APPENDIX B.—HOSPITALS AS OF JANUARY 1, 2000 THAT MAY QUALIFY AS RURAL WITHIN A GOLDSMITH MODIFICATION AREA—Continued

[Based on 1990 Census Data]

Hospital name	County	State
Sierra View District Hospital	TULARE	CALIFORNIA.
Tulare District Hospital	TULARE	CALIFORNIA.
Lindsay District Hospital	TULARE	CALIFORNIA.
Exeter Memorial Hospital	TULARE	CALIFORNIA.
Estes Park Medical Center	LARIMER	COLORADO.
McKee Medical Center	LARIMER	COLORADO.
Glades General Hospital	PALM BEACH	FLORIDA.
Bartow Memorial Hospital	POLK	FLORIDA.
Heart of Florida Hospital	POLK	FLORIDA.
Polk General Hospital	POLK	FLORIDA.
Lake Wales Medical Center	POLK	FLORIDA.
Susan B. Allen Memorial Hospital	BUTLER	KANSAS.
Millinocket Regional Hospital	PENOBSCOT	MAINE.
Penobscot Valley Hospital	PENOBSCOT	MAINE.
Harrington Memorial Hospital	WORCESTER	MASSACHUSETTS.
Heywood Hospital	WORCESTER	MASSACHUSETTS.
Athol Memorial Hospital	WORCESTER	MASSACHUSETTS.
Clinton Hospital	WORCESTER	MASSACHUSETTS.
First Care Medical Services	POLK	MINNESOTA.
Riverview Healthcare Association	POLK	MINNESOTA.
Ely-Bloomenson Community Hospital	ST. LOUIS	MINNESOTA.
Eveleth Health Services Park	ST. LOUIS	MINNESOTA.
Cook Hospital & Convalescent Center	ST. LOUIS	MINNESOTA.
University Medical Center—Mesabi	ST. LOUIS	MINNESOTA.
Virginia Regional Medical Center	ST. LOUIS	MINNESOTA.
White Community Hospital	ST. LOUIS	MINNESOTA.
Albany Area Hospital & Medical Center	STEARNS	MINNESOTA.
''St Michael's Hospital''	STEARNS	MINNESOTA.
Melrose Hospital & Pine Villa	STEARNS	MINNESOTA.
Paynesville Area Health Care	STEARNS	MINNESOTA.
Nye Regional Medical Center	NYE	NEVADA.
Lake Tahoe Medical Center	WASHOE	NEVADA.
Little Falls Hospital	HERKIMER	NEW YORK.
Northwood Deaconess Healthcare	GRAND FORKS	NORTH DAKOTA.
Fairfax Memorial Hospital	OSAGE	OKLAHOMA.
Pawhuska Hospital	OSAGE	OKLAHOMA.
Ashland Community Hospital	JACKSON	OREGON.
Cottage Grove Hospital	LANE	OREGON.
Peace Harbor Hospital	LANE	OREGON.
Jersey Shore Hospital	LYCOMING	PENNSYLVANIA.
Muncy Valley Hospital	LYCOMING	PENNSYLVANIA.
Angleton-Danbury General Hospital	BRAZORIA	TEXAS.
Brazosport Memorial Hospital	BRAZORIA	TEXAS.
Sweeny Community Hospital	BRAZORIA	TEXAS.
Kane County Hospital	KANE	UTAH.
Prosser Memorial Hospital	BENTON	WASHINGTON.
Providence Toppenish Hospital	YAKIMA	WASHINGTON.
Sunnyside Community Hospital	YAKIMA	WASHINGTON.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 410, 412, 413, and 485

[HCFA–1118–F]

RIN 0938–AK09

Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2001 Rates

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

ACTION: Final rule.

SUMMARY: We are revising the Medicare hospital inpatient prospective payment system for operating costs to: implement applicable statutory requirements, including a number of provisions of the Medicare, Medicaid, and State Children's Health Insurance Program Balanced Budget Refinement Act of 1999 (Pub. L. 106–113); and implement changes arising from our continuing experience with the system. In addition, in the Addendum to this final rule, we describe changes to the amounts and factors used to determine the rates for Medicare hospital inpatient services for

operating costs and capital-related costs. These changes apply to discharges occurring on or after October 1, 2000. We also set forth rate-of-increase limits and make changes to our policy for hospitals and hospital units excluded from the prospective payment systems.

We are making changes to the policies governing payments to hospitals for the direct costs of graduate medical education, sole community hospitals and critical access hospitals.

We are adding a new condition of participation on organ, tissue, and eye procurement for critical access hospitals that parallels the condition of participation that we previously published for all other Medicare-participating hospitals.

Lastly, we are finalizing a January 20, 2000 interim final rule with comment period (65 FR 3136) that sets forth the criteria to be used in calculating the Medicare disproportionate share adjustment in reference to Medicaid expansion waiver patient days under section 1115 of the Social Security Act.

DATES: The provisions of this final rule are effective October 1, 2000. This rule is a major rule as defined in 5 U.S.C. 804(2). Pursuant to 5 U.S.C. 801(a)(1)(A), we are submitting a report to Congress on this rule on August 1, 2000.

FOR FURTHER INFORMATION CONTACT:
Steve Phillips, (410) 786–4531, Operating Prospective Payment, Diagnostic Related Groups, Wage Index, Reclassifications, and Sole Community Hospital Issues
Tzvi Hefter, (410) 786–4487, Capital Prospective Payment, Excluded Hospitals, Graduate Medical Education and Critical Access Hospital Issues

SUPPLEMENTARY INFORMATION:

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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 systems: psychiatric hospitals and units, rehabilitation hospitals and 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 sections 1820 and 1834(g) of the Act, payments are made to critical access hospitals (CAHs) (that is, rural nonprofit hospitals or facilities that meet certain statutory requirements) for inpatient and outpatient services on a reasonable cost basis. Reasonable cost is determined under the provisions of section 1861(v)(i)(A) of the Act and existing regulations under 42 CFR Parts 413 and 415.

Under section 1886(a)(4) of the Act, costs of approved educational activities programs are excluded from the operating costs of inpatient hospital services. Hospitals with approved graduate medical education (GME) programs are paid for the direct costs of GME in accordance with section 1886(h) of the Act; the amount of payment for direct GME costs for a cost reporting period is based on the hospital's number of residents in that period and the hospital's costs per resident in a base year.

The 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 42 CFR Parts 412 and 413, and the GME regulations are located in 42 CFR Part 413.

On November 29, 1999, the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Balanced Budget Refinement Act of 1999, Public Law 106–113, was enacted. Public Law 106–113 made a number of changes to the Act affecting prospective payments to hospitals for inpatient services and payments to excluded hospitals. This final rule implements amendments enacted by Public Law 106–113 relating to FY 2001 payments for GME costs, disproportionate share hospitals (DSHs), sole community hospitals (SCHs), and CAHs. These changes are addressed in sections IV and VI of this preamble.

Other related provisions of Public Law 106–113 that pertain to Medicare hospital inpatient payments with an effective date prior to October 1, 2000, are addressed in an interim final rule with comment period that is published elsewhere in this issue of the **Federal Register**.

Public Law 106–113 also amended section 1886(j) of the Act, which was added by section 4421 of the Balanced Budget Act of 1997 (Public Law 105–33). Section 1886(j) of the Act provides for a fully implemented prospective payment system for inpatient rehabilitation hospitals and rehabilitation units, effective for cost reporting periods beginning on or after October 1, 2002, with payment provisions during a transitional period of October 1, 2000 to October 1, 2002 based on target amounts specified in section 1886(b) of the Act. We are issuing a separate notice of proposed rulemaking to implement the prospective payment system for inpatient rehabilitation hospitals and units.

B. Summary of the Provisions of the May 5, 2000 Proposed Rule

On May 5, 2000, we published a proposed rule in the **Federal Register** (65 FR 26282) that set forth proposed changes to the Medicare hospital inpatient prospective payment system for operating costs for FY 2001. In the proposed rule, we made no policy changes relating to payments for capital-related costs under the hospital inpatient prospective payment system in FY 2001. However, we did propose changes to the amounts and factors used in determining the rates for capital-related costs for FY 2001. The proposed rule also included changes relating to payments for GME costs and payments to excluded hospitals and units, SCHs, and CAHs.

The following is a summary of the major changes we proposed and the issues we addressed in the May 5, 2000 proposed rule:

- We proposed changes to the FY 2001 DRG classifications and relative weights, as required by section 1886(d)(4)(C) of the Act.
- We proposed an update to the FY 2001 hospital wage index, using FY 1997 wage data. We also proposed to implement the second year phaseout of Part A physician teaching-related costs, Part A certified registered nurse anesthetist (CRNA) costs and resident costs from the FY 2001 wage index calculation.
- We discussed the impact of our policy on post acute care transfers and set forth certain proposed changes concerning sole community hospitals (SCHs), rural referral centers (RRCs), the indirect medical education adjustment, the DSH adjustment and collection of data on uncompensated costs for services furnished in hospitals, the Medicare Geographic Classification Review Board (MGCRB) classifications, and payment for the direct costs of GME.
- We discussed FY 2001 as the last year of a 10-year transition established to phase-in the prospective payment system for capital-related costs for inpatient hospital services.
- We discussed a number of proposals concerning excluded hospital and hospital units and CAHs. The proposed changes addressed limits on and adjustments to the proposed target amounts for FY 2001; development of a prospective payment system for inpatient rehabilitation hospitals and units; continuous improvement bonus payments; clarification that the 5-percent threshold used in calculating an excluded hospital's cost per discharge is based only on Medicare inpatients discharged from the hospital-within-a-hospital; an all-inclusive payment rate option for CAHs; and adding a new condition of participation for CAHs relating to organ, tissue, and eye procurement.
- In the Addendum to the proposed rule, we set forth proposed changes to the amounts and factors for determining the FY 2001 prospective payment rates for operating costs and capital-related costs. We also addressed update factors for determining the rate-of-increase limits for cost reporting periods beginning in FY 2001 for hospitals and hospital units excluded from the prospective payment system.
- In Appendix A of the proposed rule, we set forth an analysis of the impact of the proposed changes on affected entities.
- In Appendix B of the proposed rule, we set forth the technical appendix on the proposed FY 2001 capital cost model.
- In Appendix C of the proposed rule, as required by section 1886(e)(3) (B) of the Act, we set forth our report to Congress on our initial estimate of a recommended update factor for FY 2001 for payments to hospitals included in the prospective payment systems, and hospitals excluded from the prospective payment systems.
- In Appendix D of the proposed rule, as required by sections 1886(e)(4) and (e)(5) of the Act, we included our recommendation of the appropriate percentage change for FY 2001 for:

—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; and

—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.

- In the proposed rule, we discussed recommendations by the Medicare Payment Advisory Commission (MedPAC) concerning hospital inpatient payment policies and presented our responses to those recommendations. Under section 1805(b) of the Act, MedPAC is required to submit a report to Congress that reviews and makes recommendations on Medicare payment policies no later than March 1 of each year. This year, MedPAC released a subsequent report in June containing additional recommendations. We respond to those recommendations in section IV.E. of this preamble.

C. Public Comments Received in Response to the Proposed Rule

We received a total of 290 timely items of correspondence containing multiple comments on the proposed rule. Major issues addressed by commenters included the creation of a new DRG for pancreas and kidney transplants, the adequacy of the DRG for heart assist devices, various aspects of the wage index calculation, rebasing of the SCH payment rates, and reclassification of hospitals.

Summaries of the public comments received and our responses to those comments are set forth below under the appropriate section heading.

D. Final Rule for the January 20, 2000 Interim Final Rule

On January 20, 2000, we published in the **Federal Register** an interim final rule with comment period (65 F 3136) to implement a change in the Medicare DSH adjustment calculation policy in reference to section 1115 expansion waiver days. The interim final rule set forth the criteria to use in calculating the Medicare DSH adjustment for hospitals for purposes of payment under the prospective payment system. This final rule finalizes the policy in this interim final rule with comment period. We discuss this policy in detail in Section IV.E.2. of this preamble.

II. Changes to DRG Classifications and Relative Weights

A. Background

Under the prospective payment system, we pay for inpatient hospital services on a rate per discharge basis that varies according to 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. Changes to the DRG classification system and the recalibration of the DRG

weights for discharges occurring on or after October 1, 2000, are discussed below.

B. DRG Reclassification

1. General

Cases are classified into DRGs for payment under the prospective payment system based on the principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay, as well as age, sex, and discharge status of the patient. The diagnosis and procedure information is reported by the hospital using codes from the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD–9–CM). Medicare fiscal intermediaries enter the information into their claims processing systems and subject 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.

After screening through the MCE and any further development of the claims, cases are classified into the appropriate DRG by the Medicare GROUPER software program. 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.

In the July 30, 1999 final rule (64 FR 41500), we discussed a process for considering non-MedPAR data in the recalibration process. In order for the use of particular 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 using the data. Subsequently, a complete database should be submitted no later than December 1 for consideration in conjunction with the next year's proposed rule, and as appropriate, in the recalibration in the final rule following the proposed rule.

Currently, cases are assigned to one of 501 DRGs (including one DRG for a diagnosis that is invalid as a discharge diagnosis and one DRG for ungroupable diagnoses) 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 presently 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, the 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.

We proposed several changes to the DRG classification system for FY 2001 and discussed other issues concerning DRGs. The proposed changes, the public comments we received concerning them, and the final DRG changes are set forth below. Unless otherwise noted, the changes we are implementing will be effective in the revised GROUPER software (Version 18.0) to be implemented for discharges on or after October 1, 2000. (Also unless otherwise specified, our DRG analysis is based on the full (100 percent) FY 1999 MedPAR file (bills received through December 31, 1999 for discharges in FY 1999).

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

In the August 29, 1997 final rule with comment period (62 FR 45974), we noted that, because of the many recent changes in heart surgery, we were considering conducting a comprehensive review of the MDC 5 surgical DRGs. In the July 31, 1998 final rule with comment period (63 FR 40956), we did adopt some changes to the MDC 5 surgical DRGs. Since that time, we have received inquiries on a continuing basis regarding these DRGs. We have continued to review Medicare claims data and, based on our analysis, we proposed several DRG changes in MDC 5 in the May 5, 2000 proposed rule.

a. Heart Transplant (DRG 103). As previously stated, cases are generally assigned to an MDC based on principal diagnosis and subsequently assigned to surgical or medical DRGs included in that MDC. However, cases involving liver, bone marrow, and lung transplants (DRGs 480, 481, and 495, respectively) and the two DRGs for tracheostomies (DRGs 482 and 483) are directly assigned on the basis of procedure codes. Cases assigned to these DRGs before classification to an MDC are referred to as pre-MDC. However, cases involving heart transplants are currently assigned first to MDC 5 and then to DRG 103.

Currently, when a bone marrow transplant and a heart transplant are performed during the same admission, the case is assigned to DRG 481 (Bone Marrow Transplant). Because bone marrow transplant cases are first classified to pre-MDC, while heart transplants are first assigned to MDC 5, the bone marrow transplant assumes precedence in the assignment of the case to a DRG. However, payment for DRG 481 is substantially less than DRG 103. For FY 2000, the relative weight for DRG 103 is 19.5100, while the relative weight for DRG 481 is 8.7285.

To ensure appropriate DRG assignment of these cases, we proposed that the heart transplant DRG, which encompasses combined heart-lung transplantation (ICD–9–CM procedure code 33.6) and heart transplantation (ICD–9–CM procedure code 37.5) be assigned to pre-MDC. In this way, cases involving a bone marrow transplant and a heart transplant would be assigned to DRG 103 (DRG 103 would be reordered higher in the pre-MDC surgical hierarchy, as discussed in section II.B.5. of this preamble).

We received two comments in support of this proposed change and are adopting it as final.

b. Heart Assist Devices. We continue to review data in MDC 5 (Diseases and Disorders of the Circulatory System) to determine if cases are being assigned to the most appropriate DRG based on clinical coherence and similar resource consumption. At the December 1, 1994 ICD–9–CM Coordination and Maintenance Committee meeting, we recommended that new codes be created to capture single and bi-ventricular heart assist systems.

These codes, 37.65 (Implant of an external, pulsatile heart assist system) and 37.66 (Implant of an implantable, pulsatile heart assist system), were adopted for use for discharges occurring on or after October 1, 1995. However, code 37.66 was deemed investigational and was not considered a covered procedure. Effective May 5, 1997, we revised Medicare coverage of heart assist devices to allow coverage of a ventricular assist device (code 37.66) used for support of blood circulation postcardiotomy if certain conditions were met.

Due to some residual misunderstanding regarding this coverage policy, we emphasize that this device was and will continue to be listed as a noncovered procedure in the Medicare Code Editor (MCE), the front-end software product in the GROUPER program that detects and reports errors in the coding of claims data. The reason that this device is listed in the MCE, in spite of the fact that its implantation is covered, is because of the stringent conditions that must be met by hospitals in order to receive payment.

In the August 29, 1997 final rule (62 FR 45973), we moved procedure code 37.66 from DRGs 110 and 111 [1] (Major Cardiovascular Procedures with and without CCs, respectively) to DRG 108 (Other Cardiothoracic Procedures). As stated in the July 31, 1998 final rule (63 FR 40956), we moved procedure code 37.66 to DRGs 104 and 105 (Cardiac Valve and Other Major Cardiothoracic Procedures with and without CCs, respectively) for FY 1999.

In the July 30, 1999 final rule (64 FR 41498), we responded to a comment suggesting that heart assist devices be assigned to DRG 103. For the proposed rule we reviewed the 100 percent FY 1999 MedPAR file containing bills through December 31, 1999, and found that there were a total of 47 implantable heart assist system procedures performed on Medicare beneficiaries. Of these cases, 13 (approximately 28 percent) were assigned to DRG 103 (Heart Transplant) and four (approximately 9 percent) were assigned to DRG 483 (Tracheostomy Except for Face, Mouth and Neck Diagnoses), and, therefore, were paid at significantly higher rates than the remaining 30 cases. All of the procedure code 37.66 cases have extremely high charges, which is consistent with past analysis, and all of these cases are subject to payment as cost outliers.

Our data analysis indicated that the most cases in any one hospital was 5, while 17 hospitals performed only one heart assist system implant each. We reiterate that only heart transplant cases can be properly assigned to the transplant DRG (August 29, 1997 final rule (62 FR 45974)). Since heart assist devices are used across DRGs, many not involving a transplant, we did not propose to assign procedure code 37.66 to DRG 103.

In addition to the review of 37.66, we also looked at procedure codes 37.62 (Implant of other heart assist system), 37.63 (Replacement and repair of heart assist system), and 37.65 (Implant of an external, pulsatile heart assist system). These cases are currently assigned to DRGs 110 and 111 (Major Cardiovascular Procedures). We believe that these procedures are similar both clinically and in terms of resource utilization to procedure code 37.66, which is already assigned to DRGs 104 and 105. Therefore, we proposed to move codes 37.62, 37.63, and 37.65 from DRGs 110 and 111 to DRGs 104 and 105.

Comment: We received four comments on this proposal.

Two comments in favor of our proposal were received from national associations concerned with health care delivery.

Two commenters requested reevaluation of the DRG assignment of mechanical heart assist devices, particularly procedure code 37.66, and suggested that a new DRG be created to classify this technology, or that these cases be assigned to DRG 103 (Heart Transplant). The commenters pointed out that the heart assist implantation procedure is typically performed in the same medical centers by the same surgical teams as the heart transplant procedure.

With respect to our past decision not to assign cases with procedure code 37.66 to DRG 103, one commenter acknowledged our analysis of 1996 MedPAR data showing the costs of these cases to be more similar to DRGs 104 and 105 than DRG 103, but suggested that we look at more recent data. The commenter also questioned our rationale for not assigning these cases to DRG 103 on the basis that heart assist devices are used across DRGs.

One commenter argued that, as all the cases with procedure code 37.66 were qualified as cost outliers, the misplacement of this procedure is evident. This commenter also noted that use of this procedure is likely to increase in the future and suggested that HCFA position itself ahead of the curve by increasing payment now in anticipation of this event. The commenter urged HCFA to examine the option of combining code 37.66 with other clinically similar low-volume procedures, and creating a new DRG that would more appropriately pay these cases. This recommended new DRG could conceivably include codes 37.62, 37.63, and 37.65, as they are similar both clinically and in terms of resource consumption.

Finally, one commenter expressed concern that the uncovered status of procedure code 37.66 in the MCE may be resulting in inappropriate payment denials. The commenter recommended that HCFA review the procedures employed by fiscal intermediaries to override the MCE edits.

Response: We are adopting our proposed change to assign procedure codes 37.62, 37.63, and 37.65 to DRGs 104 and 105.

With respect to the comments regarding procedure code 37.66, we have continually considered the issue of DRG assignment of heart assist devices since this technology was assigned an ICD–9–CM code in 1995, and became a Medicare covered procedure (if specific conditions were met) effective in 1997. As we noted in the proposed rule, these are costly cases that are currently spread across several DRGs. Although the outlier policy is intended to help hospitals offset unusually costly cases, we are concerned when a particular procedure always qualifies as an outlier case.

However, we do not believe it would be appropriate to redefine DRG 103 to include these cases at this time. The presently limited incidence of these cases, with very few cases occurring at any particular hospital over the course of a year, does not warrant disrupting the clinical coherence of DRG 103. The fact that these cases are spread across a number of DRGs indicates they do not represent a clinically cohesive group of patients in terms of their associated diagnoses or other procedures.

We will continue to monitor and evaluate these cases to determine whether a better approach might be

[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.

identified, including the possibility of a new DRG for procedure codes 37.62, 37.63, 37.65, and 37.66. We note that the classification of patients into DRGs is a constantly evolving process. As there are changes in the coding system, data collection, medical technology, or medical practice, all DRG definitions will be reviewed and potentially revised.

Concerning the concept of HCFA positioning itself ''ahead of the curve'' by anticipating increased use of heart assist devices and raising payment accordingly, we are reluctant to attempt to predict future trends in medical practice, especially when such predictions would affect payments across all DRGs as a result of DRG recalibration. We appreciate the industry's continued interest in this system, and look forward to working together to arrive at equitable payments for this and other new technologies.

With respect to the comment concerning fiscal intermediary overrides of MCE edits listing procedure code 37.66 as noncovered, we will instruct our fiscal intermediaries to be aware of this issue. We are concerned that Medicare payment for this procedure be limited to those cases for which coverage is appropriate and that payment is not inappropriately denied.

c. Platelet Inhibitors. Effective October 1, 1998, procedure code 99.20 (Injection or infusion of platelet inhibitor) was created. The use of platelet inhibitors have been shown to significantly decrease the rate of acute vessel closure, as well as the rate of cardiac complications and death.[2] Platelet inhibitors are frequently administered to patients undergoing percutaneous transluminal coronary angioplasty (PTCA). In addition, patients admitted with unstable angina may also benefit from platelet inhibitors.[2] This procedure code is designated as a non-OR procedure that does not affect DRG assignment (platelet inhibitors are administered either through intravenous injection or infusion).

For the past 2 years, a manufacturer of platelet inhibitors has submitted data to support its position that cases involving platelet inhibitor therapy receiving angioplasty should be reclassified from DRG 112 (Percutaneous Cardiovascular Procedures) to DRG 116 (Other Permanent Cardiac Pacemaker Implant or PTCA with Coronary Artery Stent Implant). Using the 100 percent FY 1999 MedPAR file that contains discharges through September 30, 1999, we performed analysis for the proposed rule of the cases for which procedure code 99.20 was reported. There were a total of 37,222 cases spread across 123 DRGs.

The majority of the platelet inhibitor cases, 28,022 (75 percent of all platelet inhibitor cases), are already assigned to DRG 116. The average standardized charges for these cases are approximately $26,683, compared to approximately $25,251 for DRG 116 overall. In DRG 112, there were 4,310 platelet inhibitor cases (12 percent of all platelet inhibitor cases) assigned. The average standardized charge for these cases is approximately $22,786, compared to approximately $20,224 for DRG 112 overall. Although the platelet inhibitor therapy cases that are classified to DRG 112 do have somewhat higher charges than the average case assigned to this DRG (11 percent, or $2,563), we found several procedures in DRG 112 with average standardized charges higher than the platelet inhibitor cases. For example, there were 1,560 cases in which a single vessel PTCA or coronary atherectomy with thrombolytic agent (procedure code 36.02) was performed with an average standardized charge of approximately $25,181, and there were 4,951 cases in which a multiple vessel PTCA or coronary atherectomy was performed, with or without a thrombolytic agent (procedure code 36.05) with an average standardized charge of approximately $23,608.

We also noted that there are several procedures assigned to DRG 112 that have average standardized charges lower than the average charges for all cases in the DRG. For example, average charges for cases with procedure code 37.34 (Catheter ablation of lesion or tissues of heart) were $18,429.

There is always some variation in charges within a DRG. The difference in variations of charges in DRG 112 is within the normal range of charge variations.

Clinical homogeneity within DRGs has always been a fundamental principle considered when assigning codes to appropriate DRGs. Currently, DRG 116 includes cases involving the insertion of a pacemaker as well as the insertion of coronary artery stents with PTCA. On the other hand, cases assigned to DRG 112 involve less invasive operating room and, in some cases, nonoperating room procedures.

The basis for DRG assignment has generally been the diagnosis of the patient or the procedures performed. To the extent the use of a particular technology becomes prevalent in the treatment of a particular type of case, the DRG system is designed to account for any increases or decreases in costs through recalibration. Hospitals frequently benefit from this process while efficiency-enhancing technology is being introduced. We believe that the update factors established in section 1886(b)(3)(B)(i) of the Act, combined with the potential for continuing improvements in hospital productivity, and annual recalibration of the DRG weights, are adequate to finance appropriate care of Medicare patients.

We also discussed in the proposed rule our analysis of cases where platelet inhibitor therapy is targeted on acute coronary syndrome patients without coronary intervention. These cases are assigned to DRG 124 (Circulatory Disorders Except Acute Myocardial Infarction with Cardiac Catheterization and Complex Diagnosis) or DRG 140 (Angina Pectoris). The concern is that both types of cases, those performed in conjunction with coronary intervention and those without, be given an equal focus in this evaluation.

Based on our analysis, we found 410 platelet inhibitor cases (1 percent) assigned to DRG 124. This is a small percentage of cases in comparison to the overall total of 134,759 cases assigned to this DRG. The platelet inhibitor cases had an average standardized charge of approximately $17,378 compared to approximately $14,730 for DRG 124 overall. As we have indicated, there is always some variation in charges within a DRG and this difference is within normal variation.

There were 66 platelet inhibitor cases (0.2 percent) assigned to DRG 140. The average standardized charge for these cases is higher than the overall DRG charge, approximately $8,992 and $5,657, respectively. However, it represents a small percentage of the total (76,913) cases assigned to DRG 140.

In summary, currently 75 percent of cases where code 99.20 is present are assigned to DRG 116. The next most common DRG where these cases are assigned is DRG 112 (12 percent). Cases assigned to DRG 116 generally involve implantation of a pacemaker or artery stent, while cases assigned to DRG 112 involve percutaneous cardiovascular procedures. Our analysis found a $3,897 difference between cases involving platelet inhibitor therapy that were assigned to DRG 116 and cases assigned to DRG 112, indicating a clinical distinction between the cases grouping to the two DRGs. Finally, among platelet

[2] Topol EJ and Serruys PW. ''Frontiers in Interventional Cardiology.'' Circulation.1998; 98: 1802. and Frishman W *et al.* ''Medical therapies for the Prevention of Restenosis after Percutaneous Coronary Interventions.'' Curr Probl Cardology. 1998; 23: 555.

inhibitor therapy cases that are assigned to DRG 112, our analysis found that the average charges are well within the normal variation around the overall average charges within the DRG. Based on these findings, we believe it would be inappropriate to assign all cases where procedure code 99.20 is present to DRG 116. Therefore, we did not propose to change our current policy that specifies that assignment of cases to this code does not affect the DRG assignment.

Comment: We received two comments on this issue. One commenter from a national hospital association supported not assigning code 99.20 to DRG 116. The other commenter argued that the analysis on which our position was based is flawed. This commenter believed that perhaps as many as five times the 37,222 cases we identified with ICD–9–CM procedure code 99.20 actually exist in the data but the procedure was not coded. To remedy this, the commenter suggested two options HCFA could pursue. The first option would be to reexamine the data file with the goal of excluding cases that appear to be miscoded. The commenter suggested that HCFA might check total pharmacy charges in MedPAR and exclude from the analysis cases without ICD–9–CM procedure code 99.20 that have pharmacy charges over a certain threshold (for example, a threshold of $500). The second option would be to use outside data to capture pharmacy information which would provide more reliable information than coding with procedure code 99.20.

The commenter recommended that HCFA make a concerted effort, perhaps through the Medicare fiscal intermediaries, to instruct hospitals to use ICD–9–CM procedure code 99.20 on the claim of any case that receives any of the three platelet inhibitors.

Response: We appreciate the support of the hospital association for our position on this issue.

In response to the comment that the MedPAR data underreport procedure code 99.20 because the data do not affect DRG assignment and payment, we believe it is in hospitals' best interest to submit accurate billing data that are utilized in the DRG reclassification and recalibration of the DRG relative weights process.

We disagree with the recommendation that we exclude from our analysis any bill with over $500 in pharmacy charges that does not report procedure code 99.20. We question the analytical validity of this approach, particularly given that many Medicare beneficiaries have multiple chronic conditions requiring multiple medications. It is simply not possible to determine coding accuracy by reviewing charge data submitted on bills. The only way to identify coding errors would be to review the actual medical records. To exclude cases with pharmacy charges exceeding a certain predetermined threshold would likely skew the results of any such analysis.

We remain open to considering and using non-MedPAR data to make DRG changes if the data are reliable and validated. In the July 31, 1999 final rule (64 FR 41499), we described the timetable and process for interested parties to submit non-MedPAR data.

With respect to the recommendation that we make a concerted effort to ensure that hospitals use procedure code 99.20 appropriately, from the inception of this procedure code, effective October 1, 1998, HCFA has collaborated with the American Hospital Association (AHA) to educate coders on platelet inhibitor therapy. An extensive article in AHA's publication, *Coding Clinic for ICD–9–CM*, Fourth Quarter 1998, identifies the platelet inhibitor drugs and includes instructions on the appropriate code assignment. Coding instructions for platelet inhibitors are also available via the 1998 regulatory updates teleconference sponsored by AHA.

d. Extracorporeal Membrane Oxygenation. Extracorporeal Membrane Oxygenation (ECMO) is a cardiopulmonary bypass technique that offers long-term cardiopulmonary support to patients who have reversible cardiopulmonary insufficiency that has not responded to conventional management. It involves passing a patient's blood through an extracorporeal membrane oxygenator that adds oxygen and removes carbon dioxide. The oxygenated blood then is passed through a heat exchanger to warm it to body temperature prior to returning it to the patient. The process and equipment are similar to those used in open heart surgery, but are continued over prolonged periods of time. ECMO attempts to provide the patient with artificial cardiopulmonary function while his or her own cardiopulmonary functions are incapable of sustaining life.

Since ECMO involves the use of a device that sustains cardiopulmonary function while the underlying condition is being treated, it is important to identify and treat underlying conditions leading to cardiopulmonary failure if the patient is to return to normal cardiopulmonary function.

ECMO is assigned to procedure code 39.65 (Extracorporeal membrane oxygenation (ECMO)). This code is not recognized as an OR procedure within the DRG system and, therefore, does not affect payment. To evaluate the appropriateness of payment under the current DRG assignment, we have reviewed a 10-percent sample of Medicare claims in the FY 1999 MedPAR file and found only 4 cases in which ECMO was used. The charges for these cases ranged from $16,006 to $198,014. Since medical literature indicates that ECMO is predominately used on newborns and pediatric cases, this low number of claims is not surprising. Only in recent years have some hospitals started to use ECMO on adults. It is reserved for cases facing almost certain mortality.

Because ECMO is a procedure clinically similar to a heart assist device, we proposed that procedure code 39.65 be classified as an OR procedure and be classified in DRGs 104 and 105 along with the heart assist system procedures (as discussed in section II.B.2.b. of this preamble). Those cases in which ECMO was provided, but for which the principal diagnosis is not classified to MDC 5, would then be assigned to DRG 468 (Extensive OR Procedure Unrelated to Principal Diagnosis). This would be appropriate since it is possible that secondary conditions or complications may arise during hospitalization that would require the use of ECMO. The relatively high weight of DRG 468 would be appropriate for these cases.

Comment: We received two comments in support of the proposal to classify procedure code 39.65 as an OR procedure and then assign it to DRGs 104 and 105. One of the commenters stated that most of the adult patients receiving ECMO will fall within MDC 5 since ECMO is used for patients with severe, but reversible, heart or lung disorders that have not responded to the usual treatments of mechanical ventilation, medicines, and extra oxygen. The commenter further stated that these severely ill patients may continue on ECMO for a period of days or weeks until the heart or lungs recover, or until the treatment is no longer effective.

Response: We acknowledge the support of the commenters to classify 39.65 as an OR procedure and then assign it to DRGs 104 and 105 and are adopting our proposal as final.

3. MDC 15 (Newborns and Other Neonates With Conditions Originating in the Perinatal Period)

a. V05.8 (Vaccination for disease, NEC). DRG 390 (Neonate with Other Significant Problems) contains newborn or neonate cases with other significant

problems, not assigned to DRGs 385 through 389, DRG 391, or DRG 469. In order to be classified into DRG 391 (Normal Newborn), the neonate must have a principal diagnosis as listed under DRG 391 and either no secondary diagnosis or a secondary diagnosis as listed under DRG 391. Neonates with a secondary diagnosis of V05.8 (Vaccination for disease, NEC) are currently classified to DRG 390. Although it would seem that healthy newborns who receive vaccinations and have no other problems would be assigned to DRG 391, code V05.8 is not included as one of the secondary diagnoses under DRG 391, and therefore the case would not be classified as a normal newborn (DRG 391). Code V05.8 is assigned to DRG 390 as a default, since it is not included under another complicated neonate DRG or the normal newborn DRG.

In the proposed rule, we discussed our review of the appropriateness of including diagnosis code V05.8 on the list of acceptable secondary diagnoses under DRG 390 based on inquires that we had received. We pointed out that by including V05.8 on the acceptable secondary diagnosis list for DRG 390, newborns who receive vaccinations are classified as having significant health problems. The inquirers believed this incorrectly labels an otherwise healthy newborn as having a significant medical condition. Providing a vaccination to a newborn is performed to prevent the infant from contracting a disease.

We agreed with the inquirers that, absent any evidence of disease, a newborn should not be considered as having a significant problem simply because a preventative vaccination was provided. Therefore, we proposed that V05.8 be removed from the list of acceptable secondary diagnoses under DRG 390 and assigned as a secondary diagnosis under DRG 391. In doing so, these cases would no longer be classified to DRG 390.

Comment: We received two comments in support of our proposal to remove code V05.8 from the list of acceptable secondary diagnoses under DRG 390. These commenters agreed that a prophylactic vaccination should not be classified as a significant problem. Newborns who receive these prophylactic vaccinations should still be considered normal newborns. We received no comments in opposition to the proposal.

Response: We are adopting the proposal to include V05.8 on the list of acceptable secondary diagnoses under DRG 391 Normal Newborn. Codes V05.3 (Viral hepatitis vaccination) and V05.4 (Varicella vaccination) are already listed as acceptable secondary diagnoses under DRG 391.

b. Diagnosis code 666.02 (Third-stage postpartum hemorrhage, delivered with postpartum complication). Diagnosis code 666.02 is assigned to DRG 373 (Vaginal Delivery without Complicating Diagnoses). This DRG was created for uncomplicated vaginal deliveries. However, code 666.22 (Delayed and secondary postpartum hemorrhage, delivered with postpartum complication) is assigned to DRG 372 (Vaginal Delivery with Complicating Diagnoses). This means that mothers who have a delayed and secondary postpartum hemorrhage would be assigned to DRG 372, while mothers who have a third-stage postpartum hemorrhage would not be considered as a complicated delivery.

We believe a third-stage postpartum hemorrhage should be considered a complicating diagnosis and, in order to categorize these cases more appropriately, we proposed to move diagnosis code 666.02 from DRG 373 and assign it as a complicating diagnosis under DRG 372.

Comment: We received two comments supporting the proposal to classify 666.02 as a complicating diagnosis under DRG 372. The commenters agreed that a third-stage postpartum hemorrhage should be classified as a complicated delivery. There were no comments submitted in opposition to this change.

Response: We are adopting as final our proposal to classify 666.02 as a complication diagnosis under DRG 372.

c. Diagnosis Code 759.89 (Specified congenital anomalies, NEC) (Alport's Syndrome). Alport's Syndrome (also referred to as hereditary nephritis) is an inherited disorder involving damage to the kidney, blood in the urine, and, in some cases, loss of hearing. It may also include loss of vision. Patients who are not treated early enough or who do not respond to treatment may progress to renal failure. A kidney transplant is one treatment option for these cases. As with many of the congenital anomalies, there is no unique ICD–9–CM code for this condition. Alport's Syndrome, along with many other rare and diverse congenital anomalies, is assigned to the rather nonspecific diagnosis code 759.89 (Specific congenital anomalies, NEC). Examples include William Syndrome, Brachio-Oto-Renal Syndrome, and Costello's Syndrome. Each of these is a unique hereditary disorder affecting a variety of body systems.

Patients can be diagnosed and treated for congenital anomalies throughout their lives; treatment is not restricted to the neonatal period. In our GROUPER, however, each diagnosis code is assigned to just one MDC. In this case, diagnosis code 759.89 is assigned to MDC 15 (Newborns and Other Neonates with Conditions Originating in the Perinatal Period) although the patient may be an adult.

In the proposed rule, we referred to a request from a physician concerning renal transplants for patients with Alport's Syndrome. The physician pointed out that when a patient with Alport's Syndrome is admitted for a kidney transplant, the case is assigned to DRG 390 (Neonate with Other Significant Problems). In these instances, when the principal diagnosis is code 759.89, the case is classified to MDC 15 although the patient may no longer be a newborn. The physician believed that these cases should be assigned to DRG 302 (Kidney Transplant).

The inquirer suggested moving diagnosis code 759.89 to MDC 11 (Diseases and Disorders of the Kidney and Urinary Tract) so that when a kidney transplant is performed, it will be assigned to DRG 302. Although this seems quite appropriate for patients with Alport's Syndrome found in diagnosis code 759.89, it does not work well for the wide variety of patients also described by this code. Many others would be inappropriately classified to MDC 11.

Alport's Syndrome cases with code 759.89 as a principal diagnosis who receive a kidney transplant are assigned to DRG 468 (Extensive OR Procedure Unrelated to Principal Diagnosis). This DRG has a FY 2000 relative weight of 3.6400. Also for FY 2000, DRG 302 (Kidney Transplant) has a relative weight of 3.5669. Therefore, the payment amounts are in fact comparable.

We discussed several options for resolving this issue:

(1) If the case is assigned a principal diagnosis code of renal failure with Alport's Syndrome as a secondary diagnosis, the case could be assigned to DRG 302. As this option would represent a change in the sequencing of congenital anomaly codes and related complications, it would have to be evaluated and subsequently approved by the Editorial Advisory Board for *Coding Clinic for ICD–9–CM.* The Editorial Advisory Board is comprised of representatives from the physician, coding, and hospital industry. Final decisions on coding policy issues are made by the representatives from the AHA, the American Health Information Management Association, the National Center for Health Statistics, and HCFA.

(2) A unique ICD–9–CM diagnosis code could be created for Alport's Syndrome that could then be evaluated for possible assignment within MDC 11. This issue has been referred to the National Center for Health Statistics for consideration as a future coding modification.

One difficulty with this option is the large number of congenital anomalies and the limited number of unused codes in this section of ICD–9–CM. Each new code must be carefully evaluated for appropriateness.

(3) A third option, which was already addressed, involves moving diagnosis code 759.89 to MDC 11. The problem with this approach is that many cases would then be misassigned to MDC 11 because the congenital anomaly would not involve diseases of the kidney and urinary tract.

(4) A fourth option would be to leave the coding and DRG assignment as they currently exist. Since few cases exist, the overall impact may be minimal.

To evaluate the impact of leaving the DRG assignment as it currently exists, in the proposed rule we examined data from a 10-percent sample of Medicare cases in the FY 1999 MedPAR file. There were 95 cases assigned to a wide range of DRGs with code 759.89 as a secondary diagnosis. There was only one case assigned to MDC 15 with a principal diagnosis of code 759.89.

In the proposed rule, we recommended that diagnosis code 759.89 remain in MDC 15, since it encompasses such a wide variety of conditions.

Comment: We received two comments in support of modifying the coding advice for this particular congenital anomaly so that renal failure is reported as the principal diagnosis and Alport's Syndrome is reported as a secondary diagnosis. One commenter pointed out that a distinction exists between those manifestations that are integral to the congenital anomaly (and thus, according to the official coding guidelines, would not be coded at all) and those that are not considered integral. This commenter also supported the recommendation for a change in guidelines that would allow sequencing a manifestation that is not integral to the congenital anomaly as the principal diagnosis. The other commenter indicated that while renal disease is usually present in Alport's Syndrome, it does not always lead to renal failure. The commenter also supported the reporting of renal failure as the principal diagnosis, with Alport's Syndrome as a secondary diagnosis.

Response: The coding and sequencing of Alport's Syndrome patients with renal failure who are admitted for renal transplant were addressed at the June 2000 meeting of the Editorial Advisory Board of Coding Clinic for ICD–9–CM. *Coding Clinic for ICD–9–CM* is a publication of the AHA. The issue specifically addressed was whether the code used for Alport's Syndrome or the code for renal failure should be sequenced first when the patient is admitted for a renal transplant for the renal failure. In cases where manifestations are a key aspect of the congenital anomaly, the congenital anomaly code is usually sequenced first.

After careful evaluation, the Board determined that, in this specific case, the code for renal failure would be sequenced first, followed by the code for Alport's Syndrome. The Board also determined that renal failure is not always present for patients with Alport's Syndrome. These patients may, in fact, develop renal failure as a result of other factors. Therefore, hospitals do not have to sequence the congenital anomaly code first. By reporting renal failure as the principal diagnosis, the case is appropriately assigned to DRG 302. The Board's advice will be published in the third quarter 2000 issue of *Coding Clinic for ICD–9–CM* and will be effective for discharges occurring on or after September 1, 2000.

4. MDC 17 (Myeloproliferative Diseases and Disorders and Poorly Differentiated Neoplasm)

Diagnosis code 273.8 (Disorders of plasma protein metabolism, NEC) is assigned to DRG 403 (Lymphoma and Nonacute Leukemia with CC) and DRG 404 (Lymphoma and Nonacute Leukemia without CC). A disorder of plasma protein metabolism does not mean one has a lymphoma with nonacute leukemia. An individual can have a disorder of plasma protein metabolism without having a lymphoma or leukemia.

In the proposed rule, we considered the appropriateness of including diagnosis code 273.8 in DRGs 403 and 404. Disorders of plasma protein metabolism are not lymphomas or leukemia, thus diagnosis code 273.8 is more closely related to DRG 413 (Other Myeloproliferative Disorders or Poorly Differentiated Neoplasm Diagnoses with CC) and DRG 414 (Other Myeloproliferative Disorders or Poorly Differentiated Neoplasm Diagnoses without CC).

We also examined charge data drawn from cases assigned to diagnosis code 273.8 in a 10-percent sample of Medicare cases in the FY 1999 MedPAR file and found that the average charges for these cases were also more closely related to DRGs 413 and 414 than to DRGs 403 and 404. We proposed to move diagnosis code 273.8 from DRGs 403 and 404 to DRGs 413 and 414.

We also noted that diagnosis code 273.8 is included in the following surgical DRGs that are performed on patients with lymphoma or leukemia:

- DRG 400 (Lymphoma and Leukemia with Major OR Procedure)
- DRG 401 (Lymphoma and Nonacute Leukemia with Other OR Procedure with CC)
- DRG 402 (Lymphoma and Nonacute Leukemia with Other OR Procedure without CC)

The same clinical issue would apply to these surgical DRGS performed on patients with lymphoma and leukemia. Code 273.8 should be assigned to the surgical DRGs for myeloproliferative disorders since the cases are clinically similar and, as stated before, code 273.8 is not clinically similar to lymphomas and leukemias. Therefore, we proposed to remove code 273.8 from the surgical DRGs related to lymphoma and leukemia (DRGS 400, 401, and 402) and assigned to the following myeloproliferative surgical DRGS, based on the procedure performed:

- DRG 406 (Myeloproliferative Disorders or Poorly Differentiated Neoplasms with Major OR Procedures with CC)
- DRG 407 (Myeloproliferative Disorders Or Poorly Differentiated Neoplasms with Major OR Procedures without CC)
- DRG 408 (Myeloproliferative Disorders or Poorly Differentiated Neoplasms with Other OR Procedures)

Comment: We received two comments supporting our proposal to remove code 273.8 from the DRGs for lymphomas and leukemia (medical DRGs 403 and 404 as well as surgical DRGs 400 through 402). They supported moving 273.8 to the DRGs for other myeloproliferative disorders (medical DRGs 413 and 414 as well as surgical DRGs 406 through 408). One commenter also pointed out that code 273.9 (Unspecified disorder of plasma protein metabolism) is clinically similar to 273.8 and is also included with the DRGs for lymphomas and leukemia. The commenter asked if HCFA also planned to move 273.9 in a similar fashion to that proposed for code 273.8 since they appear to be companion codes. The commenter asserted that it was inappropriate to keep 273.9 in the DRGS for lymphoma and leukemia.

Response: We agree that code 273.8 should be moved out of the DRGs for lymphoma and leukemia and into the DRGs for other myeloproliferative disorders. Also, we agree with the commenter who stated that code 273.9

is clinically similar to 273.8 and should be treated in the same manner. Each code would be more appropriately assigned to the DRGS for other myeloproliferative disorders. Therefore, we are removing 273.9 from medical DRGS 403 and 404 and assigning it to DRGS 413 and 414. We are adopting as final our proposal to remove 273.8 from medical DRGs 403 and 404 and assign it to medical DRGs 413 and 414. We are also removing 273.8 and 273.9 from surgical DRGs 400, 401, and 402 and assigning them to surgical DRGs 406, 407, and 408.

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. Therefore, it is 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 11, the surgical class ''kidney transplant'' consists of a single DRG (DRG 302) and the class ''kidney, ureter and major bladder procedures'' consists of three DRGs (DRGs 303, 304, and 305). 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 proposed to modify the surgical hierarchy as set forth below. As we stated in the September 1, 1989 final rule (54 FR 36457), we were unable to test the effects of proposed revisions to the surgical hierarchy and to reflect these changes in the proposed relative weights because the revised GROUPER software was unavailable at the time the proposed rule was completed. Rather, we simulated most major classification changes to approximate the placement of cases under the proposed reclassification, then determined the average charge for each DRG. These average charges then served as our best estimate of relative resource use for each surgical class.

We proposed to revise the surgical hierarchy for the pre-MDC DRGs, MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue), and MDC 10 (Endocrine, Nutritional, and Metabolic Diseases and Disorders) as follows:

- In the pre-MDC DRGs, we proposed to move DRG 103 (Heart Transplant) from MDC 5 to pre-MDC. We proposed to reorder DRG 103 (Heart Transplant) above DRG 483 (Tracheostomy Except for Face, Mouth, and Neck Diagnoses).
- In the pre-MDC DRGs, we proposed to reorder DRG 481 (Bone Marrow Transplant) above DRG 495 (Lung Transplant).
- In MDC 8, we proposed to reorder DRG 230 (Local Excision and Removal of Internal Fixation Devices of Hip and Femur) above DRGs 226 and 227 (Soft Tissue Procedures).
- In MDC 10, we proposed to reorder DRG 288 (OR Procedures for Obesity) above DRG 285 (Amputation of Lower Limb for Endocrine, Nutritional, and Metabolic Disorders).

Comment: One commenter supported the surgical hierarchy proposals. Another commenter opposed the reordering of DRG 230 above DRGs 226 and 227 in MDC 8. The commenter stated that, if both procedures are performed during the same operative episode, reordering DRGs 226 and 227 above DRG 230 would more appropriately capture facility resources.

Response: Although local excision and removal of internal fixation devices of hip and femur procedures may be less resource intensive than many of the surgical procedures in DRGs 226 and 227, we proposed the surgical hierarchy change because our data indicated cases of local excision and removal of internal fixation devices of hip and femur are more resource intensive than cases in DRGs 226 and 227. At the time of our proposed surgical hierarchy change, the average standardized charges for cases in DRG 230 were approximately $1,000 more than the average standardized charges for cases in DRGs 226 and 227. We are adopting the proposed surgical hierarchy change as final so that cases with multiple procedures will be assigned to the higher-weighted DRG. We will continue to monitor the MDC 8 surgical hierarchy as part of our ongoing review.

Based on a test of the proposed revisions using the most recent MedPAR file and the final GROUPER software, we have found that all the proposed

revisions are still supported by the data and no additional changes are indicated. Therefore, we are adopting these changes in this final rule.

6. Refinement of Complications and Comorbidities (CC) List

In the September 1, 1987 final notice (52 FR 33143) concerning changes to the DRG classification system, 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 for the following reasons: (1) To preclude coding of CCs for closely related conditions; (2) to preclude duplicative coding or inconsistent coding from being treated as CCs; and (3) to ensure that cases are appropriately classified between the complicated and uncomplicated DRGs in a pair. We developed this standard list of diagnoses 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. In the May 5, 2000 proposed rule, we proposed no deletions of the diagnosis codes on the CC list.

In the May 19, 1987 proposed notice (52 FR 18877) concerning changes to the DRG classification system, 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 coexist, 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 only as 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 (53 FR 38485) for the revision made for the discharges occurring in FY 1989; the September 1, 1989 final rule (54 FR 36552) for the FY 1990 revision; the September 4, 1990 final rule (55 FR 36126) for the FY 1991 revision; the August 30, 1991 final rule (56 FR 43209) for the FY 1992 revision; the September 1, 1992 final rule (57 FR 39753) for the FY 1993 revision; the September 1, 1993 final rule (58 FR 46278) for the FY 1994 revisions; the September 1, 1994 final rule (59 FR 45334) for the FY 1995 revisions; the September 1, 1995 final rule (60 FR 45782) for the FY 1996 revisions; the August 30, 1996 final rule (61 FR 46171) for the FY 1997 revisions; the August 29, 1997 final rule (62 FR 45966) for the FY 1998 revisions; and the July 31, 1998 final rule (63 FR 40954) for the FY 1999 revisions. In the July 30, 1999 final rule (64 FR 41490), no modifications were made to the CC Exclusions List for FY 2000 because we made no changes to the ICD–9–CM codes for FY 2000.

In this final rule, we are making limited revisions of the CC Exclusions List to take into account the changes that will be made in the ICD–9–CM diagnosis coding system effective October 1, 2000. (See section II.B.8. below, for a discussion of ICD–9-CM changes.) These changes are being made in accordance with the principles established when we created the CC Exclusions List in 1987.

Tables 6F and 6G in section V. of the Addendum to this final rule contain the revised CC Exclusions List that is effective for discharges occurring on or after October 1, 2000. Each table shows the principal diagnoses along with changes to the excluded CCs. Each of these principal diagnoses is shown with an asterisk and the additions or deletions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.

CCs that were added to the list appear in Table 6F—Additions to the CC Exclusions List. Beginning with discharges on or after October 1, 2000, the indented diagnoses will not be recognized by the GROUPER as valid CCs for the asterisked principal diagnosis.

CCs that were deleted from the list are in Table 6G—Deletions from the CC Exclusions List. Beginning with discharges on or after October 1, 2000, the indented diagnoses will be recognized by the GROUPER as valid CCs for the asterisked principal diagnosis.

Copies of the original CC Exclusions List applicable to FY 1988 can be obtained from the National Technical Information Service (NTIS) of the Department of Commerce. It is available in hard copy for $92.00 plus $6.00 shipping and handling and on microfiche for $20.50, plus $4.00 for shipping and handling. A request for the FY 1988 CC Exclusions List (which should include the identification accession number (PB) 88–133970) should be made to the following address: National Technical Information Service, United States Department of Commerce, 5285 Port Royal Road, Springfield, Virginia 22161; or by calling (703) 487–4650.

Users should be aware of the fact that all revisions to the CC Exclusions List (FYs 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, and those in Tables 6F and 6G of this document) must be incorporated into the list purchased from NTIS in order to obtain the CC Exclusions List applicable for discharges occurring on or after October 1, 2000. (Note: There was no CC Exclusions List in FY 2000 because we did not make changes to the ICD–9–CM codes for FY 2000.)

Alternatively, the complete documentation of the GROUPER logic, including the current CC Exclusions List, is available from 3M/Health Information Systems (HIS), which, under contract with HCFA, is responsible for updating and maintaining the GROUPER program. The current DRG Definitions Manual, Version 17.0, is available for $225.00, which includes $15.00 for shipping and handling. Version 18.0 of this manual, which includes the final FY 2001 DRG changes, will be available in October 2000 for $225.00. These manuals may be obtained by writing 3M/HIS at the following address: 100 Barnes Road, Wallingford, Connecticut 06492; or by calling (203) 949–0303. Please specify the revision or revisions requested.

We received no comments on the CC Exclusions List in the proposed rule.

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) 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
60.94 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 (55 FR 36135), August 30, 1991 (56 FR 43212), September 1, 1992 (57 FR 23625), September 1, 1993 (58 FR 46279), September 1, 1994 (59 FR 45336), September 1, 1995 (60 FR 45783), August 30, 1996 (61 FR 46173), and August 29, 1997 (62 FR 45981), we moved several other procedures from DRG 468 to 477, and some procedures from DRG 477 to 468. No procedures were moved in FY 1999, as noted in the July 31, 1998 final rule (63 FR 40962), or in FY 2000, as noted in the July 30, 1999 final rule (64 FR 41496).

a. Moving Procedure Codes from DRGs 468 or 477 to MDCs. We annually conduct a review of procedures producing assignment to DRG 468 or DRG 477 on the basis of volume, by procedure, to determine the appropriateness of moving procedure codes out of these DRGs into one of the surgical DRGs for the MDC into which the principal diagnosis falls. The data are arrayed two ways for comparison purposes. We look at a frequency count of each major operative procedure code. We also compare procedures across MDCs by volume of procedure codes within each MDC. That is, using procedure code 57.49 (Other transurethral excision or destruction of lesion or tissue of bladder) as an example, we determined that this particular code accounted for the highest number of major operative procedures (162 cases, or 9.8 percent of all cases) reported in the sample of DRG 477. In addition, we determined that procedure code 57.49 appeared in MDC 4 (Diseases and Disorders of the Respiratory System) 28 times as well as in 9 other MDCs.

Using a 10-percent sample of the FY 1999 MedPAR file, we determined that the quantity of cases in DRG 477 totaled 1,650. There were 106 instances where the major operative procedure appeared only once (6.4 percent of the time), resulting in assignment to DRG 477.

Using the same 10-percent sample of the FY 1999 MedPAR file, we reviewed DRG 468. There were a total of 3,858 cases, with one major operative code causing the DRG assignment 311 times (or 8 percent) and 230 instances where the major operative procedure appeared only once (or 6 percent of the time).

Our medical consultants then identified those procedures occurring in conjunction with certain principal diagnoses with sufficient frequency to justify adding them to one of the surgical DRGs for the MDC in which the diagnosis falls. Based on this year's review, we did not identify any necessary changes in procedures under either DRG 468 or 477 and, therefore, did not propose to move any procedures from either DRG 468 or DRG 477 to one of the surgical DRGs. We received no comments on our review results and, therefore, we will not move any procedures from these DRGs for FY 2001.

b. Reassignment of Procedures Among DRGs 468, 476, and 477. We also conduct an annual review of a list of ICD–9–CM procedures that, when in combination with their principal diagnosis code, result in assignment to DRGs 468, 476, and 477, to ascertain if any of those procedures should be moved from one of these DRGs to another of these DRGs based on average charges and length of stay. We analyze the data for trends such as shifts in treatment practice or reporting practice that would make the resulting DRG assignment inappropriate. If our medical consultants were to find these shifts, we would propose moving cases to keep the DRGs clinically similar or to provide payment for the cases in a similar manner. Generally, we move only those procedures for which we have an adequate number of discharges to analyze the data. Based on this year's review, we proposed not 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. We received no comments on this proposal, and therefore are not moving any procedures from the DRGs indicated.

c. Adding Diagnosis Codes to MDCs. It has been brought to our attention that an ICD–9–CM diagnosis code should be added to DRG 482 (Tracheostomy for Face, Mouth and Neck Diagnoses) to preserve clinical coherence and homogeneity of the system. In the case of a patient who has a facial infection (diagnosis code 682.0 (Other cellulitis and abscess, Face)), the face may become extremely swollen and the patient's ability to breathe might be impaired. It might be deemed medically necessary to perform a temporary tracheostomy (procedure code 31.1) on the patient until the swelling subsides enough for the patient to once again breathe on his or her own.

The combination of diagnosis code 682.0 and procedure code 31.1 resulted in assignment to DRG 483 (Tracheostomy Except for Face, Mouth and Neck Diagnoses). The absence of diagnosis code 682.0 in DRG 483 forces the GROUPER algorithm to assign the case based solely on the procedure code, without taking this diagnosis into account. Clearly this was not the intent, as diagnosis code 682.0 should be included with other face, mouth and neck diagnosis. We believe that cases such as these would appropriately be assigned to DRG 482. Therefore, we proposed to add diagnosis code 682.0 to the list of other face, mouth and neck diagnoses already in the principal diagnosis list in DRG 482.

We received one comment in support of the proposed change, and are adopting as final the proposal to add diagnosis code 682.0 to DRG 482.

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, charged with maintaining and updating the ICD–9–CM system. The Committee is jointly responsible for 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 AHA), and various physician specialty groups as well as physicians, medical record administrators, health information management professionals, and other members of the public to contribute ideas on coding matters. After considering the opinions expressed at the public meetings and in writing, the Committee formulates recommendations, which then must be approved by the agencies.

The Committee presented proposals for coding changes for FY 2000 at public meetings held on June 4, 1998 and November 2, 1998. Even though the Committee conducted public meetings and considered approval of coding changes for FY 2000 implementation, we did not implement any changes to ICD–9–CM codes for FY 2000 because of our major efforts to ensure that all of the Medicare computer systems were compliant with the year 2000. Therefore, the code proposals presented at the public meetings held on June 4, 1998 and November 2, 1998, that (if approved) ordinarily would have been included as new codes for October 1, 1999, were held for consideration for inclusion in the annual update for FY 2001.

The Committee also presented proposals for coding changes for implementation in FY 2001 at public meetings held on May 13, 1999 and November 12, 1999, and finalized the coding changes after consideration of comments received at the meetings and in writing by January 7, 2000.

Copies of the Coordination and Maintenance Committee minutes of the 1999 meetings can be obtained from the HCFA Home Page by typing http://www.hcfa.gov/medicare/icd9cm.htm. Paper copies of these minutes are no longer available and the mailing list has been discontinued.

The ICD–9–CM code changes that have been approved will become effective October 1, 2000. The new ICD–9–CM codes are listed, along with their DRG classifications, in Tables 6A and 6B (New Diagnosis Codes and New Procedure Codes, respectively) in section VI. of the Addendum to this final rule. As we stated above, the code numbers and their titles were presented for public comment at the ICD–9–CM Coordination and Maintenance Committee meetings. Both oral and written comments were considered before the codes were approved. In the May 5, 2000 proposed rule, we solicited comments only on the proposed DRG classification of these new codes.

Further, the Committee has approved the expansion of certain ICD–9–CM codes to require an additional digit for valid code assignment. Diagnosis codes that have been replaced by expanded codes or other codes, or have been deleted are in Table 6C (Invalid Diagnosis Codes). These invalid diagnosis codes will not be recognized by the GROUPER beginning with discharges occurring on or after October 1, 2000. For codes that have been replaced by new or expanded codes, the corresponding new or expanded diagnosis codes are included in Table 6A (New Diagnosis Codes). No procedure codes were replaced by expanded codes or other codes, and no procedure codes were deleted. Revisions to diagnosis code titles appear in Table 6D (Revised Diagnosis Code Titles), which also includes the DRG assignments for these revised codes. Revisions to procedure code titles appear in Table 6E (Revised Procedure Codes Titles).

Comment: One commenter questioned the DRG assignments in Table 6A for new ICD–9–CM codes V45.74, V45.76, V45.77, V45.78 and V45.79. The commenter pointed out that it has been HCFA's longstanding practice to assign a new code to the same DRG or DRGs as its predecessor code. The commenter had seen a draft conversion table prepared by the NCHS for codes being revised October 1, 2000, and indicated that the conversion table did not support the DRG assignments for these specific codes.

Response: The commenter is correct. HCFA bases DRG assignments on the DRG assignment of the predecessor code. Tables 6A through 6E in the proposed rule were prepared prior to NCHS' completion of the conversion table. The DRG assignments were based on a mapping of codes V45.74, V45.76, V45.77, and V45.78 from code V45.89. However, the correct mapping on the conversion table now shows the following predecessor codes:

New Code	Previous Code	Previous DRG
V45.74	593.89	331, 332, 333
	596.8	331, 332, 333
V45.76	518.89	101, 102
V45.77	602.8	352
	607.89	352
	608.89	352
	620.8	358, 359, 369
	621.8	358, 359, 369
	622.8	358, 359, 369
V45.78	360.89	46, 47, 48
V45.79	255.8	300, 301
	289.59	398, 399
	388.8	73, 74
	569.49	188, 189, 190
	577.8	204

New Code	Previous Code	Previous DRG
	V45.89	467

We have modified the DRG assignments for V45.74, V45.76, V45.77, and V45.78 in Table 6A of this final rule according to the mapping indicated in the third column in the preceding table. However, V45.79 has a number of predecessor codes appearing in multiple MDCs and, thus, would not relate to any specific MDC. After discussions with NCHS, we determined that this code should continue to use V45.89 as its predecessor code for purposes of DRG assignment, since it is not restricted to a specific body system. Therefore, the DRG assignment for V45.79 was not changed in Table 6A.

9. Other Issues

a. *Immunotherapy.* Effective October 1, 1994, procedure code 99.28 (Injection or infusion of biologic response modifier (BRM) as an antineoplastic agent) was created and designated as a non-OR procedure that does not affect DRG assignment. This cancer treatment involving biological response modifiers is also known as BRM therapy or immunotherapy.

In response to a comment on the May 7, 1999 proposed rule, for the FY 2000 final rule we analyzed cases for which procedure code 99.28 was reported using the 100 percent FY 1998 MedPAR file. The commenter requested that we create a new DRG for BRM therapy or assign cases in which BRM therapy is performed to an existing DRG with a high relative weight. The commenter suggested that DRG 403 (Lymphoma and Nonacute Leukemia with CC) would be an appropriate DRG.

For the proposed rule, we analyzed all cases for which procedure code 99.28 was reported. We identified 1,179 cases in 136 DRGs in 22 MDCs. No more than 141 cases were assigned to any one particular DRG.

Of the 1,179 cases, 141 cases (approximately 12 percent) were assigned to DRG 403 in MDC 17. We found approximately one-half of these cases had other procedures performed in addition to receiving immunotherapy, such as chemotherapy, bone marrow biopsy, insertion of totally implantable vascular access device, thoracentesis, or percutaneous abdominal drainage, which may account for the increased charges. There were 123 immunotherapy cases assigned to DRG 82 (Respiratory Neoplasms) in MDC 4 (Diseases and Disorders of the Respiratory System). We noted that, in some cases, in addition to immunotherapy, other procedures were performed, such as insertion of an intercostal catheter for drainage, thoracentesis, or chemotherapy.

There were 84 cases assigned to DRG 416 (Septicemia, Age >17) in MDC 18 (Infectious and Parasitic Diseases (Systemic or Unspecified Sites)). The principal diagnosis for this DRG is septicemia and, in addition to receiving treatment for septicemia, immunotherapy was also given. There were 79 cases assigned to DRG 410 (Chemotherapy without Acute Leukemia as Secondary Diagnosis) in MDC 17.

The cost of immunotherapy is averaged into the weight for these DRGS and, based on our analysis, we did not believe a reclassification of these cases was warranted. Due to the limited number of cases that were distributed throughout 136 DRGs in 22 MDCs and the variation of charges, we concluded that it would be inappropriate to classify these cases into a single DRG.

Although there were 141 cases assigned to DRG 403, it would be inappropriate to place all immunotherapy cases, regardless of diagnosis, into a DRG that is designated for lymphoma and nonacute leukemia. We establish DRGs based on clinical coherence and resource utilization. Each DRG 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. To the extent a new technology is extremely costly relative to the cases reflected in the DRG relative weight, the hospital might qualify for outlier payments, that is, additional payments over and above the standard prospective payment rate.

We did not receive any comments regarding payment for immunotherapy cases.

b. Pancreas Transplant. Effective July 1, 1999, Medicare covers whole organ pancreas transplantation if the transplantation is performed simultaneously with or after a kidney transplant (procedure codes 55.69, Other kidney transplantation, and V42.0, Organ or tissue replaced by transplant, Kidney) (Transmittal No. 115, April 1999). We noted that when we published the notification of this coverage in the July 30, 1999 final rule (64 FR 41497), we inadvertently made an error in announcing the covered codes. We cited the incorrect codes for pancreas transplantation as procedure code 52.80 (Pancreatic transplant, not otherwise specified) and 52.83 (Heterotransplant of pancreas). The correct procedure codes for pancreas transplantation are 52.80 (Pancreatic transplant, not otherwise specified) and 52.82 (Homotransplant of pancreas). The Coverage Issues Manual was revised to reflect this change via Transmittal 124, April 2000, effective October 1, 2000.

Pancreas transplantation is generally limited to those patients with severe secondary complications of diabetes, including kidney failure. However, pancreas transplantation is sometimes performed on patients with labile diabetes and hypoglycemic unawareness. Pancreas transplantation for diabetic patients who have not experienced end-stage renal failure secondary to diabetes is excluded from coverage. Medicare also excludes coverage of transplantation of partial pancreatic tissue or islet cells.

In the July 30, 1999 final rule (64 FR 41497), we indicated that we planned to review discharge data to determine whether a new DRG should be created, or existing DRGs modified, to further classify pancreas transplantation in combination with kidney transplantation.

Under the current DRG classification, if a kidney transplant and a pancreas transplant are performed simultaneously on a patient with chronic renal failure secondary to diabetes with renal manifestations (diagnosis codes 250.40 through 250.43), the case is assigned to DRG 302 (Kidney Transplant) in MDC 11 (Diseases and Disorders of the Kidney and Urinary Tract). If a pancreas transplant is performed following a kidney transplant (that is, during a different hospital admission) on a patient with chronic renal failure secondary to diabetes with renal manifestations, the case is assigned to DRG 468 (Extensive OR Procedure Unrelated to Principal Diagnosis). This is because pancreas transplant is not assigned to MDC 11, the MDC to which a principal diagnosis of chronic renal failure secondary to diabetes is assigned.

For the proposed rule, using 100 percent of the data in the FY 1999 MedPAR file (which contains hospital bills received for FY 1999 through

December 31, 1999), we analyzed the cases for which procedure codes 52.80 and 52.83 were reported. We identified a total of 79 cases in 8 DRGs, in 3 MDCs, and in 1 pre-MDC. Of the 79 cases identified, 49 cases were assigned to DRG 302, 14 cases were assigned to DRG 468, and 8 cases were assigned to DRG 191 (Pancreas, Liver and Shunt Procedures with CC). The additional 8 cases were distributed over 5 other assorted DRGs, and due to their disparity, were not considered in our evaluation.

We examined our data to determine whether it was appropriate to propose a new kidney and pancreas transplant DRG. We identified 49 such dual transplant cases in the FY 1999 MedPAR file. We do not believe this to be a sufficient sample size to warrant the creation of a new DRG. Furthermore, we noted that nearly half of these cases occurred at a hospital in Maryland, which is not paid under the prospective payment system. The rest of the cases are spread across multiple hospitals, with no single hospital having more than 5 cases in the FY 1999 MedPAR.

We received 261 comments on this issue, 244 of which were form letters.

We will continue to monitor these dual transplant cases to determine whether it may be appropriate in the future to establish a new DRG. However, we are not establishing a new DRG for these cases for FY 2001 and the current procedure code classification will remain in effect.

Comment: All commenters called for the establishment of a unique DRG recognizing the combined transplant of kidney and pancreas in the same operative episode. Some commenters cited increased utilization of hospital resources, especially operating-room time, recovery time, and immunosuppressive drugs as justification for a separate DRG for a combined pancreas-kidney transplant. One commenter forwarded to us facility-specific charge data for four dual-transplant patients seen at that center through December 1997.

Response: We stated in the proposed rule that there does appear to be a difference between the charges for dual kidney-pancreas transplant patients assigned to DRG 302 (Kidney Transplant) and those patients who received only a kidney transplant. However, the numbers of dual transplant cases in our database were insufficient to warrant establishing a new DRG for dual transplants.

We point out that, given the low volume of these cases and their infrequent occurrence in any particular hospital, we believe our outlier policy will provide adequate protection for any extraordinarily costly cases. Furthermore, there is always variation in terms of the costs for cases within a DRG relative to the payments under the prospective payment system for that DRG. Although examining these cases in isolation from other DRG 302 cases appears to suggest that dual transplants are more expensive, the nature of the prospective payment system is such that hospitals are expected to be able to offset cases where costs are greater than payments with those cases where payments exceed costs.

We further point out that additional Medicare coverage of a transplanted organ does not necessarily and immediately result in creation of a unique DRG. A specific example of not creating a unique DRG is the combined heart-lung transplant procedure. Effective for discharges occurring on or after October 1, 1990, Medicare was able to identify combined heart-lung transplant using ICD–9–CM code 33.6 (Combined heart-lung transplantation). Instead of assigning this new code to its own specific DRG, however, it was combined with heart transplant in DRG 103 (Heart Transplant). When DRG 495 (Lung Transplant) was created for cases discharged on or after October 1, 1994, review of our data revealed that assignment of code 33.6 was more clinically coherent with DRG 103 than DRG 495. Therefore, code 33.6 was not moved into the new lung transplant DRG. Although this does not indicate we will not create a distinct DRG for combined kidney and pancreas transplants, it does show a precedent for allowing a sufficient sample of cases to accumulate before deciding whether a new DRG is necessary.

Finally, one of the risks of establishing a new DRG based on few documentable cases is that a few extremely low-cost cases could dramatically reduce the average charges in a year, thereby lowering the relative weight and potentially underpaying cases in this DRG by a significant amount.

Comment: Several commenters argued that combined pancreas and kidney transplants are underpaid every time they are performed and expressed concern that this lack of funding provides limited access to this procedure for Medicare beneficiaries.

Response: We do not believe that beneficiaries' access will be limited by our decision. In addition, it is a violation of a hospital's Medicare provider agreement to place restrictions on the number of Medicare beneficiaries it accepts for treatment unless it places the same restrictions on all other patients.

Comment: One commenter argued that the incremental cost of the pancreas transplant was insufficient to cause the claim to move into outlier status.

Response: Our data show covered charges submitted by hospitals ranging from a low of approximately $42,000 to a high in excess of $182,000 for cases in DRG 302. Outlier payments are meant to alleviate the financial effects of treating extraordinarily high-cost cases. Therefore, the commenter may be correct in saying that some of the cases with lower charges might not be further compensated by outlier payments. However, other cases are further compensated to mitigate losses experienced by hospitals.

Comment: One commenter stated we underrepresented the volume of future dual transplants under Medicare, citing mid-year approval of Medicare coverage for pancreas transplants, and noting that this is not enough time to accurately reflect the numbers of procedures since patients normally must accrue longer wait times before they receive organ offers for transplant.

Response: It is true that we did not attempt to project the future volume of combined kidney and pancreas transplant procedures. We reported the number of actual hospital claims in our MedPAR data base, submitted through December 1999, when we published the proposed rule in the May 5, 2000 **Federal Register** (65 FR 26294). DRG categories and payment are always based on actual historical hospital charge data, not projected data. What must also be considered, however, is that dual transplants would only appear in statistics concerning DRG 302, while HCFA also covers pancreas transplants performed in separate operative episodes, subsequent to kidney transplantation. Those pancreatic transplants occurring after kidney transplant would appear in DRG 468, or potentially other DRGs as well, depending on the principal diagnosis.

Comment: Several commenters noted that the 1998 Annual Report of United Network for Organ Sharing (UNOS) indicated there were 966 simultaneous kidney-pancreas transplants, and questioned HCFA's reported 49 cases appearing in DRG 302 as being too low. One commenter, citing the inability of HCFA to be able to identify cases of dual kidney-pancreas transplants, pointed out the need for a specific DRG for this category of patients. Another commenter noted that data were lost because of the incorrect publication of ICD–9–CM code 52.83 (Heterotransplant

of pancreas) as being a covered procedure.

Response: Most patients who are experiencing end-stage renal disease should be eligible for Medicare benefits. We note, however, that none of the commenters submitted specific evidence contrary to our finding that, outside of a single hospital in Maryland, no individual hospital had more than five Medicare dual transplant cases during FY 1999.

Obviously one issue is the timing of the creation of the coverage benefit, which was conferred for cases discharged on or after July 1, 1999. Cases transplanted prior to that date should not have appeared in our data as covered procedures.

We recognize that 52.83 is an incorrect code, and have corrected this typographical error in the Medicare Coverage Issues Manual, as noted above. Interestingly, the original data reported in the proposed notice contained 79 cases of pancreas transplant, but there were only 7 instances in which code 52.83 was reported. We believe that hospital coders recognized the error in the original coverage instruction, and chose to submit the less specific code 52.80 instead.

Comment: Several commenters asserted that it was contradictory for us to argue that 49 cases is too few to establish a DRG but we indicated in the May 5, 2000 proposed rule that there were 40 DRGs with fewer than 10 cases per year.

Response: These low-volume DRGs are not new, but in most cases were created very early during or even prior to the implementation of the prospective payment system. Many of these DRGs are related to patient categories that are rare in the Medicare population, such as age less than 17 or labor and delivery during childbirth. The DRG relative-weights for these DRGs are adjusted based on the overall change in the DRG weights rather than through normal recalibration.

We do not believe our policy not to establish a new dual transplant DRG for combined kidney and pancreas transplants is contradicted by the existence of these low-volume DRGs. As the commenters indicated, the number of combined kidney and pancreas transplants is likely to increase in the next few years, and therefore it is important to ensure an accurate and stable DRG payment is established.

Comment: Several commenters offered to work closely with HCFA to identify cases and costs associated with this category of patients.

Response: We appreciate these offers and the cooperative spirit in which they were presented. Our ability to evaluate and implement potential DRG changes depends on the availability of validated, representative data. We remain open to using non-MedPAR data if the data are reliable and validated and enable us to appropriately measure relative resource use. We will continue to monitor this category of patients, and will address this issue in the FY 2002 proposed rule.

C. Recalibration of DRG Weights

We proposed to use the same basic methodology for the FY 2001 recalibration as we did for FY 2000 (July 30, 1999 final rule (64 FR 41498)). That is, we recalibrated the weights based on charge data for Medicare discharges. However, we used the most current charge information available, the FY 1999 MedPAR file. (For the FY 2000 recalibration, we used the FY 1998 MedPAR file.) The MedPAR file is based on fully coded diagnostic and procedure data for all Medicare inpatient hospital bills.

The final recalibrated DRG relative weights are constructed from FY 1999 MedPAR data (discharges occurring between October 1, 1998 and September 30, 1999), based on bills received by HCFA through March 2000, from all hospitals subject to the prospective payment system and short-term acute care hospitals in waiver States. The FY 1999 MedPAR file includes data for approximately 11.0 million Medicare discharges.

The methodology used to calculate the DRG relative weights from the FY 1999 MedPAR file is as follows:

- To the extent possible, all the claims were regrouped using the proposed DRG classification revisions discussed in section II.B. of this preamble.
- 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 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 are eliminated.
- 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 transfer payment under the per diem payment methodology to the full DRG payment for nontransfer cases. That is, transfer cases paid under the transfer methodology equal to half of what the case would receive as a nontransfer would be 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 1999 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, lung, and pancreas 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); DRG 480 (Liver Transplant); DRG 495 (Lung Transplant); and DRG 468 (Pancreas)). 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 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 proposed to use the same case threshold in recalibrating the DRG weights for FY 2001. Using the FY 1999 MedPAR data set, there were 40 DRGs containing fewer than 10 cases. We computed the weights for these 40 low-volume DRGs by adjusting the FY 2000 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 DRG classification changes, resulted in an average case weight that differs from the average case weight before recalibration. Therefore, the new weights are normalized by an adjustment factor (1.45507) 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.

We received no comments on DRG recalibration.

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.a. of the Addendum to this final rule, we make a budget neutrality adjustment to assure that the requirement of section 1886(d)(4)(C)(iii) of the Act is met.

III. 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). The OMB also designates Consolidated MSAs (CMSAs). A CMSA is a metropolitan area with a population of one million or more, comprising 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. For purposes of the wage index, we combine all of the rural counties in a State to calculate a rural wage index for that State.

We note that, effective April 1, 1990, the term Metropolitan Area (MA) replaced the term MSA (which had been used since June 30, 1983) to describe the set of metropolitan areas consisting 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 2001 Wage Index Update

The FY 2001 wage index values in section VI of the Addendum to this final rule (effective for hospital discharges occurring on or after October 1, 2000 and before October 1, 2001) are based on the data collected from the Medicare cost reports submitted by hospitals for cost reporting periods beginning in FY 1997 (the FY 2000 wage index was based on FY 1996 wage data).

The FY 2001 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 2000 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 2000, the wage index for FY 2001 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 Public Law 105–33 provides that, for discharges on or after October 1, 1997, the area wage index applicable to any hospital that is not located in a rural area may not be less than the area wage index applicable to hospitals located in rural areas in that State.

Comment: One commenter believed that the FY 2001 wage calculation does not allow for inflationary effects or existing contractual increases, and recommended that we consider using a more recent Medicare cost reporting year and allow for inflationary wage adjustments.

Response: Due to the time period allowed for: (1) hospitals to complete and submit their cost reports to their intermediaries, (2) intermediaries to review and submit the cost reports to HCFA, (3) intermediaries to perform a separate, detailed review of all wage data and submit the results to HCFA, and (4) HCFA to compile a complete set of all hospitals' wage data from a given Federal fiscal year, we do not have available more recent reliable data to calculate the wage index. As described in the proposed rule (65 FR 26299) and section III.E. of this final rule, we adjust the wage data to a common period that reflects the latest cost reporting period for the filing year. Because the wage index is a relative measure, comparing area average hourly wages to a national average hourly wage, we believe the wage index is minimally impacted by inflationary effects beyond those accounted for by adjusting the data to a common period.

C. FY 2001 Wage Index

Because the hospital wage index is used to adjust payments to hospitals under the prospective payment system, it should, to the extent possible, reflect the wage costs associated with the areas of the hospital included under the hospital inpatient prospective payment system. In response to concerns within the hospital community related to the removal from the wage index calculation costs related to GME (teaching physicians and residents) and certified registered nurse anesthetists (CRNAs), which are paid by Medicare separately from the prospective

payment system, in 1998 the AHA convened a workgroup to develop a consensus recommendation on this issue. The workgroup recommended that costs related to GME and CRNAs be phased out of the wage index calculation over a 5-year period. Based upon our analysis of hospitals' FY 1996 wage data, and consistent with the AHA workgroup's recommendation, we specified in the July 30, 1999 final rule (64 FR 41505) that we would phase-out these costs from the calculation of the wage index over a 5-year period, beginning in FY 2000. In keeping with the decision to phase-out costs related to GME and CRNAs, the final FY 2001 wage index is based on a blend of 60 percent of an average hourly wage including these costs, and 40 percent of an average hourly wage excluding these costs.

Comment: We received one comment in support of our continued transition of removing GME and CRNA costs from the wage index calculation. We also received a comment from a national association representing nurse anesthetists expressing concern that, as a result of disparities in cost reporting systems and vague fiscal intermediary instructions, CRNA costs that should be paid under Part B might still be reported in hospitals' FY 1997 cost reports. The commenter also stated that removing CRNA costs from the wage index eliminates a payment mechanism for the indirect patient care activities performed by CRNAs, resulting in a disincentive for hospitals to employ CRNAs. To avoid any disruption in the ''continuous operations of hospitals,'' the commenter recommended that, prior to implementing any changes to the wage index calculation, HCFA should refine the Part A cost data collection and cost reporting process and instruct the fiscal intermediaries to provide all hospitals with ''explicit instructions as to the appropriate reporting of CRNA costs.'' The commenter believed this refinement to the cost data will identify and exclude only the CRNA salary costs related to the rural hospital cost pass-through provisions and allow Part A reimbursement for indirect patient care which are not reimbursed under Medicare Part B. In keeping with the general policy to exclude costs that are not paid through the Medicare prospective payment system, the commenter also recommended that HCFA exclude salaries reported under Medicare Part A for anesthesia assistants.

Response: We note that the FY 2001 wage index is the second year of the transition to eliminating Part A CRNA costs from the wage index. As evidenced in the impact analysis in the May 5, 2000 proposed rule (65 FR 26415), eliminating these CRNA and GME costs has an insignificant impact, with no category of hospitals impacted by more than 0.1 percent. Therefore, we do not believe it is necessary to delay further removal of CRNA costs.

Payment for CRNA services is made under a fee schedule under Medicare Part B (Supplementary medical insurance), with the sole exception of payments to hospitals under the rural pass-through provision. Although a hospital contracting for CRNA services would include the costs on its cost report, the fiscal intermediary forwards the information to the carrier for payment under the fee schedule. As the commenter noted, this payment structure has been in place since January 1, 1989. We believe that intermediaries and carriers are generally well informed and experienced in the handling of these costs. However, we will consider whether further clarification of our instructions is necessary.

The commenter also stated that Medicare does not specifically exclude anesthesia assistants, who are also reimbursed under Part B, from the wage index. The cost report instructions for Worksheet A, Line 20, refer to nonphysician anesthetists, which include both CRNAs and anesthesia assistants. We will consider whether our Worksheet S–3 instructions need to be revised to explicitly instruct hospitals to remove the Part B costs associated with anesthesia assistants as well.

1. Teaching Physician Costs and Hours Survey

As discussed in the July 30, 1999 final rule, because the FY 1996 cost reporting data did not separate teaching physician costs from other physician Part A costs, we instructed our fiscal intermediaries to survey teaching hospitals to collect data on teaching physician costs and hours payable under the per resident amounts (§ 413.86) and reported on Worksheet A, Line 23 of the hospitals' cost report.

The FY 1997 cost reports also do not separately report teaching physician costs. Therefore, we once again conducted a special survey to collect data on these costs. (For the FY 1998 cost reports, we have revised the Worksheet S–3, Part II so that hospitals can separately report teaching physician Part A costs. Therefore, after this year, it will no longer be necessary for us to conduct this special survey.)

The survey data collected as of mid-January 2000 were included in the preliminary public use data file made available on the Internet in February 2000 at HCFA's home page (http://www.hcfa.gov). At that time, we had received teaching physician data for 459 out of 770 teaching hospitals reporting physician Part A costs on their Worksheet S–3, Part II. Also, in some cases, fiscal intermediaries reported that teaching hospitals did not incur teaching physician costs. In early January 2000, we instructed fiscal 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 hospitals, through our fiscal intermediaries, that they could review the survey data on the Internet, we also notified hospitals that requests for changes to the teaching survey data had to be submitted by March 6, 2000. We instructed fiscal intermediaries to review the requests for changes received from hospitals and submit necessary data revisions to HCFA by April 3, 2000. We removed from the wage data the physician Part A teaching costs and hours reported on the survey form for every hospital that completed the survey. These data had been verified by the fiscal intermediary before submission to HCFA.

For the FY 2000 wage index, the AHA workgroup recommended that, if reliable teaching physician data were not available for removing teaching costs from hospitals' total physician Part A costs, HCFA should remove 80 percent of the costs and hours reported by hospitals attributable to physicians' Part A services. In calculating the FY 2000 wage index, if we did not receive survey data for a teaching hospital, we removed 80 percent of the hospital's reported total physician Part A costs and hours from the calculation. In the May 5, 2000 proposed rule, for the FY 2001 wage index, we proposed a different approach. In some instances, fiscal intermediaries had verified that teaching hospitals do not have teaching physician costs; for these hospitals, it is not necessary to adjust the hospitals' physician Part A costs. We conferred with the fiscal intermediaries to distinguish teaching hospitals that did not have teaching physician costs from teaching hospitals that had not identified the portion of their physician Part A costs associated with teaching physicians (that is, hospitals that did not complete the teaching survey).

In calculating the final FY 2001 wage index, we removed 100 percent of the physician Part A costs and hours (reported on Worksheet S–3, Lines 4, 10, 12, and 18) in the FY 2001 wage index calculation for those hospitals where the fiscal intermediary verifies that the hospital has otherwise unidentified teaching physician costs included in physician Part A costs and hours. For those teaching hospitals whose fiscal intermediaries identified as having costs attributable to teaching physicians but reported no physician Part A costs on the Worksheet S–3, we removed 100 percent of Worksheet A, Line 23, Column 1. To determine the hours to be removed, the costs reported on Line 23 of the Worksheet A, Column 1 are divided by the national average hourly wage for teaching physicians of $59.17 based upon the survey.

We note that Line 23 of Worksheet A, Column 1, flows directly into hospitals' total salaries on Worksheet S–3, Part II. Line 23 contains GME costs not directly attributable to residents' salaries or fringe benefits. Therefore, these costs tend to be costs associated with teaching physicians. To the extent a hospital fails to separately identify the proportion of its Line 23, Worksheet A costs associated with teaching physicians, we believe it is reasonable to remove all of these costs under the presumption that they are all associated with teaching physicians.

Thus, as we proposed in the May 5 proposed rule, for the FY 2001 wage index, we are either using the data submitted on the teaching physician survey (837 hospitals), or, in the absence of such data, removing 100 percent of physician Part A costs reported on Worksheet S–3 (287 hospitals), or removing the amount reported on Line 23 of Worksheet A, Column 1 (18 hospitals).

We received one comment in support of removing 100 percent of physician Part A costs and hours from teaching hospitals where the fiscal intermediary verifies that the hospital has otherwise unidentifiable teaching costs included in physician Part A costs and hours.

2. Nurse Practitioner and Clinical Nurse Specialist Costs

The current wage index includes salaries and wage-related costs for nurse practitioners (NPs) and clinical nurse specialists (CNSs) who, similar to physician assistants and CRNAs (unless at hospitals under the rural pass-through exception for CRNAs), are paid under the physician fee schedule. Over the past year, we have received several inquiries from hospitals and fiscal intermediaries regarding NP costs and how they should be handled for purposes of the hospital wage index. Because Medicare generally pays for NP and CNS costs under Part B outside the hospital prospective payment system, removing NP and CNS Part B costs from the wage index calculation would be consistent with our general policy to exclude, to the extent possible, costs that are not paid through the hospital prospective payment system. Because NP and CNS costs are not separately reported on the Worksheet S–3 for FYs 1997, 1998, and 1999, the FY 2000 Worksheet S–3 and cost reporting instructions will be revised to allow for separate reporting of NP and CNS Part A and Part B costs. We plan to exclude the Part B costs beginning with the FY 2004 wage index. These services are pervasive in both rural and urban settings. As such, because the wage index is a relative measure, we believe there will be no significant overall impact resulting from the removal of Part B costs for NPs and CNSs.

We did not receive any public comments on our plan to exclude NP and CNS Part B costs from the wage index calculation, beginning with the FY 2004 wage index.

3. Severance and Bonus Pay Costs

On October 6, 1999, we issued a memorandum to hospitals and fiscal intermediaries regarding our policy on treatment of severance and bonus pay costs in developing the wage index, effective beginning with the FY 2001 wage index. (The hospital cost report instructions also will be amended to reflect our policy on these costs.) We stated that severance pay costs may be included on Worksheet S–3 as salaries on Part II, Line 1, only if the associated hours are included. If the hospital has no accounting of the hours, or if the costs are not based on hours, the severance pay costs may not be included in the wage index. On the other hand, bonus pay costs may be included in the cost report on Line 1 of Worksheet S–3 with no corresponding hours. Due to the inquiries we continue to receive from hospitals regarding the inclusion of severance pay costs on cost reports, in the May 5 proposed rule, we clarified our policy in this area.

Hospitals vary in their accounting of severance pay costs. Some hospitals base the amounts to be paid on hours, for example, 80 hours worth of pay. Others do not; for example, a 15-year employee may be offered a $25,000 buyout package. Some hospitals record associated hours; others do not. The Wage Index Workgroup has suggested that we not include any severance pay costs in the wage index calculation, that these costs are for terminated employees, and, therefore, they should be considered an administrative rather than a salary expense.

Severance pay costs can be substantial amounts, particularly in periods of downsizing. In the proposed rule, we state our view that, if severance pay costs are included with no associated hours, the wage index, which is a relative measure of wage costs across labor market areas, would be distorted.

We included severance pay costs in the proposed FY 2001 wage index as a salary cost to the extent that associated hours also were reported. However, we solicited public comments on this issue. We received two comments on this issue.

Comment: Two national hospital associations disagree with our policy clarification that severance pay costs may be included on Worksheet S–3, Part II, Line 1 as salaries only if associated hours are included. These commenters argued that HCFA's wage index policy is that wages and benefits are to be determined in accordance with generally accepted accounting principles (GAAP) rather than Medicare cost reimbursement principles and that under GAAP severance pay is classified as salaries and wages. They also argued that, unless a terminated employee continues to work or is still considered to be employed by the provider after the last regular pay period that additional hours should not be reported for severance pay. Further, for employees receiving severance pay, ''there are no hours to report'' because ''their job has been eliminated and they are no longer employed by the provider.''

Response: As indicated in the proposed rule, we exclude severance pay costs from the wage index calculation if there are no associated hours because we believe that inclusion of such costs might lead to a distortion of the wage index. The wage index is a relative measure of average hourly wages across geographic areas, and we believe that severance pay costs (which might be significant) without associated hours might inappropriately inflate the average hourly wage for a given hospital or area for a given time period (which in turn would distort the relative measure of wages across areas). For example, if we included severance pay costs with no associated hours, then a hospital might be more likely to qualify for geographic reclassification for purposes of the wage index simply because it incurred significant severance pay costs in a given year. In light of the comments, we will continue to examine this issue to determine whether inclusion of severance pay costs with no

associated hours would lead to a better measure of relative wages as opposed to a distortion in the measure and to determine whether it is feasible and appropriate to revise our policy on severance pay costs in the future.

4. Health Insurance and Health-Related Costs

In the September 1, 1994 final rule (59 FR 45356), we stated that health insurance, purchased or self-insurance, is a core wage-related cost. Over the past year, we have received several inquiries from hospitals and hospital associations requesting that we define ''purchased health insurance costs.'' In response, in the May 5 proposed rule, we clarified that, for wage index purposes, we define ''purchased health insurance costs'' as the premiums and administrative costs a hospital pays on behalf of its employees for health insurance coverage. ''Self-insurance'' includes the hospital's costs (not charges) for covered services delivered to its employees, less any amounts paid by the employees, and less the personnel costs for hospital staff who delivered the services (these costs are already included in the wage index). For purchased health insurance and self-health insurance, the included costs must be for services covered in a health insurance plan.

Also, in the September 1, 1994 final rule (59 FR 45357), we addressed a comment about the inclusion of health-related costs in the calculation of the wage index. Such health-related costs include employee physical examinations, flu shots, and clinic visits, and other services that are not covered by employees' health insurance plans but are provided at no cost or at discounted rates to employees of the hospital. In the May 5 proposed rule, we proposed to clarify that the costs for these services may be included as an ''other'' wage-related cost if (among other criteria), when all such health-related costs are combined, the total of such costs is greater than one percent of the hospital's total salaries (less excluded area salaries). As discussed in the September 1, 1994 final rule, a cost may be allowable as an ''other wage-related cost'' if it meets certain criteria. Under one criterion, the wage-related cost must be greater than one percent of total salaries (less excluded area salaries). For purposes of applying this 1-percent test with respect to the health-related costs at issue here, we look at the combined total of the health-related costs (not charges) for services delivered to its employees, less any amounts employees paid, and less the personnel costs for hospital staff who delivered the services (as these costs are already included in the wage index).

Comment: We received several comments regarding our policy and definitions for health insurance and health-related costs. Some commenters interpreted the policy clarification in the proposed rule as stating that self-insurance will no longer be included as core wage-related costs. They believe that not including these costs is inconsistent with the fundamental concept of core wage-related costs. One commenter pointed to the 1994 HCFA/Industry workgroup which established the list of core wage-related costs still in use, and contended that ''(t)hese proposed changes are inconsistent with the agreements reached in those original workgroup meetings.''

Response: As noted in the May 5 proposed rule, we previously stated our policy regarding health insurance and health-related costs in the FY 1995 final rule. We emphasize again in this final rule that, health insurance costs, whether purchased or self-insured, is, and will continue to be, a core wage-related cost. We did not propose a change in this policy, nor are we implementing a change in this policy in this final rule.

Comment: Some commenters objected to our statement in the proposed rule that only health self-insurance costs (not charges, and exclusive of any amounts paid by covered employees and less the personnel costs for hospital staff who delivered the services) are allowable core wage-related costs, and also argued that health self-insurance costs should be determined in accordance with GAAP which would include charges and personnel costs. They suggested that excluding costs that are determined in accordance with GAAP would create major inconsistencies among hospitals and inevitably result in major swings in the wage index for individual MSAs.

Two commenters recommended that HCFA review this policy to avoid creating disincentives to hospitals that develop cost-effective health-insurance benefits; they asserted that there should be no differentiation between purchased health insurance and self-funded health insurance.

Response: We disagree with the commenters that we are unfairly and inconsistently treating hospitals that self-insure by not allowing as a wage-related cost the salary costs for employees who deliver the health services. The personnel costs of delivering health care to all of a hospital's patients are already included in the wage index through line 1 of Worksheet S–3, Part II. Accounting for these hospital personnel costs on lines 13 or 14 for wage-related costs would falsely overstate a hospital's average hourly wage. Unless a hospital actually incurs the personnel costs twice, it is inappropriate to include the costs twice. Our policy does not require the exclusion of staff personnel costs from the premium costs for hospitals that purchase health insurance. As defined above and in the proposed rule, purchased health insurance costs include the premiums and administrative costs a hospital pays on behalf of its employees for health insurance coverage. The commenters suggested that the premium costs may include a hospital's staff personnel costs. We believe it is appropriate to allow the entire premium cost to a hospital as a wage-related cost if the intermediary verifies that the amount is an actual cost to the hospital.

Nevertheless, we agree with the commenters that, overall, for ''wage-related costs'', the application of GAAP creates a more static wage index and a better measure of relative wages across areas. For the FY 2002 wage index, we will advise hospitals to apply GAAP for wage-related costs, including health insurance and health-related costs. However, for self-health insurance and health-related costs, personnel costs associated with hospital staff that deliver the services to the employees must continue to be excluded from wage-related costs, if the costs are already included in the wage data as salaries on Worksheet S–3, Part II, Line I.

Comment: One commenter recommended that the insurance plan requirements be eliminated from our definition of health insurance costs, stating that hospitals should be required to maintain adequate records in support of the services they provide to their employees at either no cost or below cost. In expressing the concern that employee health benefits are ever-changing, the commenter recommended that not only must HCFA's definition of insurance plans be specific but it should also be implemented prospectively with sufficient clarification to reduce inconsistency in interpretation by the fiscal intermediaries.

Response: We are concerned that adopting this recommendation would make it difficult for intermediaries to accurately track benefits provided to a hospital's employees, leading to greater disparity in the treatment of these costs across hospitals. We will give further consideration to the implications of this recommendation, however.

Comment: One commenter recommended that health-related costs, for such items as ''employee physicals,

flu shots, and clinic visits'' should be included as a core wage-related cost; therefore, the 1-percent threshold criteria for health related costs should be eliminated.

Response: In the September 1, 1994 final rule, when we published the list of core wage-related costs agreed upon by the workgroup, we responded to comments specifically suggesting that health-related services (as opposed to self-insured health services, which was clearly on the original core list) be added to the core list. In our response, we pointed out that the core list was developed in conjunction with the hospital industry, to establish a list of commonly recognized costs that contribute significantly to the wage costs of a hospital and are readily identifiable in the hospital's records. Health-related benefits was not included on the core list at that time. We continue to believe these health-related benefits do not fit the criteria established by the workgroup for identifying core wage-related costs.

5. Elimination of Wage Costs Associated With Rural Health Clinics and Federally Qualified Health Centers

The current hospital wage index includes the salaries and wage-related costs of hospital-based rural health clinics (RHCs) and federally qualified health centers (FQHCs). However, Medicare pays for these costs outside the hospital inpatient prospective payment system. Effective January 1, 1998, under section 1833(f) of the Act, as amended by section 4205 of Public Law 105–33, Medicare pays both hospital-based and freestanding RHCs and FQHCs on a cost-per-visit basis. Medicare cost reporting forms for RHCs and FQHCs were revised to reflect this legislative change, beginning with cost reporting periods ending on or after September 30, 1998 (the FY 1998 cost report). Other cost-reimbursed outpatient departments, such as ambulatory surgical centers, community mental health centers, and comprehensive outpatient rehabilitation facilities, are presently excluded from the wage index. Therefore, consistent with our wage index refinements that exclude, to the extent possible, costs associated with services not paid under the hospital inpatient prospective payment system, we believe it would be appropriate to exclude all salary costs associated with RHCs and FQHCs from the wage index calculation if we had feasible, reliable data for such exclusion.

Because RHC and FQHC costs are not separately reported on the Worksheet S–3 for FYs 1997, 1998, and 1999, we cannot exclude these costs from the FY 2001, FY 2002, or FY 2003 wage indexes. Therefore, we will revise the FY 2000 Worksheet S–3 to begin providing for the separate reporting of RHC and FQHC salaries, wage-related costs, and hours. We will evaluate the wage data for RHCs and FQHCs in developing the FY 2004 wage index.

We received no public comments on this issue.

D. Verification of Wage Data From the Medicare Cost Report

The data for the FY 2001 wage index were obtained from Worksheet S–3, Parts II and III of the FY 1997 Medicare cost reports. The data file used to construct the wage index includes FY 1997 data submitted to HCFA as of mid-July 2000. As in past years, we performed an intensive review of the wage data, mostly through the use of edits designed to identify aberrant data.

We asked our fiscal intermediaries to revise or verify data elements that resulted in specific edit failures. The unresolved data elements that were included in the calculation of the proposed FY 2001 wage index have been resolved and are reflected in calculation of the final FY 2001 wage index. We note that, as part of this process to identify aberrant data and correct any errors prior to the calculation of the final FY 2001 wage index, we notified by letter those hospitals that were leading to large variations in the wage indexes of their labor market areas compared to the FY 2000 wage index. These hospitals were instructed to review their data to identify the reason for the large increases or decreases and notify their fiscal intermediary of any necessary corrections. This resulted in several revisions to the data.

Also, as part of our editing process, in the final wage index, we removed data for 15 hospitals that failed edits. For eight 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 erroneous average hourly wages (negative and zero) after allocating overhead to their excluded areas and, therefore, were removed from the calculation. The data from the remaining five hospitals also failed the edits and were removed. As a result, the final FY 2001 wage index is calculated based on FY 1997 wage data for 4,950 hospitals.

E. Computation of the FY 2001 Wage Index

The method used to compute the FY 2001 wage index follows. We note one technical change to the formula used to calculate the proposed wage index. For the first time, in the proposed rule we subtracted line 13 of Worksheet S–3, Part III from total hours when determining the excluded hours ratio used to estimate the amount of overhead attributed to excluded areas. Although we continue to believe this is the correct formula for determining this ratio, it resulted in very large and inappropriate increases in the average hourly wages for some hospitals. Therefore, in calculating the final FY 2001 wage index, we are not subtracting line 13 of Worksheet S–3, Part III in the calculation.

Step 1—As noted above, we based the FY 2001 wage index on wage data reported on the FY 1997 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, 1996 and before October 1, 1997. In addition, we included data from a few hospitals that had cost reporting periods beginning in September 1996 and reported a cost reporting period exceeding 52 weeks. These data were included because they did not have a cost report begin during the period described above. However, we generally describe these wage data as FY 1997 data. We note that, if a hospital had more than one cost reporting period beginning during FY 1997 (for example, a hospital had two short cost reporting periods beginning on or after October 1, 1996 and before October 1, 1997), we included wage data from only one of the cost reporting periods, the longest, in the wage index calculation. If there was more than one cost reporting period and the periods were equal in length, we included the wage data from the latest period in the wage index calculation.

Step 2—Salaries—The method used to compute a hospital's average hourly wage is a blend of 60 percent of the hospital's average hourly wage including all GME and CRNA costs, and 40 percent of the hospital's average hourly wage after eliminating all GME and CRNA costs.

In calculating a hospital's average salaries plus wage-related costs, including all GME 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. In addition, wage-related costs for specific categories of employees (Lines 16, 18, and 20) are excluded if no corresponding salaries are reported for those employees (Lines 2, 4, and 6, respectively).

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, 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 the sum of Part II, Lines 3, 5, and 7). 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, 1996 through April 15, 1998 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
10/14/96	11/15/96	1.02848
11/14/96	12/15/96	1.02748
12/14/96	01/15/97	1.02641
01/14/97	02/15/97	1.02521
02/14/97	03/15/97	1.02387
03/14/97	04/15/97	1.02236
04/14/97	05/15/97	1.02068
05/14/97	06/15/97	1.01883
06/14/97	07/15/97	1.01695
07/14/97	08/15/97	1.01520
08/14/97	09/15/97	1.01357
09/14/97	10/15/97	1.01182
10/14/97	11/15/97	1.00966
11/14/97	12/15/97	1.00712
12/14/97	01/15/98	1.00451
01/14/98	02/15/98	1.00213
02/14/98	03/15/98	1.00000
03/14/98	04/15/98	0.99798

For example, the midpoint of a cost reporting period beginning January 1, 1997 and ending December 31, 1997 is June 30, 1997. An adjustment factor of 1.01695 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 1997 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 section 1886(d)(8)(B) or section 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 (with and without GME and CRNA costs) 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 FY 2001 wage index is based on a blend of average hourly wages, we then added 60 percent of the average hourly wage calculated without removing GME and CRNA costs, and 40 percent of the average hourly wage calculated with these costs excluded.

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 $21.7702.

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 $10.1902 for Puerto Rico.

For each labor market area in Puerto Rico, we calculated the Puerto Rico-specific wage index value by dividing the area average hourly wage (as calculated in Step 7) by the overall Puerto Rico average hourly wage.

Step 11—Section 4410 of Public Law 105–33 provides that, for discharges on or after October 1, 1997, the area wage index applicable to any hospital that is located in an urban 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 2001, this change affects 193 hospitals in 34 MSAs. The MSAs affected by this

provision are identified in Table 4A by a footnote.

F. Revisions to the Wage Index Based on Hospital Redesignation

Under section 1886(d)(8)(B) of the Act, hospitals in certain rural counties adjacent to one or more MSAs are considered to be located in one of the adjacent MSAs if certain standards are met. Under section 1886(d)(10) of the Act, the Medicare Geographic Classification Review Board (MGCRB) considers applications by hospitals for geographic reclassification for purposes of payment under the prospective payment system. Applications for MGCRB reclassification are now on the internet at http://www.hcfa.gov/regs/appeals.

1. Provisions of Public Law 106–113

Under section 152(b) of Public Law 106–113, hospitals in certain counties are deemed to be located in specified areas for purposes of payment under the hospital inpatient prospective payment system, for discharges occurring on or after October 1, 2000. For payment purposes, these hospitals are to be treated as though they were reclassified for purposes of both the standardized amount and the wage index. In the May 5 proposed rule we calculated FY 2001 wage indexes for hospitals in the affected counties as if they were reclassified to the specified area.

For purposes of making payments under section 1886(d) of the Act for FY 2001, section 152(b) provides the following:

- Iredell County, North Carolina is deemed to be located in the Charlotte-Gastonia-Rock Hill, North Carolina-South Carolina MSA;
- Orange County, New York is deemed to be located in the New York, New York MSA;
- Lake County, Indiana and Lee County, Illinois are deemed to be located in the Chicago, Illinois MSA;
- Hamilton-Middletown, Ohio is deemed to be located in the Cincinnati, Ohio-Kentucky-Indiana MSA;
- Brazoria County, Texas is deemed to be located in the Houston, Texas MSA;
- Chittenden County, Vermont is deemed to be located in the Boston-Worcester-Lawrence-Lowell-Brockton, Massachusetts-New Hampshire MSA.

Section 152(b) also requires that these reclassifications be treated for FY 2001 as though they are reclassification decisions by the MGCRB. Therefore, in the May 5 proposed rule, we proposed that the wage indexes for the areas to which these hospitals are reclassifying, as well as the wage indexes for the areas in which they are located, would be subject to all of the normal rules for calculating wage indexes for hospitals affected by reclassification decisions by the MGCRB, as described below.

In addition, we proposed that the reclassifications enacted by section 152(b) pertain only to the hospitals located in the specified counties, not to hospitals in other counties within the MSA or hospitals reclassified into the MSA by the MGCRB.

Under section 154(b) of Public Law 106–113, the Allentown-Bethlehem-Easton, Pennsylvania MSA wage index was calculated including the wage data for Lehigh Valley Hospital. Section 154(b) states that, for FY 2001, ''[n]otwithstanding any other provision of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), in calculating and applying the wage indices under that section for discharges occurring during fiscal year 2001, Lehigh Valley Hospital shall be treated as being classified in the Allentown-Bethlehem-Easton Metropolitan Statistical Area.'' We stated in the proposed rule that this statutory language directs us to include Lehigh Valley Hospital's wage data in the wage index calculation for the Allentown-Bethlehem-Easton MSA for FY 2000 and FY 2001.

Section 1886(d)(8)(B) of the Act established that a hospital located in a rural county adjacent to one or more urban areas is treated as being located in the MSA to which the greatest number of workers in the county commute, if the rural county would otherwise be considered part of an MSA (or NECMAs), if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or counties of all contiguous MSAs. Through FY 2000, hospitals are required to use standards published in the Federal Register on January 3, 1980, by the Office of Management and Budget. For FY 2000, there were 27 hospitals affected by this provision.

Section 402 of Public Law 106–113 amended section 1886(d)(8)(B) of the Act to allow hospitals to elect to use the standards published in the **Federal Register** on January 3, 1980 (1980 decennial census data) or March 30, 1990 (1990 decennial census data) during FY 2001 and FY 2002. As of FY 2003, hospitals will be required to use the standards published in the **Federal Register** by the Director of the Office of Management and Budget based on the most recent available decennial population data.

We are in the process of working with the Office of Management and Budget to identify the hospitals that would be affected by this amendment. We will revise payments to hospitals in the affected counties as soon as data is available. Hospitals will have this option during FY 2001 and FY 2002. After FY 2002, hospitals will be required to use data based on the 2000 decennial census. We refer the reader to the September 30, 1988 final rule (53 FR 38499) for a complete discussion of our approach to identify the outlying counties using the standards published in the January 3, 1980 **Federal Register**.

Comment: We received three comments on our proposed policy to treat hospitals reclassifying into an area containing one of the counties reclassified by section 152(b) in a manner similar to any other situation where a hospital reclassifies into an area where hospitals in that area have been reclassified into another area. The commenters, all hospitals that have been granted a reclassification into an area containing a county reclassified by section 152(b), requested that they should be permitted to reclassify along with the county identified by section 152(b). They added that, in the event it was determined that their preferred solution was not permissible, the wage index of the area to which they were reclassified should be calculated by including the wage data for the hospitals reclassified by section 152(b).

The commenters noted that they would be at a competitive disadvantage by the section 152(b) reclassifications if they were treated similar to other decisions by the MGCRB. In addition, they believed that the Secretary has some discretion with respect to calculating the wage indexes for areas with hospitals that have been reclassified, noting that the legislation does not specifically direct the Secretary to exclude reclassified hospitals from the calculation for the area in which a hospital is actually located.

Response: We have reconsidered the methodology for calculating the wage index applicable to hospitals reclassified into the MSAs that contain the counties specified in section 152(b) of Public Law 106–113. We continue to believe that the hospitals located in the counties specified in section 152(b) should be distinguished from the hospitals that were reclassified by the MGCRB into the MSAs containing those counties. Congress provided special treatment for hospitals in the counties specified in the statute, but it did not provide special treatment for hospitals

reclassified to the MSAs that contain those counties. Moreover, under the MGCRB process, hospitals are reclassified into MSAs as a whole, not into specific counties within an MSA; for example, some hospitals were reclassified by the MGCRB into the Newburgh, NY–PA MSA, which contains Orange County, NY and one other county, but those hospitals were not reclassified into Orange County itself. Thus, the benefits of section 152(b) apply only to the hospitals located in the counties specified by Congress.

Consistent with one of the suggestions of the commenters, however, we are revising the methodology reflected in the proposed rule with respect to the calculation of the wage index values for the MSAs containing the counties specified in section 152(b). The proposed rule reflected our normally applicable policy with respect to reclassifications, under which the wages of hospitals reclassified out of an MSA would be excluded from the calculation of the wage index value for that MSA; application of our normal rules might lead to an unexpected decrease in the wage index value for an MSA arising from the provisions of section 152(b). To address the unexpected decrease that might otherwise occur, we believe that it is appropriate to calculate the wage index values for the MSAs that contain the counties specified in section 152(b) (e.g., the Newburgh MSA) by including the wages of hospitals that were reclassified out of the area by section 152(b). We believe that we should not exclude the wages of those hospitals because Congress has provided special treatment for those hospitals, and we believe that including the wages of the reclassified hospitals appropriately reconciles the provisions of section 152(b) of Public Law 106–113, the MGCRB statutory and regulatory scheme, section 1886(d)(3)(E) of the Act, as well as the expectations of the hospitals prior to the enactment of section 152(b).

Comment: We received one comment related to our proposed treatment of Lehigh Valley Hospital's wage data under section 154(b) of Public Law 106–113. For FY 2001, Lehigh Valley Hospital was reclassified by the MGCRB to the Philadelphia MSA. The commenter argued that it was not Congress' intent that Lehigh Valley Hospital should be precluded from reclassifying.

The commenter also contended that the statutory language of section 154(b) could allow HCFA to permit Lehigh Valley Hospital to reclassify to Philadelphia, while the hospital's wage data would still be used to calculate the Allentown-Bethlehem-Easton MSA wage index. The commenter stated that by indicating this provision that Lehigh Valley ''shall be treated'' as being in the Allentown MSA, Congress did not intend to prohibit Lehigh Valley from reclassifying. If this had been Congress' intent, it would have been stated as such.

Response: In the proposed rule, we included Lehigh Valley Hospital's wage data in the wage index calculation for the Allentown-Bethlehem-Easton MSA. We also indicated that we believed the statutory language of section 154(b) required us to apply the Allentown-Bethlehem-Easton MSA wage index to Lehigh Valley Hospital for payments during FY 2001. However, we note that, despite the language of section 154(b), the MGCRB did reclassify Lehigh Valley Hospital to the Philadelphia MSA for FY 2001, and the HCFA Administrator did not reverse that decision. This has the effect of leaving stand the decision by the MGCRB to reclassify Lehigh Valley Hospital into the Philadelphia MSA for purposes of calculating and applying the Philadelphia wage index.

With respect to calculating the Allentown-Bethlehem-Easton MSA wage index, section 154(b) requires that we include Lehigh Valley Hospital's wage data in calculating the wage index for this MSA. We note that the provision is effective ''(n)otwithstanding any other provision of section 1886(d) of the Social Security Act.'' Therefore, although our normal policy is to remove the wage data of a hospital reclassified out of an area when calculating that area's wage index, section 154(b) directs us to include Lehigh's wage data in calculating the wage index for the A–B–E MSA.

2. Effects of Reclassification

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, except as discussed above, 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 redesignated hospitals 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 final wage index values for FY 2001 are shown in Tables 4A, 4B, 4C, and 4F in the Addendum to this final 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 area 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 area 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 area 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 1997 wage data. In addition, Table 3C in the Addendum to this final rule includes the adjusted average hourly wage for each hospital based on the FY 1997 data as of July 2000 (reflecting the phase-out of GME and CRNA wages as described at section III.C of this preamble). The MGCRB will use the average hourly wage published in this final rule to evaluate a hospital's application for reclassification for FY 2002 (unless that average hourly wage is later revised in accordance with the wage data correction policy described in § 412.63(w)(2)). We note that in adjudicating these wage index reclassifications the MGCRB will use the average hourly wages for each hospital and labor market area that are reflected in the final FY 2001 wage index.

We indicated in the proposed rule that, at the time the proposed wage index was constructed, the MGCRB had completed its review of FY 2001 reclassification requests. The final FY 2001 wage index values incorporate all 493 hospitals redesignated for purposes of the wage index (hospitals redesignated under section 1886(d)(8)(B) or 1886(d)(10) of the Act, and section 152(b) Public Law 106–113) for FY 2001). Since publication of the May 5 proposed rule, the number of reclassifications has changed because some MGCRB decisions were still under review by the Administrator and because some hospitals decided to withdraw their requests for reclassification.

Changes to the wage index that resulted from withdrawals of requests for reclassification, wage index corrections, appeals, and the Administrator's review process have been incorporated into the wage index values published in this final rule. The changes 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 is affected.

Comment: One commenter recommended that the average hourly wages shown in Tables 4D and 4E should be consistent with the values shown in Tables 4A and 4B. In support of this recommendation, the commenter suggested that, because our policy for computing the wage index values for urban areas excludes wages for hospitals that have reclassified to another area, the average hourly wages shown in Table 4D should be computed exclusive of the reclassified hospitals. The commenter believed the recommended change has the potential of impacting a hospital's efforts to reclassify because the hospital may not qualify based on the ''unadjusted'' hourly wage currently shown in Table 4D.

Response: As discussed above and in the May 5 proposed rule (65 FR 26301), the average hourly wages in Tables 4D and 4E reflect the labor market area average hourly wages before hospital redesignations. We provide the unadjusted rather than adjusted average hourly wages because the MGCRB must use unadjusted average hourly wages in determining a hospital's eligibility for reclassification. A hospital that wishes to apply for reclassification for the FY 2002 wage index (deadline is September 1, 2000) should use the average hourly wage data in Tables 3C, 4D, and 4E of the FY 2001 proposed and final rules to determine whether it meets the requirements for reclassification. With the exception of urban areas that receive the statewide rural wage index value, an urban area's adjusted average hourly wage may be calculated by multiplying the area wage index value in Table 4A by the national average hourly wage.

Comment: One commenter questioned whether the number of hospitals reclassified for the wage index for FY 2001 cited in the proposed rule (586) was accurate.

Response: The correct number of wage index reclassifications for FY 2001 at the time the proposed rule was published was 386. As stated above, the final number of wage index reclassifications is 490.

A. Wage Data Corrections

In the proposed rule, we stated that, to allow hospitals time to evaluate the wage data used to construct the proposed FY 2001 hospital wage index, we would make available in May 2000 a final public data file containing the FY 1997 hospital wage data.

The final wage data file was released on May 5, 2000. As noted above in section III.C. of this preamble, this file included hospitals' teaching survey data as well as cost report data. As with the file made available in February 2000, we made the final wage data file released in May 2000 available to hospital associations and the public (on the Internet). However, this file was made available only for the limited purpose of identifying any potential errors made by HCFA or the fiscal intermediary in the entry of the final wage data that the hospital could not have known about before the release of the final wage data public use file. It is not for the initiation of new wage data correction requests.

If, after reviewing the May 2000 final data file, a hospital believed that its wage data were incorrect due to a fiscal intermediary or HCFA error in the entry or tabulation of the final wage data, it was provided an opportunity to send a letter to both its fiscal intermediary and HCFA, outlining why the hospital believed an error exists and provide all supporting information, including dates. These requests had to be received by us and the intermediaries no later than June 5, 2000.

Changes to the hospital wage data were made only in those very limited situations involving an error by the intermediary or HCFA that the hospital could not have known about before its review of the final wage data file. Specifically, neither the intermediary nor HCFA accepted 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 3, 2000.
- Requests for correction of errors that were not, but could have been, identified during the hospital's review of the February 2000 wage data file.
- Requests to revisit factual determinations or policy interpretations made by the intermediary or HCFA during the wage data correction process.
- Verified corrections to the wage index received timely (that is, by June 5, 2000) are incorporated into the final wage index in this final rule, to be effective October 1, 2000.

We believe the wage data correction process provides hospitals with sufficient opportunity to bring errors in

their wage data to the intermediary's attention. Moreover, because hospitals had access to the final wage data by early May 2000, they had the opportunity to detect any data entry or tabulation errors made by the intermediary or HCFA before the development and publication of the FY 2001 wage index and its implementation on October 1, 2000. If hospitals avail themselves of this opportunity, the FY 2001 wage index implemented on October 1 should be free of these errors. Nevertheless, 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 2001 (that is, by the June 5, 2000 deadline). As indicated earlier, since a hospital had the opportunity to verify its data, and the intermediary notified 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.

Comment: One commenter expressed concern about the process used in preparing the final wage index data, especially teaching survey data. The commenter was concerned that errors would not be corrected before the publication of the final rule. Without providing specific information, the commenter further stated that it still believed that there were a number of ''omission errors in the data'' and that the situation would have been better handled if the data were corrected and reposted.

Response: We acknowledge the commenter's concern and reiterate that the purpose of making the wage data available for review on the Internet is to allow hospitals time to evaluate the wage data used in constructing the hospital wage index. We encourage hospitals to review their data and to address and resolve issues in dispute prior to the publication of the final wage index data file. We acknowledge that the teaching physician data submitted by several providers were not accurately reported in the public use wage index data file published on May 5, 2000. Once we became aware of the errors, we took the necessary steps to review and incorporate the appropriate data. The updated file was then made available on our Internet website at: http://www.hcfa.gov/medicare/ippsmain.htm.

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

A. Expanding the Transfer Definition to Include Postacute Care Discharges (§ 412.4)

In accordance with section 1886(d)(5)(I) of the Act, the prospective payment system distinguishes between ''discharges,'' situations in which a patient leaves an acute care (prospective payment) hospital after receiving complete acute care treatment, and ''transfers,'' situations in which the patient is transferred to another acute care hospital for related care. Our policy, as set forth in the regulations at § 412.4, provides that, in a transfer situation, full payment is made to the final discharging hospital and each transferring hospital is paid a per diem rate for each day of the stay, not to exceed the full DRG payment that would have been made if the patient had been discharged without being transferred.

Effective with discharges on or after October 1, 1998, section 1886(d)(5)(J) of the Act required the Secretary to define and pay as transfers all cases assigned to one of 10 DRGs (identified below) selected by the Secretary if the individuals are discharged to one of the following settings:

- A hospital or hospital unit that is not a subsection 1886(d) hospital. (Section 1886(d)(1)(B) of the Act identifies the hospitals and hospital units that are excluded from the term ''subsection (d) hospital'' as psychiatric hospitals and units, rehabilitation hospitals and units, children's hospitals, long-term care hospitals, and cancer hospitals.)
- A skilled nursing facility (as defined at section 1819(a) of the Act).
- Home health services provided by a home health agency, if the services relate to the condition or diagnosis for which the individual received inpatient hospital services, and if the home health services are provided within an appropriate period (as determined by the Secretary).

Therefore, any discharge from a prospective payment hospital from one of the selected 10 DRGs that is admitted to a hospital excluded from the prospective payment system on the date of discharge from the acute care hospital, on or after October 1, 1998, would be considered a transfer and paid accordingly under the prospective payment systems (operating and capital) for inpatient hospital services. Similarly, a discharge from an acute care inpatient hospital paid under the prospective payment system to a skilled nursing facility on the same date would be defined as a transfer and paid as such. We consider situations in which home health services related to the condition or diagnosis of the inpatient admission are received within 3 days after the discharge as a transfer.

The statute specifies that the Secretary select 10 DRGs based upon a high volume of discharges to postacute care and a disproportionate use of postacute care services. We identified the following DRGs with the highest percentage of postacute care:

- DRG 14 (Specific Cerebrovascular Disorders Except Transient Ischemic Attack (Medical))
- DRG 113 (Amputation for Circulatory System Disorders Except Upper Limb and Toe (Surgical))
- DRG 209 (Major Joint Limb Reattachment Procedures of Lower Extremity (Surgical))
- DRG 210 (Hip and Femur Procedures Except Major Joint Procedures Age >17 with CC (Surgical))
- DRG 211 (Hip and Femur Procedures Except Major Joint Procedures Age >17 without CC (Surgical))
- DRG 236 (Fractures of Hip and Pelvis (Medical))
- DRG 263 (Skin Graft and/or Debridement for Skin Ulcer or Cellulitis with CC (Surgical))
- DRG 264 (Skin Graft and/or Debridement for Skin Ulcer or Cellulitis without CC (Surgical))
- DRG 429 (Organic Disturbances and Mental Retardation (Medical))
- DRG 483 (Tracheostomy Except for Face, Mouth and Neck Diagnoses (Surgical))

Generally, we pay for transfers based on a per diem payment, determined by dividing the DRG payment by the average length of stay for that DRG. The transferring hospital receives twice the per diem rate the first day and the per diem rate for each following day, up to the full DRG payment. Of the 10 selected DRGs, 7 are paid under this method. However, three DRGs exhibit a disproportionate share of costs very early in the hospital stay. For these three DRGs, hospitals receive one-half of the DRG payment for the first day of the stay and one-half of the payment they would receive under the current transfer payment method, up to the full DRG payment.

As required by section 1886(d)(5)(J)(iv) of the Act, we included in the FY 2001 proposed rule published on May 5, 2000 (65 FR 26302), a description of the effect of the provision to treat as transfers cases that are assigned to one of the 10 selected DRGs and receive postacute care upon their discharge from the hospital. Under contract with HCFA (Contract No. 500–95–0006), Health Economics Research, Inc. (HER) conducted an analysis of the impact on hospitals and hospital payments of the postacute transfer provision. The analysis sought to obtain information on four primary areas: How hospitals responded in terms of their transfer practices; a comparison of payments and costs for these cases; whether hospitals are attempting to circumvent the policy by delaying postacute care or coding the patient's discharge status as something other than a transfer; and what the next possible step is for expanding the transfer payment policy beyond the current 10 selected DRGs or the current postacute destinations.

In addition, in accordance with section 1886(d)(5)(J)(iv)(I) of the Act, we included in the May 5, 2000 proposed rule for FY 2001 a discussion of whether other postdischarge services should be added to this postacute care transfer provision. Since FY 1999 was the first year this policy was effective and because of pending changes to payment policies for other postacute care settings such as hospital outpatient departments, we have limited data to assess whether additional postacute care settings should be included. We will continue to closely monitor this issue as more data become available.

In its analysis, HER relied on HCFA's Standard Analytic Files containing claims submission data through September 1999. However, the second and third quarter submissions for calendar year 1999 were not complete. It was decided that transfer cases would be identified by linking acute hospital discharges with postacute records based on Medicare beneficiary numbers and dates of discharge from the acute hospital with dates of admission or provision of service by the postacute provider. This method was used rather than selecting cases based on the discharge status code on the claim even though this code is being used for payment to these cases because we wanted to also assess how accurately hospitals are coding this status. However, the need to link acute and postacute episodes further limited the analytic data, due to the greater time lag for collecting postacute records. Therefore, much of HER's analysis focused on only the first two quarters of FY 1999. The two preceding fiscal years served as a baseline for purposes of comparison.

Since the publication of the May 5, 2000 proposed rule for FY 2001, HER has updated the results of its study of the impact on hospitals and hospital payments of the postacute transfer provision. In its revised analysis, HER found that the volume of postacute transfers qualifying for the lower per diem payment during the first 6 months of FY 1999 fell from 28 percent of total discharges under the 10 DRGs before the implementation of the payment change to 18 percent. It appears this decline was largely the result of a drop in the geometric mean length of stay in two high-volume DRGs (DRGs 14 and 209) that reduced the number of days qualifying a case for the per diem payment. In FY 1998, the geometric mean length of stay was 5.1 days for DRG 14 and 5.3 days for DRG 209. The geometric mean length of stay for both DRGs in FY 1999 was 4.9 days. To qualify for a per diem payment, a case's length of stay must be less than the DRG's geometric mean length of stay minus one day. Therefore, cases in these two DRGs with lengths of stay of five days were counted as qualified for per diem payments under the postacute care transfer rules in FY 1998 but not in FY 1999. Because DRGs 14 and 209 account for approximately 65 percent of the cases in the 10 DRGs, the drop in the threshold for qualifying cases contributed significantly to the magnitude of the decline in qualifying cases overall.

Correspondingly, HER found an increase in the volume and share of postacute transfers that did not qualify for the lower per diem payment. The share of long-stay postacute transfers paid under the full DRG amount (*e.g.,* those with a length of stay equal to at least one day less than the geometric mean length of stay minus one day) increased from 35 percent during the first half of FY 1998 to 43 percent during the first 6 months of FY 1999. Again, some of this increase is attributable to the drop in the geometric mean lengths of stay in DRGs 14 and 209.

According to HER, to some extent, the shift in the distribution of postacute transfers from qualifying to nonqualifying cases may suggest that hospitals have responded to the policy change by holding patients longer before releasing them to a postacute care provider. Total postacute transfers fell by 13 percent between the two payment periods, suggesting that hospitals may also have responded by resuming the provision of services that were previously performed by postacute care providers, resulting in an elimination of some postacute transfers. However, additional analysis would be necessary to separate the effects of the drop in the geometric mean length of stay from the hospital behavioral effects.

The study shows that the average length of stay of qualifying postacute transfers rose slightly between the two payment periods, from 4.16 days before the policy change to 4.33 days after. In contrast, the average length of stay of long-stay transfers and nontransfers for the same set of DRGs fell between the two 6-month study periods, by 15.9 and 16.6 percent, respectively. This indicates that, overall, hospitals were keeping cases slightly longer prior to transfer.

The figures on the impact of ''delayed'' transfers (for example, those patients transferred to a postacute care provider beyond the 1 or 3 day qualifying time period) remain unchanged. HER found little evidence that hospitals are responding to the policy change by increasing the time interval between prospective payment system discharge and postacute care admission or visit.

The study also did not find evidence that changes in prospective payment system hospital treatment and discharge behavior are resulting in increased lengths of stay or numbers of visits during the subsequent postacute care episode. Average lengths of stay and number of visits at postacute care providers following provider payment system discharge actually fell between the two payment periods. It is likely that any adverse effects of hospital behavior on patient care would have manifested itself in greater postacute care lengths of stay and number of visits following the implementation of the payment reform. HER found no evidence of this.

The average cost of qualifying postacute transfers rose in real terms by 2.4 percent after the policy change. According to HER, average profits for qualifying postacute transfers fell from $3,496 per case prior to the transfer policy change to $2,255 following the implementation of the payment reform. Average payments with adjustments for IME, DSH and outliers declined in real terms by 9.6 percent.

HER found that the postacute transfer policy resulted in a reduction in expenditures of $239 million during the first half of FY 1999. Annualized over a 1-year period, the policy reform lowered annual payments by an estimated $478 million. (In our estimate of the impacts of this policy, we estimated the total impact to be $480

million (63 FR 40977).) The estimated annual savings resulting from the policy change is equivalent to a 4.5 percent reduction in program expenditures in the 10 pilot DRGs and a 0.5 percent reduction in overall prospective payment system expenditures. The ''price'' effect (for example, holding hospital treatment and admission patterns constant) resulted in a savings of $276 million during the first half of FY 1999 (or an estimated $552 million annually). However, the decline in the number of transfers qualifying for the lower per diem, as well as the longer lengths of stay of short-stay postacute transfer cases, resulted in an offsetting reduction in savings of $37 million during the first 6 months of FY 1999 (or $74 million annually). As stated above, the combination of the positive ''price'' effect and the negative ''volume'' effect led to a net savings of $239 million during the first half of FY 1999 (or an estimated $478 million annually).

The study also examined the discharge destination codes as reported on the acute care hospital claims against postacute care transfers identified on the basis of a postacute care claim indicating the patient qualifies as a transfer. This analysis found that, in 1998, only 74 percent of transfer cases had discharge destination codes on the acute care hospital claim that were consistent with whether there was a postacute care claim for the case matching the date of discharge. In FY 1999, the year the postacute care transfer policy went into effect, this rate rose to 79 percent. This indicates that hospitals are improving the accuracy of coding transfer cases.

Transfers to hospitals or units excluded from the prospective payment system must have a discharge destination code (Patient Status) of 05. Transfers to a skilled nursing facility must have a discharge destination code of 03. Transfers to a home health agency must have a discharge destination code of 06. If the hospital's continuing care plan for the patient is not related to the purpose of the inpatient hospital admission, a condition code 42 must be entered on the claim. If the continuing care plan is related to the purpose of the inpatient hospital admission, but care did not start within 3 days after the date of discharge, a condition code 43 must be entered on the claim. The presence of either of these condition codes in conjunction with discharge destination code 06 will result in full payment rather than the transfer payment amount. We intend to closely monitor the accuracy of hospitals' discharge destination coding in this regard and take whatever steps are necessary to ensure that accurate payment is made under this policy.

Section 1886(d)(5)(J)(iv)(II) of the Act authorized but did not require the Secretary to include as part of the proposed rule additional DRGs to include under the postacute care transfer provision. As part of ''The President's Plan to Modernize and Strengthen Medicare for the 21st Century'' (July 2, 1999), the Administration committed to not expanding the number of DRGs included in the policy until FY 2003. Therefore, we did not propose any change to the postacute care settings or the 10 DRGs.

HER did undertake an analysis of how additional DRGs might be considered for inclusion under the policy. The analysis supports the initial 10 DRGs selected as being consistent with the nature of the Congressional mandate. According to HER, ''[t]he top 10 DRGs chosen initially by HCFA exhibit very large PAC [postacute care] levels and PAC discharge rates (except for DRG 264, Skin Graft and/or Debridement for Skin Ulcer or Cellulitis without CC, which was paired with DRG 263). All 10 appear to be excellent choices based on the other criteria as well. Most have fairly high short-stay PAC [postacute care] rates (except possibly for Strokes, DRG 14, and Mental Retardation, DRG 429).''

Extending the policy beyond these initial DRGs, however, may well require more extensive analysis and grouping of like-DRGs. One concern raised in the analysis relates to single DRGs including multiple procedures with varying lengths of stay. Because the transfer payment methodology only considers the DRG overall geometric mean length of stay for a DRG, certain procedures with short lengths of stay relative to other procedures in the same DRG may be more likely to be treated as transfers. The analysis also considers pairs of DRGs, such as DRGs 263 and 264, as well as larger bundles of DRGs (grouped by common elements such as trauma, infections, and major organ procedures). According to HER, ''[i]n extending the PAC transfer policy, it is necessary to go beyond the flawed concept of a single DRG to discover multiple DRGs with a common link that exhibit similar PAC statistics. Aggregation of this sort provides a logical bridge in expanding the PAC transfer policy that is easily justified to Congress and that avoids unintended inequities in the way DRGs-and potentially hospitals-are treated under this policy. Hospitals can be inadvertently penalized or not under the current implementation criteria due to systematic differences in the DRG mix.''

Finally, the HER report concludes with a discussion of the issues related to potentially expanding the postacute care transfer policy to all DRGs. On the positive side, HER points to the benefits of expanding the policy to include all DRGs:

- A simple, uniform formula-driven policy;
- Same policy rationale exists for all DRGs-the statutory provision requiring the Secretary to select only 10 DRGs was a political compromise;
- DRGs with little utilization of short-stay postacute care would not be harmed by the policy;
- Less confusion in discharge destination coding; and
- Hospitals that happen to be disproportionately treating the current 10 DRGs may be harmed more than hospitals with an aggressive short-stay postacute care transfer policy for other DRGs.

According to HER, the negative implications of expanding the policy to all DRGs include:

- The postacute care transfer policy is irrelevant for many DRGs;
- Added burden for the fiscal intermediaries to verify discharge destination codes;
- Diluted program savings beyond the initial 10 DRGs;
- Difficulty in identifying ongoing postacute care that resumes after discharge; and
- Heterogeneous procedures within single DRGs having varying lengths of stay.

The HER report in final format may be obtained from the HCFA website at: http://www.hcfa.gov/medicare/ippsmain.htm

Comment: One commenter observed that in our discussion in the proposed rule (65 FR 26303) of postacute care transfers to a skilled facility, we stated that ''(t)his would include cases discharged from one of the 10 selected DRGs to a designated swing bed for skilled nursing facilities.'' The commenter believed that HCFA clearly excluded swing bed transfers from the postacute care transfer policy in the July 31, 1998 final rule and asked for clarification.

Response: The commenter is correct that we excluded swing bed transfers from the postacute care transfer policy in the July 31, 1998 final rule (63 FR 40977). We are not changing the policy to include swing beds at this time. The sentence in question was inadvertently included in the proposed rule.

Comment: One commenter believed the transfer policy is contrary to the

design of the prospective payment system and penalizes clinical decision making by physicians in discharging their patients to the appropriate level of care. The commenter suggested that the HER study shows that the net outcome of the policy has been to pay hospitals less and increase the complexity and administrative costs of the inpatient prospective payment system. The commenter cited the disadvantages of expanding the policy to all DRGs set forth in the HER report and recommended that the Administration revisit this policy in light of the findings of the researchers that care, not finances, is driving the length of stay in these cases.

Response: We disagree with the commenter that the postacute transfer policy penalizes clinical decisionmaking by physicians in discharging their patients to the appropriate level of care, but rather believe that the policy appropriately adjusts payments to hospitals to reflect the amount of care actually provided in the acute care setting. Furthermore, this policy does not require a change in physician clinical decisionmaking nor in the manner in which physicians and hospitals practice medicine. It simply addresses the appropriate level of payments once those decisions have been made.

With respect to whether the provision is contrary to the original intent of the prospective payment system, we believe it is entirely consistent with the following statement made in the **Federal Register** during the first year of the prospective payment system in response to a comment concerning the hospital-to-hospital transfer policy: ''(t)he rationale for per diem payments as part of our transfer policy is that the transferring hospital generally provides only a limited amount of treatment. Therefore, payment of the full prospective payment rate would be unwarranted'' (49 FR 244). We also note that in its earliest update recommendations, the Prospective Payment Assessment Commission (MedPAC's predecessor organization) included what it called a site-of-service substitution adjustment to account for the shifting of portions of inpatient care to other settings. We believe this provision is an appropriate and consistent response to the changing treatment practice of the hospital industry.

Though we are not expanding the policy to include all DRGs at this time, HER points to advantages as well as the disadvantages cited by the commenter of doing so, including:

- A simple, uniform formula-driven policy;
- Same policy rationale exists for all DRGs—the statutory provision requiring the Secretary to select only 10 DRGs was a political compromise;
- DRGs with little utilization of short-stay postacute care would not be harmed by the policy;
- Less confusion in discharge destination coding; and
- Hospitals that happen to be disproportionately treating the current 10 DRGs may be harmed more than hospitals with an aggressive short-stay postacute care transfer policy for other DRGs.

Finally, we also believe that care, not finances, should drive the length of stay and all other clinical decisions in these cases, and that payments should be aligned with the care given in each provider setting.

Comment: One commenter agreed with our decision to not expand the number of DRGs subject to the postacute transfer policy. The commenter believed that the policy should be revoked because the cost savings have far exceeded the estimates relied on in developing the policy and, more fundamentally, because it violates the notion of averaging that is at the heart of an appropriate prospective payment system. The commenter also believed that the introduction of prospective payment in virtually all postacute settings obviates the need for this expansion of transfer policy.

The commenter stated that the use of the geometric mean length of stay to determine the payment amount does not fully consider the medical practice patterns of physicians in different regions of the country and appears to penalize those areas that already achieved a lower length of stay.

Response: Since updating its study after the proposed rule was published, HER reports that the policy resulted in savings of $478 million, remarkably close to our estimate of $480 million published in the July 31, 1998 final rule (63 FR 40977). Furthermore, as we stated in our previous response, we believe that the policy is entirely consistent with the original intent of the prospective payment system.

We disagree with the commenter's belief that the introduction of prospective payment systems to postacute settings obviates the need for the transfer policy. The purpose of the policy is to align payments with the care actually provided in the inpatient setting. The policy is particularly appropriate for areas of the country where care has been more aggressively shifted from acute to postacute settings.

B. Sole Community Hospitals (SCHs)(§§ 412.63, 412.73, and 413.75, proposed new § 412.77, and § 412.92)

Under the hospital inpatient prospective payment system, special payment protections are provided to sole community hospitals (SCHs). Section 1886(d)(5)(D)(iii) of the Act defines an SCH as, among other things, a hospital that, by reason of factors such as isolated location, weather conditions, travel conditions, or absence of other hospitals (as determined by the Secretary), is the sole source of inpatient hospital services reasonably available to Medicare beneficiaries. The regulations that set forth the criteria a hospital must meet to be classified as an SCH are located at § 412.92(a).

Currently SCHs are paid based on whichever of the following rates yields the greatest aggregate payment to the hospital for the cost reporting period: The Federal national rate applicable to the hospital; or the hospital's ''target amount''—that is, either the updated hospital-specific rate based on FY 1982 costs per discharge, or the updated hospital-specific rate based on FY 1987 costs per discharge.

Section 405 of Public Law 106–113, which amended section 1886(b)(3) of the Act, provides that an SCH that was paid for its cost reporting period beginning during 1999 on the basis of either its FY 1982 or FY 1987 target amount (the hospital-specific rate as opposed to the Federal rate) may elect to receive payment under a methodology using a third hospital-specific rate based on the hospital's FY 1996 costs per discharge. This amendment to the statute means that, for cost reporting periods beginning on or after October 1, 2000, eligible SCHs can elect to use the allowable FY 1996 operating costs for inpatient hospital services as the basis for their target amount, rather than either their FY 1982 or FY 1987 costs.

We are aware that language in the Conference Report accompanying Public Law 106–113 indicates that the House bill (H.R. 3075) would have permitted SCHs that were being paid the Federal rate to rebase, not SCHs that were paid on the basis of either their FY 1982 or FY 1987 target amount (H.R. Conf. Rep. No. 106–479, 106th Cong., 1st Sess. at 890 (1999)). The language of the section 405 amendment to section 1886(b)(3) (which added new subparagraph (I)(ii)) clearly limits the option to substitute the FY 1996 base year to SCHs that were paid for their cost reporting periods beginning during 1999 on the basis of the target amount applicable to the hospital under section 1886(b)(3)(C).

In the May 5 proposed rule, we proposed that, when calculating an eligible SCH's FY 1996 hospital-specific rate, we utilize the same basic methodology used to calculate FY 1982 and FY 1987 bases. That methodology is set forth in §§ 412.71 through 412.75 of the regulations and discussed in detail in several prospective payment system documents published in the **Federal Register** on September 1, 1983 (48 FR 3977); January 3, 1984 (49 FR 256); June 1, 1984 (49 FR 23010); and April 20, 1990 (55 FR 15150).

Since we anticipate that eligible hospitals will elect the option to rebase using their FY 1996 cost reporting periods, we proposed that our fiscal intermediaries would identify those SCHs that were paid for their cost reporting periods beginning during 1999 on the basis of their target amounts. For these hospitals, fiscal intermediaries would calculate the FY 1996 hospital-specific rate as described below in this section IV.B. If this rate exceeds a hospital's current target amount based on the greater of the FY 1982 or FY 1987 hospital-specific rate, the hospital will receive payment based on the FY 1996 hospital-specific rate (based on the blended amounts described at section 1886(b)(3)(I)(i) of the Act) unless the hospital notifies its fiscal intermediary in writing prior to the end of the cost reporting period that it does not wish to be paid on the basis of the FY 1996 hospital-specific rate. Thus, if a hospital does not notify its fiscal intermediary before the end of the cost reporting period that it declines the rebasing option, we would deem the lack of such notification as an election to have section 1886(b)(3)(I) of the Act apply to the hospital.

We further proposed that an SCH's decision to decline this option for a cost reporting period will remain in effect for subsequent periods until such time as the hospital notifies its fiscal intermediary otherwise.

The FY 1996 hospital-specific rate will be based on FY 1996 cost reporting periods beginning on or after October 1, 1995 and before October 1, 1996, that are 12 months or longer. If the hospital's last cost reporting period ending on or before September 30, 1996 is less than 12 months, the hospital's most recent 12-month or longer cost reporting period ending before the short period report would be utilized in the computations. If a hospital has no cost reporting period beginning in FY 1996, it would not have a hospital-specific rate based on FY 1996.

For each hospital eligible for FY 1996 rebasing, the fiscal intermediary will calculate a hospital-specific rate based on the hospital's FY 1996 cost report as follows:

- Determine the hospital's total allowable Medicare inpatient operating cost, as stated on the FY 1996 cost report.
- Divide the total Medicare operating cost by the number of Medicare discharges in the cost reporting period to determine the FY 1996 base period cost per case. For this purpose, transfers are considered to be discharges.
- In order to take into consideration the hospital's individual case-mix, divide the base year cost per case by the hospital's case-mix index applicable to the FY 1996 cost reporting period. This step is necessary to standardize the hospital's base period cost for case-mix and is consistent with our treatment of both FY 1982 and FY 1987 base-period costs per case. A hospital's case-mix is computed based on its Medicare patient discharges subject to DRG-based payment.

We proposed that the fiscal intermediary will notify eligible hospitals of their FY 1996 hospital-specific rate prior to October 1, 2000. Consistent with our policies relating to FY 1982 and FY 1987 hospital-specific rates, we proposed to permit hospitals to appeal a fiscal intermediary's determination of the FY 1996 hospital-specific rate under the procedures set forth in 42 CFR part 405, subpart R, which concern provider payment determinations and appeals. In the event of a modification of base period costs for FY 1996 rebasing due to a final nonappealable court judgment or certain administrative actions (as defined in § 412.72(a)(3)(i)), the adjustment would be retroactive to the time of the intermediary's initial calculation of the base period costs, consistent with the policy for rates based on FY 1982 and FY 1987 costs.

Section 405 prescribes the following formula to determine the payment for SCHs that elect rebasing:

For discharges during FY 2001:

- 75 percent of the updated FY 1982 or FY 1987 former target (identified in the statute as the ''subparagraph (C) target amount''), plus
- 25 percent of the updated FY 1996 amount (identified in the statute as the ''rebased target amount'').

For discharges during FY 2002:

- 50 percent of the updated FY 1982 or FY 1987 former target, plus
- 50 percent of the updated FY 1996 amount.

For discharges during FY 2003:

- 25 percent of the updated FY 1982 or FY 1987 former target, plus
- 75 percent of the updated FY 1996 amount.

For discharges during FY 2004 or any subsequent fiscal year, the hospital-specific rate would be determined based on 100 percent of the updated FY 1996 amount.

We proposed to add a new § 412.77 and amend § 412.92(d) to incorporate the provisions of section 1886(b)(3)(I) of the Act, as added by section 405 of Public Law 106–113.

Section 406 of Public Law 106–113 amended section 1886(b)(3)(B)(i)(XVI) of the Act to provide, for fiscal year 2001, for full market basket updates to both the Federal and hospital-specific payment rates applicable to sole community hospitals. In the May 5 proposed rule, we proposed to amend §§ 412.63, 412.73, and 412.75 to incorporate the amendment made by section 406 of Public Law 106–113.

We received several public comments on our proposal.

Comment: Several commenters discussed the difference between the language in the statutory provision, which limits the updated 1996-rebasing option to SCHs that were paid on the basis of their target amount (hospital specific rate) in 1999, and the language of the accompanying Conference report (H.R. Conf. Rep. No. 106–479, 106th Cong., 1st Sess. at 890 (1999)). The Conference report indicated that the House bill (H.R. 3075) would have permitted SCHs that were being paid the Federal rate to rebase rather than SCHs that were paid on the basis of either their FY 1982 or FY 1987 target amount. One commenter, in particular, believed that despite the clear statutory language, HCFA had the ability to allow leeway in determining which hospitals were eligible to elect 1996 rebasing. In support of this view, the commenter made the assertion that the Federal rate used in SCH payment computations included outlier and disproportionate share payments (DSH) as well as other special provisions. Therefore, the hospital-specific rate should be compared to the base Federal rate of the geographic area, without the add-ons, to determine which amount would yield the largest payment. Additionally, the total Federal payments on the hospital's cost report may exceed the hospital-specific payments in some years, while falling below them in other years because of the potential fluctuations of outliers and DSH payments. The commenter argued, therefore, that to determine whether an SCH is to be paid on the basis of the target amount, hospital-specific payments should be compared to the base Federal payments without the addition of outliers and DSH payments.

Response: We disagree with the commenter's argument. The commenter is correct in saying that in any one year, the target amount may be exceeded by calculations of the Federal rate. This is the reason why the calculation is done yearly, so that the hospital may receive the highest possible payment for that specific year based on a comparison of what each payment scheme would generate for the hospital. The statute clearly states the rebasing option is available to an SCH that, for its cost reporting period beginning on or after October 1, 2000, is paid on the basis of the target amount. As we stated in the proposed rule, we are aware of the difference between this rebasing plan set forth in section 405 of Public Law 106–113 and the one described in the Conference Report, but the unambiguous language of the statute controls over the language of the Conference Report.

Comment: One commenter pointed to an inconsistency between the text of proposed § 412.77 and the preamble to the proposed rule. The preamble stated that, in the absence of notification to the contrary from the hospital, the intermediary will base payment on the 1996 hospital specific rate, if this rate exceeds the 1982 or 1987 hospital-specific rate. The proposed regulation language at § 412.77(a) indicated that, in the absence of notification, the hospital payment would be based on the 1996 hospital specific rate without the qualification that this rate would need to exceed the 1982 or 1987 base year rates.

Response: We believe that the commenter's concern about inconsistency may stem from a typographical error that appeared in the text of proposed § 412.77 in the proposed rule, that incorrectly referenced § 412.72, rather than revised § 412.92. The payment determination formula used for SCHs is set forth in § 412.92(d), which has been revised to include the 1996 rebasing option. That formula clearly states that an SCH is paid based on whichever yields the greatest aggregate payment for the cost reporting period: the Federal payment rate, the 1982 or 1987 hospital-specific rate, or the 1996 hospital-specific rate. We have deleted the incorrect reference to § 412.72. In addition, for the sake of clarity, we have added a sentence to § 412.77(a)(1), further modified § 412.92(d)(1), and added a new § 412.92(d)(2) (the existing paragraph (d)(2) is redesignated as paragraph (d)(3)).

Comment: One commenter disagreed with the proposal that the intermediary should include the 1996 hospital specific rate in its payment calculations it if it is higher than either the 1982 or 1987 hospital specific rates, in the absence of notification to the contrary. Rather, the commenter suggested that an eligible hospital be required to state its choice to be paid on this basis.

Response: We believe that it is more efficient from an administrative standpoint to require a hospital to notify its fiscal intermediary if it chooses not to receive payment based on the (higher) FY 1996 hospital-specific rate. The only time that a hospital that is eligible for rebasing will be paid based on its 1996 amount is if that amount is higher than either the 1982 or 1987 hospital specific rates and also higher than the Federal rate. We do not know why a hospital would elect not to receive payment based on the highest of its possible choices. Therefore, rather than requiring a hospital to provide written notification to the fiscal intermediary when its FY 1996 hospital-specific rate is higher than its FY 1982 and FY 1987 hospital-specific rates, we deem the hospital to have made an election to be paid based on the FY 1996 hospital-specific rate, unless it notifies its fiscal intermediary otherwise.

Comment: Two commenters requested a clarification as to the proposed timing for a hospital that is eligible for payment based on its 1996 hospital-specific rate to notify its intermediary of its intention not to elect payment based on this rate.

Response: We agree that in the proposed rule the preamble and the proposed regulation language were contradictory. Accordingly, we are revising § 412.77(a)(2) to require that an eligible hospital must notify its intermediary of its intent not to elect payment based on its FY 1996 hospital-specific rate prior to the end of the cost reporting period for which the payments would otherwise be made. This schedule will allow hospitals an opportunity to consider their options.

C. Rural Referral Centers (§ 412.96)

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

As discussed in 62 FR 45999 and 63 FR 26317, under section 4202 of Public Law 105–33, a hospital that was classified as an RRC for FY 1991 is to be classified as an RRC for FY 1998 and later years so long as that hospital continued to be located in a rural area and did not voluntarily terminate its RRC status. Otherwise, a hospital seeking RRC status must satisfy applicable criteria. One of the criteria under which a hospital may qualify as an RRC is to have 275 or more beds available for use. A rural hospital that does not meet the bed size requirement can qualify as an RRC if the hospital meets two mandatory prerequisites (specifying a minimum case-mix index and a minimum number of discharges) and at least one of three optional criteria (relating to specialty composition of medical staff, source of inpatients, or referral volume). With respect to the two mandatory prerequisites, a hospital may be classified as an RRC 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 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 RRC status. The methodology we use to determine the 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 for FY 2001 in the May 5 proposed rule included all urban hospitals nationwide, and the 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 were based on discharges occurring during FY 1999 (October 1, 1998 through September 30, 1999) and include bills posted to HCFA's records through March 2000.

We proposed that, in addition to meeting other criteria, hospitals with fewer than 275 beds, if they are to qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2000, must have a case-mix index value for FY 1999 that is at least—

- 1.3408; 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. (See the table set forth in the May 5, 2000 proposed rule at 65 FR 26306.)

Based on the latest data available (FY 1999 bills received through March 31, 2000), the median case-mix values by region are set forth in the table below.

Region	Case-mix index value
1. New England (CT, ME, MA, NH, RI, VT)	1.2289
2. Middle Atlantic (PA, NJ, NY)	1.2385
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.3113
4. East North Central (IL, IN, MI, OH, WI)	1.2623
5. East South Central (AL, KY, MS, TN)	1.2661
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.1822
7. West South Central (AR, LA, OK, TX)	1.2813
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.3250
9. Pacific (AK, CA, HI, OR, WA)	1.3036

For the benefit of hospitals seeking to qualify as RRCs or those wishing to know how their case-mix index value compares to the criteria, we are publishing each hospital's FY 1999 case-mix index value in Table 3C in section VI. of the Addendum to this final 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 RRC status. As specified in section 1886(d)(5)(C)(ii) of the Act, the national standard is set at 5,000 discharges. However, in the May 5 proposed rule, we proposed to update the regional standards. The proposed regional standards were based on discharges for urban hospitals' cost reporting periods that began during FY 1998 (that is, October 1, 1997 through September 30, 1998). That is the latest year for which we have complete discharge data available.

Therefore, we proposed that, in addition to meeting other criteria, a hospital, if it is to qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2000, must have as the number of discharges for its cost reporting period that began during FY 1999 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. (See the table set forth in the May 5, 2000 proposed rule at 65 FR 26307.)

Based on the latest discharge data available for FY 1999, the final median number of discharges for urban hospitals by census region areas are as follows:

Region	Number of discharges
1. New England (CT, ME, MA, NH, RI, VT)	6,725
2. Middle Atlantic (PA, NJ, NY)	8,736
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	7,911
4. East North Central (IL, IN, MI, OH, WI)	7,661
5. East South Central (AL, KY, MS, TN)	6,883
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	5,829
7. West South Central (AR, LA, OK, TX)	5,385
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	8,026
9. Pacific (AK, CA, HI, OR, WA)	6,268

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.

We reiterate that an osteopathic hospital, if it is to qualify for RRC status for cost reporting periods beginning on or after October 1, 2000, must have at least 3,000 discharges for its cost reporting period that began during FY 1999.

We did not receive any comments on the RRC criteria.

D. Indirect Medical Education (IME) 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.

Section 111 of Public Law 106–113 modified the transition for the IME adjustment that was established by Public Law 105–33. We are publishing these changes in a separate interim final rule with comment period that appears elsewhere in this issue of the **Federal Register**. However, for discharges occurring during FY 2001, the adjustment formula equation used to calculate the IME adjustment factor is $1.54 \times [(1+r)^{.405} - 1]$. (The variable r represents the hospital's resident-to-bed ratio.)

In the proposed rule, we inadvertently omitted the revised transition for the IME adjustment for FYs 2002 and thereafter. Specifically, for discharges occurring on or after October 1, 2001, the adjustment formula equation used to calculate the IME adjustment factor is $1.35 \times [(1+r)^{.405} - 1]$. We are adding a new § 412.105(d)(3)(vi) to reflect this change.

In the July 30, 1999 final rule (64 FR 41517), we set forth certain policies that affected payment for both direct and indirect GME. These policies related to adjustments to full-time equivalent (FTE) resident caps for new medical residency programs affecting both direct and indirect GME programs; the adjustment to GME caps for certain hospitals under construction prior to August 5, 1997 (the enactment date of Public Law 105–33) to account for residents in new medical residency training programs; and the temporary adjustment to FTE caps to reflect residents affected by hospital closures. When we amended the regulations under § 413.86 for direct GME, we inadvertently did not make the corresponding changes in § 412.105 for IME. In the May 5 proposed rule, we proposed to make the following conforming changes:

- To amend § 412.105(f)(1)(vii) to provide for an adjustment to the FTE caps for new medical residency programs as specified under § 413.86(g)(6).
- To add a new § 412.105(f)(1)(viii) related to the adjustment to the FTE caps for newly constructed hospitals that sponsor new residency programs in effect on or after January 1, 1995, and on or before August 5, 1997, that either received initial accreditation by the appropriate accrediting body or temporarily trained residents at another hospital(s) until the facility was completed, to conform to the provisions of § 413.86(g)(7).
- To add a new § 412.105(f)(1)(ix) to specify that a hospital may receive a

temporary adjustment to its FTE cap to take into account residents added because of another hospital's closure if the hospital meets the criteria listed under § 413.86(g)(8).

In addition, we proposed to add a cross-reference to ''§ 413.86(d)(3)(i) through (v)'' in § 412.105(g), and to correct the applicable period in both §§ 412.105(g) and 413.86(d)(3) by revising the phrase ''For portions of cost reporting periods beginning on or after January 1, 1998'' to read ''For portions of cost reporting periods occurring on or after January 1, 1998''.

We received one public comment on the proposed changes to the IME regulations.

Comment: One commenter recommended that the temporary adjustment allowed to a hospital's FTE cap under the proposed § 412.105(f)(1)(ix) to account for residents added because of another hospital's closure should be a permanent adjustment to maintain the current level of trainees.

Response: In the proposed rule, we were merely making a conforming change to the IME regulations based on a change in the GME regulations in the July 30, 1999 final rule. As indicated in the July 30, 1999 final rule (65 FR 41522), we continue to believe that, when a hospital assumes the training of additional residents because of another hospital's closure, an adjustment to the hospital's FTE cap should only be available for the period of time necessary to train those displaced residents. At that time we provided for the temporary adjustment because of hospitals' reluctance to accept additional residents from a closed hospital without a temporary adjustment to their caps. We do not believe currently there is justification for a permanent adjustment because of the temporary training provisions for the displaced residents.

E. Payments to DSH Hospitals (§ 412.106)

1. Changes to the DSH Formula

Effective for discharges beginning on or after May 1, 1986, hospitals that treat a disproportionately large number of low-income patients (as defined in section 1886(d)(5)(F) of the Act) receive additional payments through the DSH adjustment. Section 4403(a) of Public Law 105–33 amended section 1886(d)(5)(F) of the Act to reduce the payment a hospital would otherwise receive under the current DSH formula by 1 percent for FY 1998, 2 percent for FY 1999, 3 percent for FY 2000, 4 percent for FY 2001, 5 percent for 2002, and 0 percent for FY 2003 and each subsequent fiscal year. Subsequently, section 112 of Public Law 106–113 modified the amount of the reductions under Public Law 105–33 by changing the reduction to 3 percent for FY 2001 and 4 percent for FY 2002. The reduction continues to be 0 percent for FY 2003 and each subsequent fiscal year. In the May 5 proposed rule, we proposed to revise § 412.106(e) to reflect the changes in the statute made by Public Law 106–113.

Section 112 of Public Law 106–113 also directs the Secretary to require prospective payment system hospitals to submit data on the costs incurred by the hospitals for providing inpatient and outpatient hospital services for which the hospitals are not compensated, including non-Medicare bad debt, charity care, and charges for medical and indigent care to the Secretary as part of hospitals' cost reports. These data are required for cost reporting periods beginning on or after October 1, 2001. We will be revising our instructions to hospitals for cost reports for FY 2002 to capture these data.

Comment: Several commenters provided positive reinforcement concerning the impending collection of uncompensated care data via offers of assistance in this effort. Also, commenters made the point that, at this time, uncompensated care does not have a common national definition.

Response: We are aware that uncompensated care does not currently have a common national definition. One of our tasks will be to define the reporting parameters so that the data will be reported in a uniform manner. This is the main reason that we have not sought to use uncompensated care data in the Medicare DSH adjustment calculation in the past. We will keep these comments in mind as we proceed.

Comment: One commenter was concerned about the pending publication of the Report to Congress on the Medicare DSH formula. This commenter asked HCFA to complement its data collection efforts by issuing the report as required by Public Law 105–33.

Response: We are in the process of completing this report and intend to submit it to Congress in the near future.

2. DSH Adjustment Calculation: Change in the Treatment of Certain Medicaid Patient Days in States With Section 1115 Expansion Waivers

On January 20, 2000, we published in the **Federal Register** an interim final rule with comment period (65 FR 3136) to implement a change in the Medicare DSH adjustment calculation policy in reference to section 1115 expansion waiver days. That interim final rule set forth criteria to use in calculating the Medicare DSH adjustment for hospitals for purposes of payment under the prospective payment system.

Under section 1886(d)(5)(F) of the Act, an adjustment is made to the hospital's inpatient prospective payment system payment for serving a disproportionate share of low-income or Medicaid and Medicare patients. The size of a hospital's Medicare DSH adjustment is based on the sum of the percentage of patient days attributable to patients eligible for both Medicare Part A and Supplemental Security Income (SSI) and the percentage of patient days attributable to patients eligible for Medicaid but not Medicare Part A.

Some States provide medical assistance (Medicaid) under a demonstration project (also referred to as a section 1115 waiver).

Under policy in existence before the January 20, 2000 interim final rule, hospitals were to include in the Medicare DSH calculation only those days for populations under the section 1115 waiver who were or could have been made eligible under a State Medicaid plan. Patient days of the expanded eligibility groups, however, were not to be included in the Medicare DSH calculation.

In the January 20, 2000 interim final rule with comment period, we revised the policy, effective with discharges occurring on or after January 20, 2000, to allow hospitals to include the patient days of all populations eligible for Title XIX matching payments in a State's section 1115 waiver in calculating the hospital's Medicare DSH adjustment. This policy was reflected in a revision to § 412.106 of the regulations.

We received 11 public comments on the inclusion of Section 1115 waiver days in the Medicare disproportionate share adjustment calculation.

Comment: Several commenters were concerned with the inclusion in the January 20, 2000 interim final rule with comment period of expansion waiver days in the Medicaid portion of the Medicare DSH adjustment calculation. States without a Medicaid expansion waiver in place believed that States that did have a Medicaid expansion waiver in place received an unfair advantage. In addition, comments from Pennsylvania hospitals supported the continued inclusion of general assistance days in the Medicaid portion of the Medicare DSH adjustment calculation as well as expansion waiver days. Finally, some commenters urged HCFA to revise the

Medicare DSH adjustment calculation to include charity care days.

Response: While we initially determined that States under a Medicaid expansion waiver could not include those expansion waiver days as part of the Medicare DSH adjustment calculation, we have since consulted extensively with Medicaid staff and have determined that section 1115 expansion waiver days are utilized by patients whose care is considered to be an approved expenditure under Title XIX. While this does advantage States that have a section 1115 expansion waiver in place, these days are considered to be Title XIX days by Medicaid standards.

Some States operate under a section 1115 waiver without an expansion (for example, Arizona). The days that are utilized by patients under the section 1115 waiver are already part of the Medicaid portion of the Medicare DSH adjustment calculation because the section 1115 waiver includes patients who otherwise would have been eligible for Medicaid Title XIX.

General assistance days are days for patients covered under a State-only or county-only general assistance program, whether or not any payment is available for health care services under the program. Charity care days are those days that are utilized by patients who cannot afford to pay and whose care is not covered or paid by any health insurance program. While we recognize that these days may be included in the calculation of a State's Medicaid DSH payments, these patients are not Medicaid-eligible under the State plan and are not considered Title XIX beneficiaries. Therefore, Pennsylvania, and other States that have erroneously included these days in the Medicare disproportionate share adjustment calculation in the past, will be precluded from including such days in the future. We would like to point out that these States were held harmless from adverse action in this matter for any cost reporting period beginning prior to December 31, 1999. We are in the process of preparing a Report to Congress on the Medicare DSH adjustment calculation which presents various options for calculating the adjustment.

Comment: One commenter was concerned about the inclusion of days in the Medicaid portion of the Medicare DSH adjustment calculation for additional States that are approved for expansion waivers in the future. Also, this commenter questioned whether or not the expenditures related to the expansion waiver days for Medicare DSH would be considered in the budget neutrality evaluation prior to approval of the expansion waiver application.

Response: As stated in the January 20, 2000 interim final rule with comment period, days utilized under section 1115 expansion waivers will be included in the Medicaid portion of the Medicare DSH adjustment calculation. As a result, the days utilized under any approved section 1115 expansion waiver in the future would be included in this calculation. However, the State will not be held accountable for the expenditures associated with Medicare DSH in the budget neutrality test for the section 1115 expansion waiver, as those payments are made from the Medicare program, not the Medicaid program.

Comment: Several commenters were concerned that the inclusion of section 1115 expansion waiver days was effective on January 20, 2000, rather than on January 1, 2000. These same commenters pointed out that the hold harmless provisions of Program Memorandum A–99–62 (December 1999) concern hospitals whose cost reporting periods begin on or prior to December 31, 1999. Therefore, many hospitals may be paid differently during different periods of the same cost report.

Response: We understand that discharges prior to January 20, 2000 will be handled one way, and discharges as of January 20, 2000 may be paid differently. While we can enforce an existing policy for a previous time period, we do not believe we can retroactively institute new policy.

F. Medicare Geographic Classification Review Board (§§ 412.256 and 412.276)

With the creation of the Medicare Geographic Classification Review Board (MGCRB), beginning in FY 1991, under section 1886(d)(10) of the Act, hospitals could request reclassification from one geographic location to another for the purpose of using the other area's standardized amount for inpatient operating costs or the wage index value, or both (September 6, 1990 interim final rule with comment period (55 FR 36754), June 4, 1991 final rule with comment period (56 FR 25458), and June 4, 1992 proposed rule (57 FR 23631)). Implementing regulations in Subpart L of Part 412 (§ 412.230 *et seq.*) set forth criteria and conditions for redesignations from rural to urban, rural to rural, or from an urban area to another urban area with special rules for SCHs and RRCs.

1. Provisions of Public Law 106–113

Section 401 of Public Law 106–113 amended section 1886(d)(8) of the Act by adding subparagraph (E), which creates a mechanism, separate and apart from the MGCRB, permitting an urban hospital to apply to the Secretary to be treated as being located in the rural area of the State in which the hospital is located. The statute directs the Secretary to treat a qualifying hospital as being located in a rural area for purposes of provisions under section 1886(d) of the Act. In addition, section 401 of Public Law 106–113 went on to provide for such reclassifications from urban to rural for purposes of Medicare payments to outpatient departments and to hospitals that would qualify to become critical access hospitals.

Regulations implementing section 1886(d)(8)(E) of the Act are included in an interim final rule with comment period implementing certain provisions of Public Law 106–111 published elsewhere in this issue of the **Federal Register**. The statutory language of section 1886(d)(8)(E) of the Act does not address the issue of interactions between changes in classification under section 1886(d)(8)(E) of the Act and the MGCRB reclassification process under section 1886(d)(10) of the Act. The Secretary has extremely broad authority under section 1886(d)(10) of the Act to establish criteria for reclassification under the MGCRB process. Section 401 of Public Law 106–113 does not amend section 1886(d)(10) of the Act to limit the agency's discretion under the provision in any way, nor does section 1886(d)(8)(E) of the Act (as added by section 401) refer to section 1886(d)(10) of the Act. However, we note that in the Conference Report accompanying Public Law 106–113, the language discussing the House bill (H.R. 3075, as passed) indicates that: ''[H]ospitals qualifying under this section shall be eligible to qualify for all categories and designations available to rural hospitals, including sole community, Medicare dependent, critical access, and referral centers. Additionally, qualifying hospitals shall be eligible to apply to the Medicare Geographic Reclassification Review Board for geographic reclassification to another area''.

In the May 5, 2000 proposed rule, we indicated that we are concerned that section 1886(d)(8)(E) might create an opportunity for some urban hospitals to take advantage of the MGCRB process by first seeking to be reclassified as rural under section 1886(d)(8)(E) (and receiving the benefits afforded to rural hospitals) and in turn seek reclassification through the MGCRB back to the urban area for purposes of their standardized amount and wage index and thus also receive the higher payments that might result from being treated as being located in an urban area. That is, we were concerned that

some hospitals might inappropriately seek to be treated as being located in a rural area for some purposes and as being located in an urban area for other purposes. In light of the Conference Report language noted above discussing the House bill and what appears to be the potential for inappropriately inconsistent treatment of the same hospital on the other hand, in the May 5 proposed rule, we solicited public comment on this issue, and indicated that we might impose a limitation on such MGCRB reclassifications in this final rule for FY 2001, if such action appears warranted. We also sought specific comments on how such a limitation, if any, should be imposed and provided several examples and alternatives.

We received seven public comments on the interaction of urban to rural reclassification under section 1886(d)(8)(E) and reclassification under the MGCRB. Several additional comments were received regarding specific aspects of implementation of section 1886(d)(8)(E) of the Act (added by section 401 of Public Law 106–113). These issues are addressed in the interim final rule with comment period, published elsewhere in this issue of the **Federal Register**, that implements certain provisions of Public Law 106–113.

Comment: Several of our commenters urged HCFA to place no restrictions on access to MGCRB reclassification for urban hospitals that have elected to reclassify to rural under section 1886(d)(8)(E) of the Act, citing the Conference Report as evidence of the Congressional intent in enacting this provision. These commenters argued that these now-rural hospitals should receive the same treatment as geographically rural hospitals, noting that current Medicare policy permits geographically rural hospitals to reclassify, under the MGCRB, to urban areas for their wage index or standard payment amounts, or both. This means that geographically rural hospitals can take advantage of both rural as well as urban payment amounts. This same option, these commenters asserted, should be available to urban hospitals that petition for reclassification under section 1886(d)(8)(E).

Response: Under section 1886(d)(8)(E) of the Act, as added by section 401 of the Public Law 106–113, a hospital located in an urban area may file an application to be treated as being located in a rural area for purposes of payment under section 1886(d) of the Act. The issue here is whether a hospital that has been reclassified from an urban area to a rural area under section 1886(d)(8)(E) of the Act should be permitted to subsequently be reclassified under the MGCRB process from the rural area to another area. As discussed below, we believe that, for purposes of the MGCRB process, it is appropriate to distinguish between hospitals that are reclassified as rural under section 1886(d)(8)(E) of the Act and hospitals that are geographically rural. However, in light of our understanding of the intent underlying the language in the Conference Report for Public Law 106–113, we are revising a policy relating to RRCs so that certain urban hospitals that are not RRCs under current policy will be granted RRC status and can receive special treatment under the MGCRB process.

Section 1886(d)(8)(E) of the Act, as added by section 401 of Public Law 106–113, provides that, for purposes of section 1886(d) of the Act, if a hospital files an application and meets applicable criteria, the Secretary ''shall treat the hospital as being located in the rural area * * * of the State in which the hospital is located.'' As discussed above and in the proposed rule, a description of the House bill in the Conference Report for Public Law 106–113 indicates that hospitals reclassified as rural under section 1886(d)(8)(E) of the Act would be ''eligible to apply'' to the MGCRB for reclassification under the MGCRB process. Significantly, however, the terms of section 1886(d)(8)(E) of the Act do not refer to section 1886(d)(10) of the Act (which addresses the MGCRB reclassification process), and section 401 of Public Law 106–113 did not amend section 1886(d)(10) of the Act to limit the agency's discretion under that provision in any way. Put another way, section 1886(d)(8)(E) of the Act does not contain any language indicating that hospitals treated as rural under that provision can subsequently be treated as urban under section 1886(d)(10) of the Act, and section 1886(d)(10) does not contain language indicating that the Secretary must permit reclassification to an urban area of hospitals treated as rural under section 1886(d)(8)(E) of the Act. Thus, under the statute, the Secretary has broad discretion to determine when MGCRB reclassification is appropriate and, in enacting section 401 of Public Law 106–113, Congress did not enact any statutory amendments to limit that discretion in any way.

The statutory language of section 1886(d)(8)(E) of the Act directs the Secretary to treat qualifying hospitals, for purposes of section 1886(d) of the Act, ''as being located in the rural area * * * of the State in which the hospital is located''. Section 1886(d) of the Act encompasses the hospital wage index and the standardized amount. Consistent with the statutory language, we are providing that a hospital reclassified as rural under section 1886(d)(8)(E) of the Act will be treated as being located in a rural area for purposes of section 1886(d) of the Act, and cannot subsequently be reclassified under the MGCRB process to an urban area (in order to be treated as being located in an urban area for certain purposes under section 1886(d) of the Act).

This policy is consistent not only with the statutory language but also with the policy considerations underlying the MGCRB process. The MGCRB process permits a hospital to be reclassified from one geographic area to another if it is significantly disadvantaged by its geographic location and would be paid more appropriately if it were reclassified to another area. We believe that it would be illogical to permit a hospital that applied to be reclassified from urban to rural under section 1886(d)(8)(E) of the Act because it was disadvantaged as an urban hospital to then utilize a process that was established to enable hospitals significantly disadvantaged by their rural or small urban location to reclassify to another urban location. If an urban hospital applies under section 1886(d)(8)(E) of the Act in order to be treated as being located in a rural area, then it would be anomalous at best for the urban hospital to subsequently claim that it is significantly disadvantaged by the rural status for which it applied and should be reclassified to an urban area.

Furthermore, permitting hospitals the option of seeking rural reclassification under section 1886(d)(8)(E) of the Act for certain payment advantages, coupled with the ability to pursue a subsequent MGCRB reclassification back to an urban area, could have implications beyond those originally envisioned under Public Law 106–113. In particular, we are concerned about the potential interface between rural reclassifications under section 401 and section 407(b)(2) of Public Law 106–113, which authorizes a 30-percent expansion in a rural hospital's resident full-time equivalent count for purposes of Medicare payment for the indirect costs of medical education (IME) under section 1886(d)(5)(B) of the Act. (Reclassification from urban to rural under section 1886(d)(8)(E) of the Act can affect IME payments to a hospital, which are made under section 1886(d)(5)(B) of the Act, but not payments for the direct costs of GME,

which are made under section 1886(h) of the Act.)

Congress clearly intended hospitals that become rural under section 1886(d)(8)(E) of the Act to receive some benefit as a result. For example, some hospitals currently located in very large urban counties are in fact fairly small, isolated hospitals. Some of these hospitals will now be able to be designated a rural hospital and become eligible to be designated a critical access hospital.

In addition, one of the criteria under section 1886(d)(8)(E) of the Act is that the hospital would qualify as an SCH or an RRC if it were located in a rural area. An SCH would be eligible to be paid on the basis of the higher of its hospital-specific rate or the Federal rate. On the other hand, the only benefit under section 1886(d) of the Act for an urban hospital to become an RRC would be waiver of the proximity requirements that are otherwise applicable under the MGCRB process, as set forth in § 412.230(a)(3).

We agree with the commenters that Congress contemplated that hospitals might seek to be reclassified as rural under section 1886(d)(E) of the Act in order to become RRCs so that the hospital would be exempt from the MGCRB proximity requirement and could be reclassified by the MGCRB to another urban area. -

Therefore, we sought a policy approach that would appropriately account for our concern that these urban to rural redesignations not be utilized inappropriately, but would benefit hospitals seeking to reclassify under the MGCRB process by achieving RRC status. We decided to reconsider our application of section 4202(b) of Public Law 105–33, which states, in part, ''Any hospital classified as a rural referral center by the Secretary * * * for FY 1991 shall be classified as such a rural referral center for fiscal year 1998 and each subsequent fiscal year.'' In the August 29, 1997 final rule with comment period, we reinstated RRC status for all hospitals that lost the status due to triennial review or MGCRB reclassification, but not to hospitals that lost RRC status because they were now urban for all purposes because of the OMB designation of their geographic area as urban (62 FR 45999). Our rationale at that time for not reinstating RRC status for these hospitals was that a hospital had to be rural in order to qualify for reinstatement as an RRC, and these hospitals were no longer located in rural areas.

We are aware of several specific hospitals that were RRCs for FY 1991, but subsequently lost their status when the county in which they were located became urban, and have expressed their wish to be redesignated as an RRC in order to be eligible to reclassify. We believe that the language in the Conference Report accompanying Public Law 106–113 was intended to address these hospitals; that is, we believe that the intent underlying this language (a description of the House bill) was to allow certain urban hospitals to become RRCs (upon reclassifying from urban to rural under section 1886(d)(8)(E) of the Act) and then reclassify under the MGCRB process (as RRCs, the hospitals would be exempt from the MGCRB's proximity requirements). Accordingly, in light of section 1886(d)(8)(E) of the Act and the language in the Conference Report, we have decided to revisit our policy decision on section 4202(b) of Public Law 105–33. Effective as of October 1, 2000, hospitals located in what is now an urban area, if they were ever an RRC, will be reinstated to RRC status under section 4202(b) of Public Law 105–33. (In the August 27, 1997 final rule, we indicated that we recognized there were hospitals that qualified for RRC status after 1991 that lost their status in a subsequent year due to MGCRB reclassification. Therefore, we determined that we would permit any hospital that qualified as an RRC at any point that had lost its RRC status as a result of MGCRB reclassification to be reinstated, regardless of whether it was designated an RRC in 1991. Similarly, for purposes of this policy, we will permit hospitals that previously qualified as an RRC and that lost their status due to OMB redesignation of the county in which they are located from rural to urban to be reinstated as an RRC.) Such hospitals would benefit from the waiver of the MGCRB's proximity requirements, as long as they are designated as RRCs at the time the MGCRB acts on their application.

We are not permitting hospitals redesignated as rural under section 1886(d)(8)(E) of the Act to be eligible for subsequent reclassification by the MGCRB, and are revising the regulations governing MGCRB reclassifications (§ 412.230) accordingly.

Comment: Several commenters suggested alternative policy options regarding the interaction of the distinct reclassification provisions found under sections 1886(d)(8)(E) and 1886(d)(10) of the Act. First, it was recommended that HCFA formulate a policy that would allow urban hospitals reclassifying to rural under section 1886(d)(8)(E) of the Act the same access to urban reclassification under the MGCRB process that the law makes available to geographically rural hospitals. One commenter posits two possible limitations on MGCRB reclassifications for these now-rural hospitals. One possibility is that an urban hospital that reclassifies to rural under section 1886(d)(8)(E) of the Act be permitted to reclassify only to another MSA, but be precluded from reclassifying back to the MSA in which it is situated. Second, the commenter suggested that reclassifications under the MGCRB process be restricted solely to the wage index for formerly urban hospitals that have elected to reclassify to rural under section 1886(d)(8)(E) of the Act.

Response: Although the alternatives suggested by the commenters would limit to some degree the possible inappropriate incentives for hospitals to become rural under section 1886(d)(8)(E) of the Act, we are concerned that they would still allow these hospitals to receive inappropriate payments, albeit on a more limited basis. Therefore, we have not selected these alternative approaches.

Comment: One health system argued that preventing an urban hospital that has reclassified to rural under section 1886(d)(8)(E) of the Act from reclassifying through restricting the MGCRB process would reduce the number of hospitals reclassifying as rural under section 1886(d)(8)(E) of the Act. The commenter further noted that even if we permitted an urban hospital that reclassified to a rural area under section 1886(d)(8)(E) of the Act to reclassify through the MGCRB process, the hospital would suffer financial losses during the period between when it was rural for all payment purposes and its reclassification back to urban.

Response: We wish to emphasize that urban to rural reclassification under section 1886(d)(8)(E) of the Act is entirely voluntary. Each hospital anticipating that it may qualify under this provision should determine the impact of Medicare payment policies if it were to reclassify. As discussed above, we believe that our policies here are consistent with the Secretary's broad authority under section 1886(d)(10) of the Act, the statutory language in section 1886(d)(8)(E) of the Act, as well as our understanding of the intent underlying the description of the House bill in the Conference Report.

2. Revised Thresholds Applicable to Rural Hospitals for Wage Index Reclassifications

Existing §§ 412.230(e)(1)(iii) and (e)(1)(iv) provide that hospitals may obtain reclassification to another area for purposes of calculating and applying

the wage index if the hospital's average hourly wages are at least 108 percent of the average hourly wages in the area where it is physically located, and at least 84 percent of the average hourly wages in a proximate area to which the hospital seeks reclassification. These thresholds apply equally to urban and rural hospitals seeking reclassification.

Historically, the financial performance of rural hospitals under the prospective payment system has lagged behind that of urban hospitals. Despite an overall increase in recent years of Medicare inpatient operating profit margins, some rural hospitals continue to struggle financially (as measured by Medicare inpatient operating prospective payment system payments minus costs, divided by payments). For example, during FY 1997, while the national average hospital margin was 15.1 percent, it was 8.9 percent for rural hospitals. In addition, approximately one-third of rural hospitals continue to experience negative Medicare inpatient margins despite this relatively high average margin.

In response to the lower margins of rural hospitals and the potential for a negative impact on beneficiaries' access to care if these hospitals were to close, we considered potential administrative changes that could help improve payments for rural hospitals. One approach in that regard would be to make it easier for rural hospitals to reclassify for purposes of receiving a higher wage index. The current thresholds for applying for wage index reclassification are based on our previous analysis showing the average hospital wage as a percentage of its area wage was 96 percent, and one standard deviation from that average was equal to 12 percentage points (see the June 4, 1992 proposed rule (57 FR 23635) and the September 1, 1992 final rule (57 FR 39770)). Because rural hospitals' financial performance has consistently remained below that of urban hospitals, we now believe that rural hospitals merit special dispensation with respect to qualifying for reclassification for purposes of the wage index. Therefore, we proposed to change those average wage threshold percentages so more rural hospitals can be reclassified. Specifically, we proposed to lower the upper threshold for rural hospitals to 106 percent and the lower threshold to 82 percent. The thresholds for urban hospitals seeking reclassification for purposes of the wage index would be unchanged. We note that rural hospitals comprised nearly 90 percent of FY 2000 wage index reclassifications. Under the proposal, beginning October 1, 2000, rural hospitals would be able to reclassify for the wage index if, among other things, their average hourly wages are at least 106 percent of the area in which they are physically located, and at least 82 percent of the average hourly wages in the proximate area to which it seeks reclassification.

Although it is difficult to estimate precisely how many additional hospitals might qualify by lowering the thresholds because we do not have data indicating which hospitals meet all of the other reclassification criteria (e.g., proximity), our analysis indicated that, if we were to raise the 108 percent threshold to 109 percent, approximately 20 rural hospitals would no longer qualify. If the upper threshold were to be raised to 110 percent, another 16 hospitals would not qualify. On the other hand, increasing the lower threshold from 84 percent to 85 percent would result in only 2 rural hospitals becoming ineligible to reclassify. Only 1 additional hospital would be affected by raising the threshold to 86 percent. Based on this analysis, we anticipated approximately 50 rural hospitals are likely to benefit from the proposed change.

We believe this proposal, as adopted, achieves an appropriate balance between allowing certain hospitals that are currently just below the thresholds to become eligible for reclassification, while not liberalizing the criteria so much that an excessive number of hospitals begin to reclassify. Because these reclassifications are budget neutral, nonreclassified hospitals' payments are negatively impacted by reclassification.

We believe there are many factors associated with lower margins among rural hospitals. We note that section 410 of Public Law 106–113 requires the Comptroller General of the United States to ''conduct a study of the current laws and regulations for geographic reclassification of hospitals to determine whether such reclassification is appropriate for purposes of applying wage indices.'' In addition, section 411 of Public Law 106–113 requires MedPAC to conduct a study on the adequacy and appropriateness of the special payment categories and methodologies established for rural hospitals. We anticipate that the results of these studies will help identify other areas to help improve payments for rural hospitals, either through reclassifications or other means.

Comment: Commenters were unclear about the effective date for the change in wage index thresholds for rural hospitals applying for reclassification.

Response: The revised thresholds apply to applications submitted to the MGCRB (by September 1, 2000) for reclassification for FY 2002. These revised guidelines do not apply to decisions that have already been issued by the MGCRB for FY 2001.

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

1. Background

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. Section 1886(h) of the Act, as amended by section 4623 of Public Law 105–33, caps the number of residents that hospitals may count for direct GME.

Section 9202 of the Consolidated Omnibus Reconciliation Act (COBRA) of 1985 (Pub. L. 99–272) established a methodology for determining payments to hospitals for the costs of approved GME programs at section 1886(h)(2) of the Act. Section 1886(h)(2) of the Act, as implemented in regulations at § 413.86(e), sets forth a payment methodology for the determination of a hospital-specific, base-period per resident amount (PRA) that is calculated by dividing a hospital's allowable costs of GME for a base period by its number of residents in the base period. The base period is, for most hospitals, the hospital's cost reporting period beginning in FY 1984 (that is, the period of October 1, 1983 through September 30, 1984). The PRA is multiplied by the number of full-time equivalent (FTE) residents working in all areas of the hospital complex (or non-hospital sites, when applicable), and the hospital's Medicare share of total inpatient days to determine Medicare's direct GME payments. In addition, as specified in section 1886(h)(2)(D)(ii) of the Act, for cost reporting periods beginning on or after October 1, 1993, through September 30, 1995, each hospital's PRA for the previous cost reporting period is not adjusted for any FTE residents who are not either a primary care or an obstetrics and gynecology resident. As a result, hospitals with both primary care/obstetrics and gynecology residents and non-primary care residents have two separate PRAs for FY 1994 and, thereafter, one for primary care and one for non-primary care. (Thus, for purposes of this proposed rule, when we refer to a hospital's PRA, this amount is inclusive of any CPI–U adjustments the hospital may have received since the hospital's base-year, including any CPI–U adjustments the hospital may have received because the hospital trains primary care/non-

primary care residents, as specified under existing § 413.86(e)(3)(ii)).

2. Use of National Average Per Resident Amount Methodology in Computing Direct GME Payments

Section 311 of Public Law 106–113 amended section 1886(h)(2) of the Act to establish a methodology for the use of a national average PRA in computing direct GME payments for cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2005. Generally, section 311 establishes a ''floor'' and a ''ceiling'' based on a locality-adjusted, updated, weighted average PRA. Each hospital's PRA is compared to the floor and ceiling to determine whether its PRA should be revised. Accordingly, in the May 5, 2000 proposed rule, we proposed to implement section 311 by setting forth the prescribed methodology for calculation of the weighted average PRA. We then discussed the proposed steps for determining whether a hospital's PRA will be adjusted based upon the proposed calculated weighted average PRA, in accordance with the methodology specified under section 311 of Public Law 106–113.

We proposed to calculate the weighted average PRA based upon data from hospitals' cost reporting periods ending during FY 1997 (October 1, 1996 through September 30, 1997), as directed by section 311 of Public Law 106–113. We accessed these FY 1997 cost reporting data from the Hospital Cost Report Information System (HCRIS) and also obtained the necessary data for those hospitals that are not included in HCRIS (because they file manual cost reports), from those hospitals' fiscal intermediaries. If a hospital had more than one cost reporting period ending in FY 1997, we proposed to include all of its cost reports ending in FY 1997 in our calculations. However, if a hospital did not have a cost reporting period ending in FY 1997, such as a hospital with a long cost reporting period beginning in FY 1996 and ending in FY 1998, the hospital is excluded from our calculations.

We have slightly revised the weighted average PRA in this final rule because of changes in the data that have come to our attention since the publication of the proposed rule. In the proposed rule, one hospital was excluded from our calculations because it was a new teaching hospital with no established PRA (the first year of training for a new teaching hospital is paid for by Medicare on a cost basis; a PRA is applied in calculating a hospital's payment beginning with the hospital's second year of residency training) even though it did have a cost reporting period ending during FY 1997. In the weighted average calculation in this final rule, we have excluded one more hospital because we learned that this hospital was also a new teaching hospital in FY 1997 with no established PRA. We also have added one hospital to the weighted average calculation because it was inadvertently excluded in the calculation in the proposed rule. In addition, we found that the data of two hospitals that were used in the weighted average calculation in the proposed rule were incorrect, and we have made the corrections for the weighted average calculation in this final rule. The total number of hospitals that we include in our calculation is unchanged from the proposed rule and remains at 1,235. Thirty-five of these hospitals are hospitals with more than one cost report.

In accordance with section 311 of Public Law 106–113, we proposed to calculate the weighted average PRA in the following manner:

Step 1: We determine each hospital's single PRA by adding each hospital's primary care and non-primary care PRAs, weighted by its respective FTEs, and dividing by the sum of the FTEs for primary care and non-primary care residents.

Step 2: We standardize each hospital's single PRA by dividing it by the 1999 geographic adjustment factor (GAF) (which is an average of the three geographic index values (weighted by the national average weight for the work component, practice expense component, and malpractice component)) in accordance with section 1848(e) of the Act and 42 CFR 414.26 (which is used to adjust physician payments for the different wage areas), for the physician fee schedule area in which the hospital is located.

Step 3: We add all the standardized hospital PRAs (as calculated in Step 2), each weighted by hospitals' respective FTEs, and then divide by the total number of FTEs.

Based upon this three-step calculation, we determined the weighted average PRA (for cost reporting periods ending during FY 1997) to be $68,464. (The weighted average PRA calculated for the proposed rule was $68,487.)

For cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2005 (FY 2001 through FY 2005), the national average PRA is applied using the following three steps:

Step 1: Update the weighted average PRA for inflation. Under section 1886(h)(2) of the Act, as amended by section 311 of Public Law 106–113, the weighted average PRA is updated by the estimated percentage increase in the consumer price index for all urban consumers (CPI–U) during the period beginning with the month that represents the midpoint of the cost reporting periods ending during FY 1997 and ending with the midpoint of the hospital's cost reporting period that begins in FY 2001. Therefore, the weighted average standardized PRA ($68,464) would be updated by the increase in CPI–U for the period beginning with the midpoint of all cost reporting periods for hospitals with cost reporting periods ending during FY 1997 (October 1, 1996), and ending with the midpoint of the individual hospital's cost reporting period that begins during FY 2001.

For example, Hospital A has a calendar year cost reporting period. Thus, for Hospital A, the weighted average PRA is updated from October 1, 1996 to July 1, 2001, because July 1 is the midpoint of its cost reporting period beginning on or after October 1, 2000. Or, for example, if Hospital B has a cost reporting period starting October 1, the weighted average PRA is updated from October 1, 1996 to April 1, 2001, the midpoint of the cost reporting period for Hospital B. Therefore, the starting point for updating the weighted average PRA is the same date for all hospitals (October 1, 1996), but the ending date is different because it is dependent upon the cost reporting period for each hospital.

Step 2: Adjust for locality. In accordance with section 1886(h)(2) of the Act, as amended by section 311 of Public Law 106–113, once the weighted average PRA is updated according to each hospital's cost reporting period, the updated weighted average PRA (the national average PRA) is further adjusted to calculate a locality-adjusted national average PRA for each hospital. This is done by multiplying the updated national average PRA by the 1999 GAF (as specified in the October 31, 1997 **Federal Register** (62 FR 59257)) for the fee schedule area in which the hospital is located.

Step 3: Determine possible revisions to the PRA. For cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2005, the locality-adjusted national average PRA, as calculated in Step 2, is then compared to the hospital's individual PRA. Based upon the provisions of section 1886(h)(2) of the Act, as amended by section 311 of Public Law 106–113, a hospital's PRA is revised, if appropriate, according to the following:

• *Floor*—For cost reporting periods beginning in FY 2001, to determine which PRAs (primary care and non-primary care separately) are below the 70 percent floor, a hospital's locality-adjusted national average PRA is multiplied by 70 percent. This resulting number is then compared to the hospital's PRA that is updated for inflation to the current cost reporting period. If the hospital's PRA would be less than 70 percent of the locality-adjusted national average PRA, the individual PRA is replaced by 70 percent of the locality-adjusted national average PRA for that cost reporting period and would be updated for inflation in future years by the CPI–U.

We noted that there may be some hospitals with primary care and non-primary care PRAs where both PRAs are replaced by 70 percent of the locality-adjusted national average PRA. In these situations, the hospital would receive identical PRAs; no distinction in PRAs would be made for differences in inflation (because a hospital has both primary care and non-primary care PRAs, each of which is updated as described in § 413.86(e)(3)(ii)) as of cost reporting periods beginning on or after October 1, 2000.

For example, if the FY 2001 locality-adjusted national average PRA for Area X is $100,000, then 70 percent of that amount is $70,000. If, in Area X, Hospital A has a primary care FY 2001 PRA of $69,000 and a non-primary care FY 2001 PRA of $67,000, both of Hospital A's FY 2001 PRAs are replaced by the $70,000 floor. Thus, $70,000 is the amount that would be used to determine Hospital A's direct GME payments for both primary care and non-primary care FTEs in its cost reporting period beginning in FY 2001, and the $70,000 PRA would be updated for inflation by the CPI–U in subsequent years.

• *Ceiling*—For cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2005 (FY 2001 through FY 2005), a ceiling that is equal to 140 percent of each locality-adjusted national average PRA is calculated and compared to each individual hospital's PRA. If the hospital's PRA is greater than 140 percent of the locality-adjusted national average PRA, the PRA would be adjusted depending on the fiscal year as follows:

a. FY 2001. For cost reporting periods beginning in FY 2001, each hospital's PRA from the preceding cost reporting period (that is, the PRA with which its direct GME payments were made in FY 2000) is compared to the FY 2001 locality-adjusted national average PRA. If the individual hospital's FY 2000 PRA exceeds 140 percent of the FY 2001 locality-adjusted national average PRA, the PRA is frozen at the FY 2000 PRA, and is not updated in FY 2001 by the CPI–U factor, subject to the limitation in section IV.G.2.d. of this preamble.

For example, if the FY 2001 locality-adjusted national average PRA ''ceiling'' for Area Y is $140,000 (that is, 140 percent of $100,000, the hypothetical locality-adjusted national average PRA), and if, in this area, Hospital B has a FY 2000 PRA of $140,001, then for FY 2001, Hospital B's PRA is frozen at $140,001 and is not updated by the CPI–U for FY 2001.

b. FY 2002. For cost reporting periods beginning in FY 2002, the methodology used to calculate each hospital's individual PRA would be the same as described in section IV.G.2.a. above for FY 2001. Each hospital's PRA from the preceding cost reporting period (that is, the PRA with which its direct GME payments were made in FY 2001) is compared to the FY 2002 locality-adjusted national average PRA. If the individual hospital's FY 2001 PRA exceeds 140 percent of the FY 2002 locality-adjusted national average PRA, the PRA is frozen at the FY 2001 PRA, and is not updated in FY 2002 by the CPI–U factor, subject to the limitation in section IV.G.2.d. of this preamble.

c. FY 2003, FY 2004, and FY 2005. For cost reporting periods beginning in FY 2003, FY 2004, and FY 2005, if the hospital's PRA for the previous cost reporting period is greater than 140 percent of the locality-adjusted national average PRA for that same previous cost reporting period (for example, for the cost reporting period beginning in FY 2003, compare the hospital's PRA from the FY 2002 cost reporting period to the locality-adjusted national average PRA from FY 2002), then, subject to the limitation in section IV.G.2.d. of this preamble, the hospital's PRA is updated in accordance with section 1886(h)(2)(D)(i) of the Act, except that the CPI–U applied is reduced (but not below zero) by 2 percentage points.

For example, for purposes of Hospital A's FY 2003 cost report, Hospital A's PRA for FY 2002 is compared to Hospital A's locality-adjusted national average PRA ceiling for FY 2002. If, in FY 2002, Hospital A's PRA is $100,001 and the FY 2002 locality-adjusted national average PRA ceiling is $100,000, then for FY 2003, Hospital A's PRA is updated with the FY 2003 CPI–U minus 2 percent. If, in this scenario, the CPI–U for FY 2003 is 1.024, Hospital A would update its PRA in FY 2003 by 1.004 (the CPI–U minus 2 percentage points). However, if the CPI–U factor for FY 2003 is 1.01 and subtracting 2 percentage points of 1.01 yields 0.99, the PRA for FY 2003 would not be updated, and would remain $100,001.

We note that, while the language in section 1886(h)(2)(D)(iv)(I) and in section 1886(h)(2)(D)(iv)(II) of the Act (the sections that describe the adjustments to PRAs for hospitals that exceed 140 percent of the locality-adjusted national average PRA) is very similar, the language does differ. Section 1886(h)(2)(D)(iv)(I) of the Act states that for a cost reporting period beginning during FY 2000 or FY 2001, ''if the approved FTE resident amount for a hospital for the preceding cost reporting period exceeds 140 percent of the locality-adjusted national average per resident amount * * * *for that hospital and period* * * *, the approved FTE resident amount for the period involved shall be the same as the approved FTE resident amount for such preceding cost reporting period.'' (Emphasis added.) Section 1886(h)(2)(D)(iv)(II) of the Act states that for a cost reporting period beginning during FY 2003, FY 2004, or FY 2005, ''if the approved FTE resident amount for a hospital for the preceding cost reporting period exceeds 140 percent of the locality-adjusted national average per resident amount * * * *for that hospital and preceding period,* the approved FTE resident amount for the period involved shall be updated * * *.'' (Emphasis added.) Accordingly, for FYs 2001 and 2002, a hospital's PRA from the previous cost reporting period is compared to the locality-adjusted national average PRA of the current cost reporting period. For FY 2003, FY 2004, or FY 2005, a hospital's PRA from the previous cost reporting period is compared to the locality-adjusted national average PRA from the previous cost reporting period.

d. General rule for hospitals that exceed the ceiling. For cost reporting periods beginning in FY 2001 through FY 2005, if a hospital's PRA exceeds 140 percent of the locality-adjusted national average PRA and it is adjusted under any of the above criteria, the current year PRA cannot be reduced below 140 percent of the locality-adjusted national average PRA.

For example, to determine the PRA of Hospital A, in FY 2003, Hospital A had a FY 2002 PRA of $100,001 and the FY 2002 locality-adjusted national average PRA ceiling is $100,000. For FY 2003, applying an update of the CPI–U factor minus 2 percentage points (for example, 1.024 − .02 = 1.004 would yield an updated PRA of $100,401) while the locality-adjusted national average PRA (before calculation of the ceiling) is

updated for FY 2003 with the full CPI–U factor (1.024) so that the ceiling of $100,000 is now increased to $102,400 (that is, $100,000 x 1.024 = $102,400). Therefore, applying the adjustment would result in a PRA of $100,401, which is under the ceiling of $102,400 for FY 2003. In this situation, for purposes of the FY 2003 cost report, Hospital A's PRA equals $102,400.

We note that if the hospital's PRA does not exceed 140 percent of the locality-adjusted national average PRA, the PRA is updated by the CPI–U for the respective fiscal year. If a hospital's PRA is updated by the CPI–U because it is less than 140 percent of the locality-adjusted national average PRA for a respective fiscal year, and once updated, the PRA exceeds the 140 percent ceiling for the respective fiscal year, the updated PRA would still be used to calculate the hospital's direct GME payments. Whether a hospital's PRA exceeds the ceiling is determined before the application of the update factors; if a hospital's PRA exceeds the ceiling only because of the application of the update factors, the hospital's PRA would retain the CPI–U factors.

For example, if, in FY 2001, the locality-adjusted national average PRA ceiling for Area Y is $140,000, and if, in this area, Hospital B has a FY 2000 PRA of $139,000, then for FY 2001, Hospital B's PRA is updated for inflation for FY 2001 because the PRA is below the ceiling. However, once the update factors are applied, Hospital B's PRA is now $142,000 (that is, above the $140,000 ceiling). In this scenario, Hospital B's inflated PRA would be used to calculate its direct GME payments because Hospital B has only exceeded the ceiling after the application of the inflation factors.

• *PRAs greater than or equal to the floor and less than or equal to the ceiling.* For cost reporting periods beginning in FY 2001 through FY 2005, if a hospital's PRA is greater than or equal to 70 percent and less than or equal to 140 percent of the locality-adjusted national average PRA, the hospital's PRA is updated using the existing methodology specified in § 413.86(e)(3)(i).

For cost reporting periods beginning in FY 2006 and thereafter, a hospital's PRA for its preceding cost reporting period would be updated using the existing methodology specified in § 413.86(e)(3)(i).

We proposed to redesignate the existing § 413.86(e)(4) as § 413.86(e)(5) and add the rules implementing section 1886(h)(2) of the Act, as amended by section 311 of Public Law 106–113, in the vacated § 413.86(e)(4). Because we proposed to apply the methodology for updating the PRA for inflation that is described in existing § 413.86(e)(3), we also proposed to amend § 413.86(e)(3) to make those rules applicable to the cost reporting periods (FY 2001 through FY 2005) specified in the proposed § 413.86(e)(4), and in subsequent cost reporting periods.

In addition, we proposed to make a conforming change by amending proposed redesignated § 413.86(e)(5) to account for situations in which hospitals do not have a 1984 base period and establish a PRA in a cost reporting period beginning on or after October 1, 2000. We believe there are two factors to consider when a new teaching hospital establishes its PRA under proposed redesignated § 413.86(e)(5). First, for example, when calculating the weighted mean value of PRAs of hospitals located in the same geographic area or the weighted mean of the PRAs in the hospital's census region (as specified in § 412.62(f)(1)(i)), the hospitals' PRAs used to calculate the weighted mean values are subject to the provisions of proposed § 413.86(e)(4), the national average PRA methodology. Second, the resulting PRA established under proposed redesignated § 413.86(e)(5) also would be subject to the national average PRA methodology specified in proposed § 413.86(e)(4).

We also proposed to make a clarifying amendment to the proposed redesignated § 413.86(e)(5)(i)(B) to account for an oversight in the regulations text when we amended our regulations on August 29, 1997 (62 FR 46004). In the preamble of the August 29, 1997 final rule, in setting forth our policy on the determination of per resident amounts for hospitals that did not have residents in the 1984 GME base period, we stated that we would use a ''weighted'' average of the per resident amounts for hospitals located in the same geographic area. However, we inadvertently did not include a specific reference to ''weighted'' in the language of the regulation text. Therefore, we are proposing to specify that the ''weighted mean value'' of per resident amounts of hospitals located in the same geographic wage area is used for determining the base period for certain hospitals for cost reporting periods beginning in the same fiscal years.

We received two public comments on the GME provisions included in the proposed rule.

Comment: One commenter supported the implementation of section 311 of Public Law 106–113. Another commenter suggested that there is ambiguity in our volunteer physician policy regarding the rotation of residents to nonhospital sites. The commenter requested that we explicitly state that, so long as the other criteria under the nonhospital policy are met, hospitals may receive direct GME payments for residents training in nonhospital sites when the hospitals do not incur supervisory costs, if the written agreement, which is signed by both the hospital and nonhospital site, indicates that the supervisory physician has agreed to volunteer his or her time in supervising activities.

Response: We did not propose to make any revisions to our policy regarding training residents in nonhospital sites. Any changes in policy regarding an adjustment for training at nonhospital sites would need to go through the notice and comment procedures. We will consider the merits of the commenter's recommendation for a change in policy for a future proposed rulemaking.

H. Outliers: Miscellaneous Change

Under the provisions of section 1886(d)(5)(A)(i) of the Act, the Secretary does not pay for day outliers for discharges from hospitals paid under the prospective payment systems that occur after September 30, 1997. In the May 5 proposed rule, we proposed to make a conforming change to § 412.2(a) by deleting the reference to an additional payment for both inpatient operating and inpatient capital-related costs for cases that have an atypically long length of stay. We did not receive any comments on this proposal and are adopting the change as final.

V. The Prospective Payment System for Capital-Related Costs: The Last Year of the Transition Period

Since FY 2001 is the last year of the 10-year transition period established to phase in the prospective payment system for hospital capital-related costs, for the readers' benefit, we are providing a summary of the statutory basis for the system, the development and evolution of the system, the methodology used to determine capital-related payments to hospitals, and the policy for providing exceptions payments during the transition period.

Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of inpatient hospital services ''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 the 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).

The 10-year transition period established to phase in the prospective payment system for capital-related costs is effective for discharges occurring on or after October 1, 1991 (FY 1992) through discharges occurring on or before September 30, 2001. For FY 2001, hospitals paid under the fully prospective transition period methodology will be paid 100 percent of the Federal rate and zero percent of their hospital-specific rate, while hospitals paid under the hold-harmless transition period methodology will be paid 85 percent of their allowable old capital costs (100 percent for sole community hospitals) plus a payment for new capital costs based on the Federal rate. Fiscal year 2001 is the final year of the capital transition period and, therefore, the last fiscal year for which a portion of a hold-harmless hospital's capital costs per discharge will be paid on a cost basis (except for new hospitals). In the proposed rule, we stated that since fully prospective hospitals will be paid based on 100 percent of the Federal rate and zero percent of their hospital-specific rate, we did not determine a proposed hospital-specific rate update for FY 2001 in section IV of the Addendum of the proposed rule. However, it has come to our attention that an update to the hospital-specific rate is necessary on October 1, 2000, for hospitals with cost reporting periods that do not coincide with the Federal fiscal year. Therefore, the hospital-specific rate update for FY 2001 is shown in section IV of the Addendum of this final rule. For cost reporting periods beginning on or after October 1, 2001 (FY 2002), payment for capital-related costs will be determined based solely on the capital standard Federal rate. Hospitals that were defined as ''new'' for the purposes of capital payments during the transition period (§ 412.30(b)) will continue to be paid according to the applicable payment methodology outlined in § 412.324.

Generally, during the transition period, inpatient capital-related costs are 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 lower than the Federal rate is 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 is 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 as of December 31, 1990, but put in use for patient care after December 31, 1990, also may 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 the vast majority of hospitals.

During the transition period, new hospitals are exempt from the prospective payment system for capital-related costs for their first 2 years of operation and are paid 85 percent of their reasonable cost during that period. The hospital's first 12-month cost reporting period (or combination of cost reporting periods covering at least 12 months) beginning at least 1 year after the hospital accepts its first patient serves as the hospital's base period. Those base year costs qualify as old capital and are used to establish its hospital-specific rate used to determine its payment methodology under the capital prospective payment system. Effective with the third year of operation, the hospital is paid under either the fully prospective methodology or the hold-harmless methodology. If the fully prospective methodology is applicable, the hospital is paid using the appropriate transition blend of its hospital-specific rate and the Federal rate for that fiscal year until the conclusion of the transition period, at which time the hospital will be paid based on 100 percent of the Federal rate. If the hold-harmless methodology is applicable, the hospital will receive hold-harmless payment for assets in use during the base period for 8 years, which may extend beyond the transition period.

The basic methodology for determining capital prospective payments based on the Federal rate is set forth in § 412.312. For the purpose of calculating payments for each discharge, 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 + DSH Adjustment Factor + IME Adjustment Factor).

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.

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 for qualifying classes of hospitals. For up to 10 years after the conclusion of the transition period, a hospital may also receive an additional payment under a special exceptions process if certain qualifying criteria are met and its total inpatient capital-related payments are less than the 70 percent minimum percentage of its allowable Medicare inpatient capital-related costs.

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, 1997, under amendments to the Act enacted by section 4406 of Public Law 105–33, 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-related costs.

In the August 30, 1991 final rule, we established a capital exceptions policy, which provides for exceptions payments during the transition period (§ 412.348). Section 412.348 provides that, during the transition period, a hospital may receive additional payment under an exceptions process when its regular payments are less than a minimum percentage, established by class of hospital, of the hospital's reasonable capital-related costs. The amount of the exceptions payment is the difference between the hospital's minimum payment level and the payments the hospital would receive under the capital prospective payment system in the absence of an exceptions payment. The comparison is made on a cumulative basis for all cost reporting periods during which the hospital is subject to the capital prospective payment transition rules. The minimum payment percentages for regular capital exceptions payments by class of hospitals for FY 2001 are:

- For sole community hospitals, 90 percent;
- For urban hospitals with at least 100 beds that have a disproportionate share patient percentage of at least 20.2 percent or that received more than 30 percent of their net inpatient care revenues from State or local governments for indigent care, 80 percent;
- For all other hospitals, 70 percent of the hospital's reasonable inpatient capital-related costs.

The provision for regular exceptions payments will expire at the end of the transition period. Payments will no longer be adjusted to reflect regular exceptions payments at § 412.348. Accordingly, for cost reporting periods beginning on or after October 1, 2001, hospitals will receive only the per discharge payment based on the Federal rate for capital costs (plus any applicable DSH or IME and outlier adjustments) unless a hospital qualifies for a special exceptions payment under § 412.348(g).

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. The capital special exceptions process is budget neutral; that is, 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 for 10 years beyond the conclusion of the 10-year capital transition period or through September 30, 2011.

VI. 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 Public Law 105–33) establishes caps on the target amounts for certain existing 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 classes 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); the July 31, 1998 final rule (63 FR 41000), and the July 30, 1999 final rule (64 FR 41529). For purposes of calculating the caps on existing facilities, the statute required us to calculate the national 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. Under section 1886(b)(3)(H)(iii) of the Act, the resulting amounts are updated by the market basket percentage to the applicable fiscal year. In establishing the caps on the target amounts within each class of hospital for new hospitals, section 1886(b)(7)(C) of the Act, as amended by section 4416 of Public Law 105–33, explicitly instructed the Secretary to provide an appropriate adjustment to take into account area differences in wage-related costs. However, since the statutory language under section 4414 of Public Law 105–33 did not provide for the Secretary to account for area differences in wage-related costs in establishing the caps on the target amounts for existing hospitals, HCFA did not account for wage-related differences in establishing the caps on the target amounts for existing facilities in FY 1998.

Section 121 of Public Law 106–113 amended section 1886(b)(3)(H) of the Act to direct the Secretary to provide for an appropriate wage adjustment to the caps on the target amounts for psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals, effective for cost reporting periods beginning on or after October 1, 1999, through September 30, 2002. Elsewhere in this issue of the **Federal Register** we are publishing an interim final rule with comment period implementing this provision for cost reporting periods beginning on or after October 1, 1999 and before October 1, 2000. This final rule addresses the wage adjusted caps on the target amounts for excluded hospitals and units for cost reporting periods beginning on or after October 1, 2000.

For purposes of calculating the caps on the target amounts, section 1886(b)(3)(H)(ii) of the Act requires the Secretary to first ''estimate the 75th percentile of the target amounts for such hospitals within such class for cost reporting periods ending during fiscal year 1996.'' Furthermore, section 1886(b)(3)(H)(iii), as added by Public Law 106–113, requires the Secretary to provide for ''an appropriate adjustment to the labor-related portion of the amount determined under such subparagraph to take into account the differences between average wage-related costs in the area of the hospital and the national average of such costs within the same class of hospital.''

For cost reporting periods beginning in FY 2000, we update the FY 1996 wage-neutralized national 75th percentile target amount for each class of hospital by the market basket increase through FY 2000. For cost reporting periods beginning during FY 2001 and FY 2002, we update the previous year's wage-neutralized national 75th percentile target amount for each class of hospital by the applicable market basket percentage increase. In determining the wage-neutralized 75th percentile target amount for each class of hospital and consistent with the broad authority conferred on the Secretary by section 1886(b)(3)(H)(iii) of the Act (as added by Pub. L. 106–113) to determine the appropriate wage

adjustment, we accounted for differences in wage-related costs by adjusting the caps on the target amounts for each class of hospital (psychiatric, rehabilitation, and long-term care) using the methodology, which is described in detail in the interim final rule with comment period that implements the provisions of section 121 Public Law 106–113 that is published elsewhere in this issue of the **Federal Register.**

As stated in the May 5, 2000 proposed rule, we wage neutralized each hospital's FY 1996 target amount to account for area differences in wage-related costs. For each class of hospitals, we determined the labor-related portion of each hospital's FY 1996 target amount by multiplying its target amount by the most recent actuarial estimate of the labor-related portion of excluded hospital costs (or 0.71553). This actuarial estimate of the labor-related share of PPS-excluded hospital costs was revised in connection with other revisions to the PPS-excluded hospital market basket published in the August 29, 1997 final rule (62 FR 45996). Based on the relative weights of the labor cost categories (wages and salaries, employee benefits, professional fees, postal services, and all other labor intensive services), the labor-related portion is 71.553 percent. The remaining 28.447 percent is the nonlabor-related portion. Similarly, we determined the nonlabor-related portion of each hospital's FY 1996 target amount by multiplying its target amount by the actuarial estimate of the nonlabor-related portion of costs (or 0.28447).

Next, as we stated in the May 5 proposed rule, we wage neutralize each hospital's FY 1996 target amount by dividing the labor-related portion of each hospital's FY 1996 target amount by the hospital's FY 1998 hospital wage index under the hospital inpatient prospective payment system (see § 412.63), as shown in Tables 4A and 4B of the August 29, 1997 final rule (62 FR 46070). Each hospital's wage-neutralized FY 1996 target amount was calculated by adding the nonlabor-related portion of its target amount and the wage-neutralized labor-related portion of its target amount. Then, the wage-neutralized target amounts for hospitals within each class were arrayed in order to determine the national wage-neutralized 75th percentile caps on the target amounts for each class of hospital.

As stated in the May 5 proposed rule, this methodology for wage-neutralizing the national 75th percentile of the target amounts is identical to the methodology we utilized for the wage index adjustment described in the August 29, 1997 final rule (62 FR 46020) to calculate the wage-adjusted 110 percent of the national median target amounts for new excluded hospitals and units. Again, we recognize that wages may differ for prospective payment hospitals and excluded hospitals, but we believe that the acute care hospital wage data utilized reflect area differences in wage-related costs. Moreover, in light of the short timeframe for implementing this provision, we used the wage data for acute hospitals since they are the most feasible data source. Reliable wage data for excluded hospitals and units are not available.

Comment: One commenter objected to our use of the FY 1998 hospital wage index, which is based on FY 1994 wage data from Medicare cost reports, to wage neutralize the labor-related portion of each hospital's FY 1996 target amount in establishing area wage adjustments to the caps on the target amounts for long-term care hospitals. The commenter favored using the most current wage data (the FY 2001 wage index, based on FY 1997 Medicare cost report data) to estimate wage adjustments to the caps on the target amounts for excluded hospitals and units.

Response: We reconsidered our methodology for wage-neutralizing each hospital's FY 1996 target amount used in determining the wage-neutralized national 75th percentile target amount for each class of hospital. In the May 5, 2000 proposed rule, the labor-related portion of each hospital's FY 1996 target amount was wage neutralized by dividing it by the FY 1998 hospital inpatient prospective payment system wage index. The FY 1998 hospital inpatient prospective payment system wage index was calculated using FY 1994 wage data due to the 4-year lag time in receiving the data used in the annual calculation of the wage index. We have reconsidered this methodology and believe it is appropriate to wage neutralize the labor-related portion of each hospital's FY 1996 target amount by the FY 2000 hospital inpatient prospective payment system wage index. The FY 2000 wage index is the most current wage data available to wage neutralize each hospital's FY 1996 target amount, and the FY 2000 wage index was calculated based on FY 1996 wage data and therefore reflects area differences in wage-related FY 1996 costs. The FY 2001 wage index will be applied to the wage-related portion of the cap to determine each hospital's FY 2001 wage-adjusted cap on its target amount.

In the May 5, 2000 proposed rule (65 FR 26314), we proposed the labor-related and nonlabor-related shares of the wage-neutralized national 75th percentile caps on the target amounts for FY 2001 as follows:

Class of excluded hospital or unit	FY 2001 proposed labor-related share	FY 2001 proposed nonlabor-related share
Psychiatric	$8,106	$3,223
Rehabilitation	15,108	6,007
Long-Term Care	29,312	11,654

Taking into account the national 75th percentile of the target amounts for cost reporting periods ending during FY 1996 (wage-neutralized using the FY 2000 acute care wage index), the wage adjustment provided for under Public Law 106–113, and the applicable update factor based on the market basket percentage increase to FY 2001, we are establishing the labor-related and nonlabor-related portions of the caps on the target amounts for FY 2001 using the methodology outlined above as follows:.

Class of excluded hospital or unit	FY 2001 labor-related share	FY 2001 nonlabor-related share
Psychiatric	$8,131	$3,233
Rehabilitation	15,164	6,029
Long-Term Care	29,284	11,642

These caps on the target amounts for FY 2001 reflect the use of the FY 2000 wage index in determining the FY 1996 national wage-neutralized 75th percentile target amounts, updated to FY 2001 by the applicable market basket percentage increase. The market basket percentage increase for excluded hospitals and units for FY 2001 is currently forecast at 3.4 percent. At the time the proposed rule was issued, the market basket increase was forecast at 3.1 percent.

Finally, the cap on a hospital's FY 2001 target amount per discharge is determined by adding the hospital's nonlabor-related portion of the national 75th percentile target amount to its wage-adjusted labor-related portion of the national 75th percentile target amount. A hospital's wage-adjusted labor-related portion of the target amount is calculated by multiplying the labor-related portion of the wage-neutralized national 75th percentile target amount for the hospital's class by the hospital's applicable wage index. For FY 2001, a hospital's applicable wage index is the wage index under the hospital inpatient prospective payment system (see § 412.63). For cost reporting periods beginning on or after October 1, 2000 and ending on or before September 30, 2001 as shown in Tables 4A and 4B of this final rule, a hospital's applicable wage index corresponds to the area in which the hospital or unit is physically

located (MSA or rural area) and is not subject to prospective payment system hospital reclassification under section 1886(d)(10) of the Act.

Comment: One commenter requested that HCFA provide long-term care hospitals the opportunity to redesignate to another rural or urban area under the standards outlined in § 412.230 for prospective payment system hospitals. The commenter believed that section 121 of Public Law 106–113 directs HCFA to make accurate area wage adjustments for excluded hospitals and that, in the interest of equity, HCFA should afford long-term care hospitals a process analogous to the MGCRB so that these providers would be able to redesignate their wage area to a rural or urban area. Additionally, the commenter recommended that long-term care hospitals located in ''close proximity'' (as defined in § 412.230(b)) to a prospective payment system hospital that has been allowed to reclassify its area wage index, should also be allowed to reclassify to that wage area.

Response: Section 121 of Public Law 106–113 directs the Secretary to make ''an appropriate adjustment'' to account for area wage-related differences. As we stated in the May 5 proposed rule, long-term care hospitals and psychiatric and rehabilitation hospitals and units which are exempt from the prospective payment system are not subject to prospective payment system hospital reclassification under section 1886(d)(10)(A) of the Act. This section establishes the MGCRB for the purpose of evaluating applications from short-term acute care providers. There is no equivalent statutory provision for HCFA to develop an alternative board for long-term care hospitals or for psychiatric and rehabilitation hospitals and units, or both.

While it would be feasible to allow units physically located in PPS hospitals that have been reclassified by the MGCRB to use the wage-index for the area to which that hospital has been reclassified, at the present time there is no process in place to make reclassification determinations for excluded free-standing providers. The wage-adjustment to the cap on the target amounts for existing excluded providers is only effective through FY 2002 and there is not enough time to develop and implement a process to determine reclassification for free-standing excluded providers. There are approximately 1000 free-standing excluded facilities (529 psychiatric, 196 rehabilitation and 242 long-term care). Therefore, in the interest of equity, we believe that in determining a hospital's wage-adjusted cap on its target amount, it is appropriate for excluded hospitals and units to use the wage index associated with the area in which it is physically located (MSA or rural area) and prospective payment system reclassification under section 1886(d)(10) of the Act is not applicable. This policy is consistent with the determination of the wage-adjusted caps on the target amounts for new excluded hospitals and units, which are not subject to reclassification when applying the wage index in the calculation of the cap. Additionally, skilled-nursing facility and ambulatory surgical center payment systems both use the acute-care inpatient hospital PPS wage index and do not allow for reclassifications since there is no analogous determination process to the MGCRB, which only has authority over PPS hospitals under section 1886(d)(10)(a) of the Act. Therefore, consistent with these policies regarding the application of the acute care wage index to other types of facilities, we are not implementing the commenter's recommendation to permit reclassification of an excluded hospital's or unit's wage index in determining the wage-adjusted cap on their target amount under § 41340(c)(4)(iii).

Comment: One commenter asserted that this is the first time HCFA has applied area wage adjustments to excluded hospitals and units. The commenter suggested that HCFA assess whether long-term care hospitals have a different mix of occupations compared to short-term acute care facilities and recommended that HCFA propose an appropriate adjustment to the acute care wage index to account for the relative wage-related costs for the occupational categories of long-term care hospitals or establish a long-term care hospital specific area wage index. The commenter noted that the acute care wage index includes some wage data derived from hospital-based psychiatric and rehabilitation units, but contains no data from long-term care hospitals. Also, the commenter argued that HCFA did not meet the statutory requirements of section 1886(b)(3)(H) of the Act as amended by section 121 of Public Law 106–113, which states that the Secretary shall provide for an appropriate adjustment ''to take into account differences between average wage-related costs in the area of the hospital and the national average of such costs *within the same class of hospital*'' (emphasis added), since the acute care wage index data are based on data exclusively from short-term acute care hospitals.

Response: As stated in the May 5, 2000 proposed rule (65 FR 26314), we recognize that wages may differ for prospective payment system acute care hospitals and excluded hospitals, but we believe the acute care wage index data accurately reflects area differences in wage-related costs and they are the most feasible data source. For this reason the acute care hospital wage index is used for the Medicare prospective payment systems for outpatient facilities, skilled nursing facilities, and home health facilities.

Currently, there is hospital specific wage data available to develop a wage index based on data from excluded hospitals (or, as the commenter specifically requested, a long-term care hospital exclusive wage index). We may consider exploring the feasibility of developing a wage index for excluded hospitals and units in the future. However, the commenter has not presented any evidence that the acute care wage index inappropriately reflects the differences in wage-related costs for excluded hospital and units. We believe that the acute care wage index provides for an appropriate adjustment to account for wage-related costs in determining a hospital's wage-adjusted cap on its target amount.

In the interim final rule with comment period implementing certain provisions of Public Law 106–113 that we are publishing elsewhere in this issue of the **Federal Register** we revised §§ 413.40(c)(4)(i) and (c)(4)(ii) to incorporate the changes in the formula used to determine the limitation on the target amounts for excluded hospitals and units, as provided for by section 121 of Public Law 106–113.

In response to the May 5, 2000 proposed rule, we received two public comments relating to establishment of the wage-adjusted caps on the target amounts for excluded hospitals and units.

Comment: One commenter believed that the provision for a wage-adjustment to the national 75th percentile target amount cap placed on hospitals excluded from the prospective payment system provided HCFA with the broad authority to transition to a wage-adjusted cap over more than one period. The commenter suggested that the wage-adjusted caps on target amounts be phased-in over a period of time in a manner similar to the removal of teaching physician costs from the wage index calculation.

Response: Public Law 106–113, which was enacted November 29, 1999, directed us to retroactively provide for

a wage adjustment for the national 75th percentile target amounts for psychiatric and rehabilitation hospitals and units and for long-term care hospitals as of October 1, 1999. The purpose of the wage-adjustment to the 75th percentile cap on target amounts for excluded providers is to account for area differences in wage-related costs. We believe that the intent of this provision is to account for these wage differences beginning with cost reporting periods starting during FY 2000. Phasing-in the wage-adjustment to the caps on the target amounts would mitigate the purpose of the wage-adjustment because hospitals located in areas with wage index values greater than one would not receive the full intended benefit of the provision. Additionally, as we stated in the interim final rule with comment that we are publishing elsewhere in this issue of the **Federal Register** we estimate that most providers (93.3 percent of psychiatric hospitals and units, 97.5 percent of rehabilitation hospitals and units, and 93.5 percent of long-term care hospitals) are either not effected or are positively effected by the wage adjustment to the caps on the target amounts. Therefore, we believe it is inappropriate to phase in the wage-adjustment to the caps on the target amounts as the commenter recommended.

Additionally, the removal of the teaching physician costs on the wage index is set for a 5-year phase-out, while the wage-adjusted caps on national target amounts are only legislated to remain in effect from FY 2000 to FY 2002. As such, the remaining period of time for which these caps are in effect is too brief to warrant the administrative resources that would be involved in such a transition. The 5-year phase-out of the removal of teaching costs from the wage index was implemented based on the recommendation of an industry group made up of representatives from national and state hospital associations. While one commenter advocated the phase-in of the wage-adjustment to the caps on the target amounts, another commenter supported the complete implementation of the wage-adjustment to the caps on the target amounts effective FY 2000, since this adjustment reflects the higher cost incurred by providers located in areas with higher than the national average of labor expenditures.

Comment: One commenter commended the wage-adjustment to the caps on the target amounts for psychiatric and rehabilitation hospital and units and long-term care hospitals mandated by section 121 of Public Law 106–113. The commenter supported the application of the acute care wage index to the caps on the national target amounts since the wage adjustment aids providers who incur costs higher than the national average simply because they are located in marketplaces with higher labor prices. The commenter also noted that the target amounts for existing hospitals are now in line with the target amounts for new hospitals, which have been wage adjusted since their implementation in FY 1998 by Public Law 105–33. The commenter further suggested that, if the three classes of hospitals have not been transitioned to prospective payment systems by FY 2002, the wage adjustment to the national target amounts for both new and existing providers should remain in place.

Response: We agree with the comment and we believe that our implementation of the wage adjustment is consistent with the statutory provision in Public Law 106–113. However, regardless of whether the prospective payment systems for these classes of providers have been implemented, we will only be in a position to continue the use of the wage-adjusted caps on the target amounts beyond FY 2002 if Congress directs us to do so through additional legislation.

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

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 payment 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 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 2001. These figures are updated to reflect the market basket increase of 3.4 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	$6,611	$2,630
Rehabilitation	13,002	5,169
Long-Term Care	16,757	6,662

3. Development of Prospective Payment System for Inpatient Rehabilitation Hospitals and Units

Section 4421 of Public Law 105–33 added section 1886(j) to the Act. Section 1886(j) of the Act 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. Section 1886(j) was amended by section 125 of Public Law 106–113 to require the Secretary to use the discharge as the payment unit under the prospective payment system for inpatient rehabilitation services and to establish classes of patient discharges by functional-related groups.

We will issue a separate notice of proposed rulemaking in the **Federal Register** on the prospective payment system for inpatient rehabilitation facilities. That document will discuss the requirements in section 1886(j)(1)(A)(i) of the Act for a transition phase covering the first two cost reporting periods under the prospective payment system. During this transition phase, inpatient rehabilitation facilities will receive a payment rate comprised of a blend of the facility specific rate (the TEFRA percentage) based on the amount that would have been paid under Part A with respect to these costs if the prospective payment system would not be implemented and the inpatient rehabilitation facility prospective payment rate (prospective payment percentage). As set forth in sections 1886(j)(1)(C)(i) and (ii) of the Act, the TEFRA percentage for a cost reporting period beginning on or after October 1, 2000, and before October 1, 2001, is 66⅔ percent; the prospective payment percentage is 33⅓ percent. For cost reporting periods beginning on or after October 1, 2001 and before October 1, 2002, the TEFRA percentage is 33⅓

percent and the prospective payment percentage is 66⅔ percent.

As provided in section 1886(j)(3)(A) of the Act, the prospective payment rates will be based on the average inpatient operating and capital costs of rehabilitation facilities and units. Payments will be adjusted for case-mix using patient classification groups, area wages, inflation, outlier status and any other factors the Secretary determines necessary. We will propose to set the prospective payment amounts in effect during FY 2001 so that total payments under the system 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.

4. Continuous Improvement Bonus Payment

Under § 413.40(d)(4), for cost reporting periods beginning on or after October 1, 1997, an ''eligible'' hospital may receive continuous improvement bonus payments in addition to its payment for inpatient operating costs plus a percentage of the hospital's rate-of-increase ceiling (as specified in § 413.40(d)(2)). An eligible hospital is a hospital that has been a provider excluded from the prospective payment system for at least three full cost reporting periods prior to the applicable period and the hospital's operating costs per discharge for the applicable period are below the lowest of its target amount, trended costs, or expected costs for the applicable period. Prior to enactment of Public Law 106–113, the amount of the continuous improvement bonus payment was equal to the lesser of—

(a) 50 percent of the amount by which operating costs were less than the expected costs for the period; or

(b) 1 percent of the ceiling.

Section 122 of Public Law 106–113 amended section 1886(b)(2) of the Act to provide, for cost reporting periods beginning on or after October 1, 2000, and before September 30, 2001, for an increase in the continuous improvement bonus payment for long-term care and psychiatric hospitals and units. Under section 1886(b)(2) of the Act, as amended, a hospital that is within one of these two classes of hospitals (psychiatric hospitals or units and long-term-care hospitals) will receive the lesser of 50 percent of the amount by which the operating costs are less than the expected costs for the period, or the increased percentages mandated by statute as follows:

(a) For a cost reporting period beginning on or after October 1, 2000 and before September 30, 2001, 1.5 percent of the ceiling; and

(b) For a cost reporting period beginning on or after

October 1, 2001, and before September 30, 2002, 2 percent of the ceiling.

We did not receive any public comments on our proposed revision of § 413.40(d)(4) to incorporate this provision of the statute and, therefore, are adopting it as final.

5. Changes in the Types of Patients Served or Inpatient Care Services That Distort the Comparability of a Cost Reporting Period to the Base Year Are Grounds for Requesting an Adjustment Payment in Accordance With Section 1886(b)(4) of the Act

Section 4419(b) of Public Law 104–33 requires the Secretary to publish annually in the **Federal Register** a report describing the total amount of adjustment (exception) payments made to excluded hospitals and units, by reason of section 1886(b)(4) of the Act, during the previous fiscal year. However, the data on adjustment payments made during the previous fiscal year are not available in time to publish a report describing the total amount of adjustment payments made to all excluded hospitals and units in the subsequent year's final rule published in the **Federal Register**.

The process of requesting, adjudicating, and awarding an adjustment payment for a given cost reporting period occurs over a 2-year period or longer. An excluded hospital or unit must first file its cost report for the previous fiscal year with its intermediary within 5 months after the close of the previous fiscal year. The fiscal intermediary then reviews the cost report and issues a Notice of Program Reimbursement (NPR) in approximately 2 months. If the hospital's operating costs are in excess of the ceiling, the hospital may file a request for an adjustment payment within 6 months from the date of the NPR. The intermediary, or HCFA, depending on the type of adjustment requested, then reviews the request and determines if an adjustment payment is warranted. This determination is often not made until more than 6 months after the date the request is filed. Therefore, it is not possible to provide data in a final rule on adjustments granted for cost reports ending in the previous Federal fiscal year, since those adjustments have not even been requested by that time. However, in an attempt to provide interested parties at least some relevant data on adjustments, we are publishing data on requests for adjustments that were processed by the fiscal intermediaries or HCFA during the previous Federal fiscal year.

The table below includes the most recent data available from the fiscal intermediaries and HCFA on adjustment payments that were adjudicated during FY 1999. By definition these were for cost reporting periods ending in years prior to FY 1998. The total adjustment payments awarded to excluded hospitals and units during FY 1999 are $73,532,146. The table depicts for each class of hospital, in aggregate, the number of adjustment requests adjudicated, the excess operating cost over the ceiling, and the amount of the adjustment payment.

Class of hospital	Number	Excess cost over ceiling	Adjustment payment
Psychiatric	198	$100,861,663	$49,986,012
Rehabilitation	53	32,690,736	16,798,634
Long-term care	4	3,239,164	2,577,455
Children's	7	3,311,758	1,470,670
Cancer	2	4,849,093	2,699,375

B. Responsibility for Care of Patients in Hospitals-Within-Hospitals (§ 413.40(a)(3))

Effective October 1, 1999, for hospitals-within-hospitals, we implemented a policy that allows for a 5-percent threshold for cases in which a patient discharged from an excluded hospital-within-a-hospital and admitted to the host hospital was subsequently readmitted to the excluded hospital-within-a-hospital. With respect to these cases, if the excluded hospital exceeds the 5-percent threshold, we do not include any previous discharges to the prospective payment hospital in calculating the excluded hospital's cost per discharge. That is, the entire stay is considered one Medicare ''discharge'' for purposes of payments to the excluded hospital. The effect of this rule, as explained more fully in the May 7, 1999 proposed rule (64 FR 24716) and in the July 30, 1999 final rule (64 FR 41490), is to prevent inappropriate Medicare payment to hospitals having a large number of such stays.

In the existing regulations at § 413.40(a)(3), we state that the 5-percent threshold is determined based on the total number of discharges from the hospital-within-a-hospital. We have received questions as to whether, in determining whether the threshold is met, we consider Medicare patients only or all patients (Medicare and non-Medicare). To avoid any further misunderstanding, in the May 5, 2000 proposed rule, we indicated our intent to clarify the definition of ''ceiling'' in § 413.40(a)(3) by specifying that the 5-percent threshold is based on the Medicare inpatients discharged from the hospital-within-a-hospital in a particular cost reporting period, not on total Medicare and non-Medicare inpatient discharges.

We did not receive any public comments on our proposed clarification of the definition of ''ceiling'' in § 413.40(a)(3) and, therefore, are adopting the revision as final.

C. Critical Access Hospitals (CAHs)

1. Election of Payment Method (§ 413.70)

Section 1834(g) of the Act, as in effect before enactment of Public Law 106–113, provided that the amount of payment for outpatient CAH services is the reasonable costs of the CAH in providing such services. However, the reasonable costs of the CAH's services to outpatients included only the CAH's costs of providing facility services, and did not include any payment for professional services. Physicians and other practitioners who furnished professional services to CAH outpatients billed the Part B carrier for these services and were paid under the physician fee schedule in accordance with the provisions of section 1848 of the Act.

Section 403(d) of Public Law 106–113 amended section 1834(g) of the Act to permit the CAH to elect to be paid for its outpatient services under another option. CAHs making this election would be paid amounts equal to the sum of the following, less the amount that the hospital may charge as described in section 1866(a)(2)(A) of the Act (that is, Part A and Part B deductibles and coinsurance):

(1) For facility services, not including any services for which payment may be made as outpatient professional services, the reasonable costs of the CAH in providing the services; and

(2) For professional services otherwise included within outpatient CAH services, the amounts that would otherwise be paid under Medicare if the services were not included in outpatient CAH services.

Section 403(d) of Public Law 106–113 added section 1834(g)(3) to the Act to further specify that payment amounts under this election are be determined without regard to the amount of the customary or other charge.

The amendment made by section 403(d) is effective for cost reporting periods beginning on or after October 1, 2000.

In the May 5, 2000 proposed rule, we proposed to revise § 413.70 to incorporate the provisions of section 403(d) of Public Law 106–113. The existing § 413.70 specifies a single set of reasonable cost basis payment rules applicable to both inpatient and outpatient services furnished by CAHs. As section 403(d) of Public Law 106–113 provides that, for outpatient CAH services, CAHs may elect to be paid on a reasonable cost basis for facility services and on a fee schedule basis for professional services, we proposed to revise the section to allow for separate payment rules for CAH inpatient and outpatient services.

We proposed to place the provisions of existing § 413.70(a) and (b) that relate to payment on a reasonable cost basis for inpatient services furnished by a CAH under proposed § 413.70(a). Proposed § 413.70(a)(2) also stated that payment to a CAH for inpatient services does not include professional services to CAH inpatients and is subject to the Part A hospital deductible and coinsurance determined under 42 CFR Part 409, Subpart G.

We proposed to include under § 413.70(b) the payment rules for outpatient services furnished by CAHs, including the option for CAHs to elect to be paid on the basis of reasonable costs for facility services and on the basis of the physician fee schedule for professional services. Under proposed § 413.70(b)(2), we would retain the existing provision that unless the CAH elects the option provided for under section 403 of Public Law 106–113, payment for outpatient CAH services is on a reasonable cost basis, as determined in accordance with section 1861(v)(1)(A) of the Act and the applicable principles of cost reimbursement in Parts 413 and 415 (except for certain payment principles that do not apply; that is, the lesser of costs or charges, RCE limits, any type of reduction to operating or capital costs under § 413.124 or § 413.130(j)(7), and blended payment amounts for ambulatory surgical center services, radiology services, and other diagnostic services).

Under proposed § 413.70(b)(3), we specified that any CAH that elects to be paid under the optional method must make an annual request in writing, and deliver the request for the election to the fiscal intermediary at least 60 days before the start of the affected cost reporting period. In addition, proposed § 413.70(b)(3)(ii) stated that if a CAH elects payment under this method, payment to the CAH for each outpatient visit will be the sum of the following two amounts:

- For facility services, not including any outpatient professional services for which payment may be made on a fee schedule basis, the amount would be the reasonable costs of the services as determined in accordance with applicable principles of cost reimbursement in 42 CFR Parts 413 and 415, except for certain payment principles that would not apply as specified above; and
- For professional services, otherwise payable to the physician or other practitioner on a fee schedule basis, the amounts would be those amounts that would otherwise be paid for the services if the CAH had not elected payment under this method.

We also proposed in § 413.70(b)(3)(iii) that payment to a CAH for outpatient services would be subject to the Part B deductible and coinsurance amounts, as determined under §§ 410.152, 410.160, and 410.161. In proposed § 413.70(c), we stated that final payment to the CAH for its facility services to inpatients and outpatients furnished during a cost reporting would be based on a cost report for that period, as required under § 413.20(b).

Comment: One commenter expressed concern about several CAH payment issues on which we did not propose to change existing policy. These comments related to payment for costs attributable to Medicare bed debts, counting of beds toward the 15- and 25-bed maximums, and payment for swing-bed services in CAHs.

Response: Because these comments dealt with matters beyond the scope of the proposed rule, we have received them with interest and will consider whether any changes in policy are needed at a later date.

We are adopting the proposed revisions to § 413.70 as final. The revised § 413.70 includes at paragraph (b)(2)(iii) the text of a paragraph (c) that was added in the interim final rule with comment period that implemented certain provisions of Public Law 106–33 published elsewhere in this issue of the **Federal Register**. We did not revise the text of this paragraph (c); we merely changed the paragraph coding to fit it into the scheme of coding of the revised § 413.70.

2. Condition of Participation: Organ, Tissue, and Eye Procurement (§ 485.643)

Sections 1820(c)(2)(B) and 1861(mm) of the Act set forth the criteria for designating a CAH. Under this authority, the Secretary has established in regulations the minimum requirements a CAH must meet to participate in Medicare (42 CFR Part 485, Subpart F).

Section 1905(a) of the Act provides that Medicaid payments may be made for any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary. The Secretary has specified CAH services as Medicaid services in regulations. Specifically, the regulations at 42 CFR 440.170(g)(1)(i), define CAH services under Medicaid as those services furnished by a provider meeting the Medicare conditions of participation (CoP).

Section 1138 of the Act provides that a CAH participating in Medicare must establish written protocols to identify potential organ donors that: (1) Assure that potential donors and their families are made aware of the full range of options for organ or tissue donation as well as their rights to decline donation; (2) encourage discretion and sensitivity with respect to the circumstances, views, and beliefs of those families; and (3) require that an organ procurement agency designated by the Secretary be notified of potential organ donors.

On June 22, 1998, as part of the Medicare hospital conditions of participation under Part 482, subpart C, we added to the regulations at § 482.45, a condition that specifically addressed organ, tissue, and eye procurement. However, Part 482 does not apply to CAHs, as CAHs are a distinct type of provider with separate CoP under Part 485. Therefore, in the proposed rule, we proposed to add a CoP for organ, tissue, and eye procurement for CAHs at a new § 485.643 that generally parallels the CoP at § 482.45 for all Medicare hospitals with respect to the statutory requirement in section 1138 of the Act concerning organ donation. CAHs are not full service hospitals and therefore are not equipped to perform organ transplantations. Therefore, we did not propose to include the standard applicable to Medicare hospitals that CAHs must be a member of the Organ Procurement and Transplantation Network (OPTN), abide by its rules and provide organ transplant-related data to the OPTN, the Scientific Registry, organ procurement agencies, or directly to the Department on request of the Secretary.

The proposed CoP for CAHs included several requirements designed to increase organ donation. One of these requirements is that a CAH must have an agreement with the Organ Procurement Organization (OPO) designated by the Secretary, under which the CAH will contact the OPO in a timely manner about individuals who die or whose death is imminent. The OPO will then determine the individual's medical suitability for donation. In addition, the CAH must have an agreement with at least one tissue bank and at least one eye bank to cooperate in the retrieval, processing, preservation, storage, and distribution of tissues and eyes, as long as the agreement does not interfere with organ donation. The proposed CoP would require a CAH to ensure, in collaboration with the OPO with which it has an agreement, that the family of every potential donor is informed of its option to either donate or not donate organs, tissues, or eyes. The CAH may choose to have OPO staff perform this function, have CAH and OPO staff jointly perform this function, or rely exclusively on CAH staff. Research indicates that consent to organ donation is highest when the formal request is made by OPO staff or by OPO staff and hospital staff together. While we require collaboration, we also recognize that CAH staff may wish to perform this function and may do so when properly trained. Moreover, the CoP would require the CAH to ensure that CAH employees who initiate a request for donation to the family of a potential donor have been trained as designated requestors.

Finally, we proposed that the CoP would require the CAH to work with the OPO and at least one tissue bank and one eye bank in educating staff on donation issues, reviewing death records to improve identification of potential donors, and maintaining potential donors while necessary testing and placement of organs and tissues is underway.

Because we were sensitive to the possible burden the proposed CoP could place on CAHs, we invited public comments and information concerning the following requirements: (1) Developing written protocols for donations; (2) developing agreements with OPOs, tissue banks, and eye banks; (3) referring all deaths to the OPO; (4) working cooperatively with the designated OPO, tissue bank, and eye bank in educating staff on donation issues, reviewing death records, and maintaining potential donors. We note that the proposed requirement allowed some degree of flexibiilty for the CAH. For example, the CAH would have the option of using an OPO-approved education program to train its own employees as routine requestors or deferring requesting services to the OPO, the tissue bank, or the eye bank to provide requestors.

We did not receive any public comments on the proposed CAH CoP on organ, tissue, and eye procurement. We are adopting § 485.643 as final.

VII. MedPAC Recommendations

On March 1, 2000 the Medicare Payment Advisory Commission (MedPAC) issued its annual report to Congress, including several recommendations related to the inpatient operating payment system. Those related to the inpatient prospective payment systems were: Congress should establish a single set of payment adjustors for both the operating and capital systems; HCFA should expand the definition of transfers which applies a transfer policy to patients transferred to postacute settings; and, Congress should reformulate the Medicare DSH adjustment. In the proposed rule, we responded to these recommendations.

In addition, this year MedPAC published another report in June with additional recommendations. Among the recommendations were: FY 2001 updates to the operating and capital payment rates; moving to refined DRGs to better capture variations in patient severity; adopting DRG-specific outlier offsets; Congress should provide the Secretary the authority to adjust the

base payment amounts for anticipated coding changes; and, Congress should fold inpatient direct GME into the prospective payment system through a revised teaching hospital adjustment. A discussion of MedPAC's update recommendation can be found in Appendix D of this final rule.

A. Combined Operating and Capital Prospective Payment Systems (Recommendation 3J: March Report)

Recommendation: The Congress should combine prospective payment system operating and capital payment rates to create a single prospective rate for hospital inpatient care. This change would require a single set of payment adjustments—in particular, for indirect medical education and disproportionate share hospital payments—and a single payment update.

Response: We responded to a similar comment in the July 30, 1999 final rule (64 FR 41552), the July 31, 1998 final rule (63 FR 41013), and 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. However, we have not yet developed such a single framework as the actual operating system update has been determined by Congress through FY 2002. In the meantime, we intend to maintain as much consistency as possible with the current operating framework in order to facilitate the eventual development of a unified framework. We maintain our goal of combining the update frameworks at the end of the 10-year capital transition period (the end of FY 2001) and may examine combining the payment systems post-transition. Because of the similarity of the update frameworks, we believe that they could be combined with little difficulty.

In the discussion of its recommendation, MedPAC notes that it ''is examining broad reforms to the prospective payment system, including DRG refinement and modifications of the graduate medical education payment and the IME and DSH adjustments. The Commission believes that a combined hospital prospective payment rate should be established whether or not broader reforms are undertaken. However, if the Congress acts on any or all of the Commission's recommendations, it should consider combining operating and capital payments as part of a larger package.''

We agree that ultimately the operating and capital prospective payment systems should be combined into a single system. However, we believe that, because of MedPAC's ongoing analysis and the Administration's pending DSH report to Congress, any such unification should occur within the context of other system refinements.

B. Continuing Postacute Transfer Payment Policy (Recommendation 3K: March Report)

Recommendation: The Commission recommends continuing the existing policy of adjusting per case payments through an expanded transfer policy when a short length of stay results from a portion of the patient's care being provided in another setting.

Response: As noted in section IV.A. of this preamble, we have undertaken (through a contract with HER) an analysis of the impact on hospitals and hospital payments of the postacute transfer provision. That analysis (based on preliminary data covering only approximately 6 months of discharge data) showed a minimal impact on the rate of short-stay postacute transfers after implementation of the policy. However, average profit margins as measured by HER declined from $3,496 prior to implementation of the policy to $2,255 after implementation. We believe these preliminary findings demonstrate that the postacute transfer provision has had only marginal impact on existing practice patterns while more closely aligning the payments to hospitals for these cases with the costs incurred. Therefore, we agree with MedPAC's recommendation that the policy should be continued.

C. Disproportionate Share Hospitals (DSH) (Recommendations 3L and 3M: March Report)

Recommendation: To address longstanding problems and current legal and regulatory developments, Congress should reform the disproportionate share adjustment to: Include the costs of all poor patients in calculating low-income shares used to distribute disproportionate share payments, and use the same formula to distribute payments to all hospitals covered by prospective payment.

Response: As we noted in section IV.E. of this preamble, Public Law 106–113 directed the Secretary to require subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Act) to submit data on costs incurred for providing inpatient and outpatient hospital services for which the hospital is not compensated, including non-Medicare bad debt, charity care, and charges for Medicaid and indigent care. These data must be reported on the hospital's cost reports for cost reporting periods beginning on or after October 1, 2001, and will provide information that will enable MedPAC and us to evaluate potential refinements to the DSH formula to address the issues referred to by MedPAC.

Medicare fiscal intermediaries will audit these data to ensure their accuracy and consistency. Our experience with administering the current DSH formula leads us to believe that this auditing function would necessarily be extensive, because the non-Medicare data that would be collected have never before been collected and reviewed by Medicare's fiscal intermediaries. The data would have to be determined to be accurate and usable, and corrected if necessary.

We agree that the current statutory payment formula could be improved, largely because of different threshold levels and different formula parameters applicable to different groups of hospitals. We are in the process of preparing a report to Congress on the Medicare DSH adjustment that includes options for amending the statutory formula.

Comment: We received one comment regarding MedPAC's recommendation. The commenter expressed the concern that any unrecoverable costs from certified registered nurse anesthetist services in providing anesthesia and related care to indigent patients may not be included in the bad debt costs of hospitals.

Response: One of the difficulties in collecting uncompensated care and non-Medicare bad debt data is defining exactly the types of data being sought, particularly when there are no existing cost reporting guidelines to follow. We will be working closely with the hospital industry to identify and collect these data.

Recommendation: To provide further protection for the primarily voluntary hospitals with mid-level low-income shares, the minimum value, or threshold, for the low-income share that a hospital must have before payment is made should be set to make 60 percent of hospitals eligible to receive disproportionate share payments.

Response: Currently, fewer than 40 percent of all prospective payment system hospitals receive DSH payments. Therefore, this recommendation would entail significant redistributions of existing DSH payments if implemented in a budget neutral manner. We are particularly concerned about the effect of this recommendation on hospitals receiving substantial DSH payments currently, including major teaching hospitals and public hospitals. The analysis by MedPAC demonstrates that

these hospitals would be negatively impacted, if more hospitals were made eligible for DSH payments.

D. Severity-Adjusted DRGs (Recommendation 3A: June Report)

Recommendation: The Secretary should improve the hospital inpatient prospective payment system by adopting, as soon as practicable, DRG refinements that more fully capture differences in severity of illness among patients. At the same time, she should make the DRG payment rates more accurate by basing the DRG relative weights on the national average of hospitals' relative values in each DRG.

Response: For its analysis, MedPAC used the severity classifications from the all patient refined diagnosis related groups (APR–DRG) system. According to MedPAC, under this system each patient is initially assigned to 1 of 355 APR–DRGs. Each APR–DRG is broken into four severity classes: minor, moderate, major or extreme. Assignment to these classes within the APR–DRG is based on specific combinations of secondary diagnoses, age, procedures, and other factors. This process yields 1,420 distinct groups, compared with fewer than 500 DRGs. The MedPAC points out that ''to avoid creating refined DRGs that might have unstable relative weights, the Secretary should be selective in adopting clinical distinctions similar to those reflected in the APR–DRGs. This will require carefully weighing the benefits of more accurate clinical and economic distinctions against the potential for instability in relative weights based on small numbers of cases (p. 64).''

The MedPAC's predecessor, the Prospective Payment Assessment Commission, made a similar recommendation in 1995. In the June 2, 1995 proposed rule (60 FR 29246), we agreed with the Commission's judgment that adopting the severity DRGs would tend to reduce discrepancies between payments and costs for individual cases and thereby improve payment equity among hospitals. In the same rule, we also agreed with the Commission that basing DRG weights on standardized charges results in weights that are somewhat distorted as measures of the relative costliness of treating a typical case in each DRG, and that the hospital-specific relative value method of setting weights may reduce or eliminate distortions present in the current system.

However, in our discussion on DRG refinements in the same rule (60 FR 29209) we reiterated our position published in the final rule on September 1, 1992 (57 FR 39761) that we would not propose to make significant changes to the DRG classification system, unless we are able either to improve our ability to predict coding changes by validating in advance the impact that potential DRG changes may have on coding behavior, or to make methodological changes to prevent building the inflationary effects of the coding changes into future program payments. In addition, we would need specific legislative authority to offset, through adjustments to the standardized amounts, any significant anticipated increase in payments attributable to changes in coding practices caused by significant changes to the DRG classification system. Because we have not been granted this authority, we do not believe it would be appropriate to adopt revised severity-adjusted DRGs at this time.

E. DRG-Specific Outlier Offsets (Recommendation 3B: June Report)

Recommendation: Congress should amend the law to change the method now used to finance outlier payments under the hospital inpatient prospective payment system. Projected outlier payments in each DRG should be financed through an offsetting adjustment to the relative weight for the category, rather than the current flat adjustment to the national average base payment amounts.

Response: Under this recommendation, outlier payments would be financed through an offset to the relative weight of each DRG based on the proportion of outlier cases in that DRG, rather than an overall offset to the standardized amounts as is done currently. This would more directly relate payments under each DRG to the proportion of outlier cases occurring within that DRG.

Because the effects on DRG weights of implementing severity refinements, changing the method used to calculate DRG relative weights, and adopting DRG-specific outlier financing are interactive, we believe that we should make appropriate changes concurrently. Therefore, as stated in our response to recommendation 3A, we would not recommend that Congress implement this recommendation until we are able to offset, through adjustments to the standardized amounts, any significant anticipated increase in payments attributable to changes in coding practices caused by significant changes to the DRG classification system.

In addition, we are concerned that any benefits of adopting the Commission's recommendation would not outweigh the additional complexity and variation it would add to the already complex process of calculating outlier thresholds so that outlier payments are projected to equal a certain percentage between 5 and 6 of DRG payments.

F. Gradual Implementation of DRG Refinement and DRG-Specific Outlier Offsets (Recommendation 3C: June Report)

Recommendation: To avoid imposing extraordinary financial burdens on individual providers, the Congress should ensure that the case-mix measurement and outlier financing policies recommended earlier are implemented gradually over a period of several years. Further, the Congress should consider including protective policies, such as exemptions or hold-harmless provisions, for providers in circumstances in which vulnerable populations' access to care might be disrupted.

Response: The Commission's analyses show that implementing its case-mix measurement and outlier financing recommendations would substantially change PPS payments for many hospitals and may impose heavy burdens on individual hospitals. The Commission believes that many of these hospitals could accommodate the changes in an orderly way under traditional phase-in mechanisms. The Commission also states that some hospitals, including some groups of rural hospitals, may need longer term relief from the financial impact of these changes. The Commission suggests that this relief might include such approaches as targeted additional payments, hold-harmless provisions, and temporary or permanent exemptions.

We are concerned that implementing the Commission's recommendations may increase the need for special payment exceptions for various categories of hospitals to ensure continued access to care for many Medicare beneficiaries. Before recommending implementation of these refinements to the payment system, they must be examined to determine how the changes would impact hospitals financially and strategies would need to be developed for countering effects that could endanger beneficiaries' access to quality health care.

G. Congress Should Grant the Secretary the Authority to Offset Payments for Anticipated Coding Changes (Recommendation 3D: June Report)

Recommendation: The Congress should give the Secretary explicit authority to adjust the hospital inpatient base payment amounts if anticipated