therefore, we are proposing an outlier adjustment factor of 0.9397 to the Federal rate. Thus, estimated capital outlier payments for FY 2000 represent a lower percentage of total capital standard payments than in FY 1999.

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 2000 is 1.0005 (0.9397/0.9392). The outlier adjustment increases the FY 2000 Federal rate by 0.05 percent compared with the FY 1999 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 1999, we calculated a GAF/DRG budget neutrality factor of 1.0027. In the February 25, 1999 final rule (64 FR 9381), we adopted an incremental GAF/DRG budget neutrality factor of 1.0028 for discharges on or after March 1, 1999. For FY 2000, we are proposing a GAF/DRG budget neutrality factor of 0.9986. 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 1999 to FY 2000 is 0.9986. The proposed cumulative change in the rate due to this adjustment is 1.0015 (the product of the incremental factors for FY 1993, FY 1994, FY 1995, FY 1996, FY 1997, FY 1998, FY 1999, and the proposed incremental factor for FY 2000: $0.9980 \times 1.0053 \times 0.9998 \times 0.9994 \times 0.9987 \times 0.9989 \times 1.0028 \times 0.9986 = 1.0015$).

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 2000 geographic reclassification decisions made by the MGCRB compared to FY 1999 decisions. However, it does not account for changes in payments due to changes in the DSH and IME 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 1999, we estimated that exceptions payments would equal 2.17 percent of aggregate payments based on the Federal rate and the hospital-specific rate. Therefore, we applied an exceptions reduction factor of 0.9783 (1–0.0217) in determining the Federal rate. For this proposed rule, we estimate that exceptions payments for FY 2000 will equal 2.48 percent of aggregate payments based on the Federal rate and the hospital-specific rate. Therefore, we are proposing an exceptions payment reduction factor of 0.9752 to the Federal rate for FY 2000. The proposed

exceptions reduction factor for FY 2000 is 0.32 percent lower than the factor for FY 1999.

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 2000 Federal rate is 0.9752/0.9783, or 0.9968.

5. Standard Capital Federal Rate for FY 2000

For FY 1999 (effective March 1, 1999), the capital Federal rate was $378.10. As a result of changes we are proposing to the factors used to establish the Federal rate, the proposed FY 2000 Federal rate is $374.31. The proposed Federal rate for FY 2000 was calculated as follows:

- The proposed FY 2000 update factor is 0.9940; that is, the proposed update is −0.60 percent.
- The proposed FY 2000 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 0.9986.
- The proposed FY 2000 outlier adjustment factor is 0.9397.
- The proposed FY 2000 exceptions payments adjustment factor is 0.9752.

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 2000 affected the computation of the proposed FY 2000 Federal rate in comparison to the FY 1999 Federal rate. The proposed FY 2000 update factor has the effect of decreasing the Federal rate by 0.60 percent compared to the rate in FY 1999, while the proposed geographic and DRG budget neutrality factor has the effect of decreasing the Federal rate by 0.14 percent. The proposed FY 2000 outlier adjustment factor has the effect of increasing the Federal rate by 0.05 percent compared to FY 1999. The proposed FY 2000 exceptions reduction factor has the effect of decreasing the Federal rate by 0.32 percent compared to the exceptions reduction for FY 1999. The combined effect of all the proposed changes is to decrease the proposed Federal rate by 1.00 percent compared to the Federal rate for FY 1999.

COMPARISON OF FACTORS AND ADJUSTMENTS: FY 1999 FEDERAL RATE AND PROPOSED FY 2000 FEDERAL RATE

	FY 1999	Proposed FY 2000	Change	Percent change
Update factor [1]	1.0010	0.9940	0.9940	−0.60
GAF/DRG Adjustment Factor [1]	1.0028	0.9986	0.9986	−0.14
Outlier Adjustment Factor [2]	0.9392	0.9397	1.0005	0.05
Exceptions Adjustment Factor [2]	0.9783	0.9752	0.9968	−0.32
Federal Rate	$378.10	$374.31	0.9900	−1.00

[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 1999 to FY 2000 resulting from the application of the 0.9986 GAF/DRG budget neutrality factor for FY 2000 is 0.9986.

[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 2000 outlier reduction factor is 0.9397/0.9392, or 1.0005.

6. Special Rate for Puerto Rico Hospitals

As explained at the beginning of section IV of this Addendum, 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 in 1998, we also propose to apply separate budget neutrality adjustments for the national GAF and for the Puerto Rico GAF. We apply the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. The Puerto Rico GAF budget neutrality factor is 1.0015, while the DRG adjustment is 1.0001, for a combined cumulative adjustment of 1.0016.

In computing the payment for a particular Puerto Rico hospital, the Puerto Rico portion of the rate (50 percent) 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 percent) 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 1999, before application of the GAF, the special rate for Puerto Rico hospitals was $181.10. With the changes we are proposing to the factors used to determine the rate, the proposed FY 2000 special rate for Puerto Rico is $174.15.

B. Determination of Hospital-Specific Rate Update

Section 412.328(e) of the regulations provides that the hospital-specific rate for FY 2000 be determined by adjusting the FY 1999 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 2000, we are proposing that the hospital-specific rate be updated by a factor of 0.9940.

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 2000, we estimate that

exceptions payments will be 2.48 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 0.9752. 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 2000 hospital-specific rate is 0.9752/0.9783, or 0.9968.

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 1999 and FY 2000 and the net adjustment for each factor. It also shows that the proposed cumulative net adjustment from FY 1999 to FY 2000 is 0.9908, which represents a proposed decrease of 0.92 percent to the hospital-specific rate. For each hospital, the proposed FY 2000 hospital-specific rate is determined by multiplying the FY 1999 hospital-specific rate by the cumulative net adjustment of 0.9908.

PROPOSED FY 2000 UPDATE AND ADJUSTMENTS TO HOSPITAL-SPECIFIC RATES

	FY 1999	Proposed FY 2000	Net adjustment	Percent change
Update Factor	1.0010	0.9940	0.9940	−0.60
Exceptions Payment Adjustment Factor	0.9783	0.9752	0.9968	−0.32
Cumulative Adjustments	0.9793	0.9703	0.9908	−0.92

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 1999 to FY 2000 is 0.9940. In contrast, the exceptions payment adjustment factor is not applied cumulatively. Thus, for example, the incremental increase in the exceptions reduction factor from FY 1999 to FY 2000 is 0.9752/0.9783, or 0.9968.

C. Calculation of Inpatient Capital-Related Prospective Payments for FY 2000

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 reduction 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) × (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).

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 2000 are 90 percent of the adjusted Federal rate and 10 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 90 percent of the Federal rate for discharges occurring in cost reporting periods beginning during FY 2000. Thus, a fully prospective hospital will receive 90 percent of the capital-related outlier payment calculated for the case for discharges occurring in cost reporting periods beginning in FY 2000. 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 2000 are in section II.A.4.c of this

Addendum. For FY 2000, 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 $14,575.

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 2000 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), June 2, 1997 (62 FR 29953), August 29, 1997 (62 FR 46050), May 8, 1998 (63 FR 25619), and July 31, 1998 (63 FR 41017).

2. Forecast of the CIPI for Federal Fiscal Year 2000

We are forecasting the CIPI to increase 0.5 percent for FY 2000. This reflects a projected 1.6 percent increase in vintage-weighted depreciation prices (building and fixed equipment, and movable equipment) and a 3.2 percent increase in other capital expense prices in FY 2000, partially offset by a 3.2 percent decline in vintage-weighted interest rates in FY 2000. The weighted average of these three factors produces the 0.5 percent increase for the CIPI as a whole.

V. 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 regulations at § 413.40. Under these limits, a hospital-specific 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 hospital unit, rehabilitation hospital or hospital unit, or long-term care hospital, the target amount may not exceed the updated figure for the 75th percentile of target amounts for hospitals and units in the same class (psychiatric, rehabilitation, and long-term care) for cost reporting periods ending during FY 1996. 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-specific target amount is adjusted annually, at the beginning of each hospital's cost reporting period, by an applicable update factor.

Section 1886(b)(3)(B) of the Act, which is implemented in regulations at § 413.40(c)(3)(vii), provides that for cost reporting periods beginning on or after October 1, 1999 and before October 1, 2000, the update factor depends on the hospital's or hospital 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 2000 for hospitals and hospital units excluded from the prospective payment system is 2.6 percent. Therefore, the update to a hospital's target amount for its cost reporting period beginning in FY 2000 would be between 0 and 2.6 percent.

In addition, § 413.40(c)(4)(iii) requires that for cost reporting periods beginning on or after October 1, 1999 and before October 1, 2000, the target amount for each psychiatric hospital or hospital unit, rehabilitation hospital or hospital unit, and long-term care hospital cannot exceed a cap on the target amounts for hospitals in the same class. For cost reporting periods beginning in FY 2000, the proposed caps are $11,076 for psychiatric hospitals and hospital units, $20,071 for rehabilitation hospitals and hospital units, and $39,596 for long-term care hospitals. Regulations at § 413.40(d) specify the formulas for determining bonus and relief payments for excluded hospitals and specify established criteria for an additional bonus payment for continuous improvement. Regulations at § 413.40(f)(2)(ii) specify the payment methodology for new hospitals and hospital units (psychiatric, rehabilitation, and long-term care) effective October 1, 1997.

VI. 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, 3C, 4A, 4B, 4C, 4D, 4E, 4F, 5, 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 3C—Hospital Case Mix Indexes for Discharges Occurring in Federal Fiscal Year 1998 and Hospital Average Hourly Wage for Federal Fiscal Year 2000 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 7A—Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 98 MEDPAR Update 12/98 GROUPER V16.0

Table 7B—Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 98 MEDPAR Update 12/98 GROUPER V17.0

Table 8A—Statewide Average Operating Cost-to-Charge Ratios for Urban and Rural Hospitals (Case Weighted) March 1999

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

Large urban areas		Other areas	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
2,804.51	1,139.95	2,760.12	1,121.90

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

	Large urban areas		Other areas	
	Labor	Nonlabor	Labor	Nonlabor
National	2,780.77	1,130.30	2,780.77	1,130.30
Puerto Rico	1,335.82	537.70	1,314.67	529.19

TABLE 1D.—CAPITAL STANDARD FEDERAL PAYMENT RATE

	Rate
National	374.31
Puerto Rico	174.15