

the beneficiary identification numbers of the Medicare patients, the dates of admission and discharge, the charges associated with each case, and all relevant ICD-9-CM codes associated with each case. We would then assess the charges of identified cases involving the new technology, accounting for the additional costs of the new technology that might not be included in the charges if the new technology is being provided by the manufacturer as part of the clinical trial. If the costs of the new technology are not included in the total charges, the requestor must submit adequate documentation upon which to formulate an estimate of the likely costs to hospitals of the new technology.

A significant sample of the data should be submitted no later than early October, approximately 6 months prior to the publication of the proposed rule. Subsequently, a complete database must be submitted no later than mid-December. This timetable is necessary to allow adequate time to assess and verify the data, as well as to work with the submitters to deal with any unique situations with respect to data availability. It is also necessary to allow us to accurately incorporate the data into the proposed rule, which we begin preparing in January. We are soliciting public comments on this process.

To illustrate the proposed use of the standard deviation thresholds, consider DRG 8 (Peripheral and Cranial Nerve and Other Nervous System Procedures Without CC). The average standardized charge of cases assigned to this DRG based on discharges during FY 2000 was \$13,212, and the standard deviation was \$8,978. Therefore, if a requestor were to seek assignment of a new technology that would otherwise be assigned to DRG 8 to a different DRG, the requestor would be expected to provide data indicating that the average standardized charge of cases receiving this new technology will exceed \$22,190. These data must be of a sufficient sample size to demonstrate a significant likelihood that the true mean across all cases likely to receive the new technology will exceed the mean for the cases in DRG 8 by one standard deviation.

Using standard deviation as the threshold takes into account the distribution of charges associated with different treatment modalities around the mean charge for a particular DRG, and the extent to which lower cost cases in the DRG should be expected to offset higher cost cases. Using this method, new technology in a DRG with very little variation in charges would be more likely to meet the criteria. This would be appropriate because there are fewer opportunities within such a DRG to

recover the costs of very high cost cases from excess payments for very low cost cases.

We note that, although we anticipate a limited number of new technologies will qualify under this proposed threshold, we will continue to evaluate the appropriateness of all DRG assignments. This applies not only to new technology but existing technologies as well.

### 3. Developing a Payment Mechanism

Section 1886(d)(5)(K)(v) of the Act, as added by section 533(b) of Public Law 106-554, provides flexibility to the Secretary in terms of deciding exactly how the requirement for an additional payment will be satisfied: a new-technology group, an add-on payment, a payment adjustment, or any other similar mechanism for increasing the amount otherwise payable. We believe the approach most consistent with the design and incentives of the inpatient hospital prospective payment system would be to assign new technology to the most appropriate DRG based on the condition of the patient as described above, and adjust payments for individual cases that involve the new technology when the costs of those cases exceed a threshold amount. That is, we would not pay an additional amount for every case involving the new technology, but only where the costs of the entire case exceed the DRG payment amount. We are concerned that the establishment of new DRGs specifically for the purpose of recognizing costly new technology could potentially severely disrupt the DRG classification structure. In particular, we are concerned that some new technologies may involve large numbers of cases across multiple DRGs. Creating new DRGs specifically for new technology would pull cases out of existing DRGs, possibly leading to severe distortions in the relative weights and inadequate payments for cases remaining in the existing DRGs.

We are proposing that Medicare provide higher payments for cases with higher costs involving identified new technologies, while preserving some of the incentives under the average-based payments for all treatment modalities for a particular patient category. The payment mechanism we are proposing would be based on the cost to hospitals for the new technology. We are proposing under § 412.88 that Medicare would pay a marginal cost factor of 50 percent for the costs of the new technology in excess of the full DRG payment. This would be calculated before any outlier payments under section 1886(d)(5)(A) of the Act, if

applicable. Similarly, cases involving new technology would be eligible for outlier payments, with the additional amounts paid for the new technology included in the base payment amount. Costs would be determined by applying the cost-to-charge ratio in a manner identical to that currently used for outlier payments. If the costs of a new technology case exceed the DRG payment by more than the estimated costs of the new technology, Medicare payment would be limited to the DRG payment plus 50 percent of the estimated costs of the new technology, except if the case qualified for outlier payments. (We are proposing a conforming change to § 412.80 by adding a new paragraph (a)(3) to provide that outlier qualifying thresholds and payments would be in addition to standard DRG payments and additional payments for new medical services and technology (effective October 1, 2001).)

For example, consider a new technology estimated to cost \$3,000, in a DRG that pays \$20,000. A hospital submits three claims for cases involving this new technology. After applying the hospital's cost-to-charge ratio, it is determined the costs of these three cases are \$19,000, \$22,000, and \$25,000. Under our proposal, Medicare would pay \$20,000 (the DRG payment) for the first claim. For the second claim, Medicare would pay one half of the amount by which the costs of the case exceed the DRG payment, up to the estimated cost of the new technology, or \$21,000 (\$20,000 plus one half of \$2,000). For the third claim, Medicare would pay \$21,500 (\$20,000 plus one half of the total estimated costs of the new technology).

We believe it is appropriate to limit the additional payment to 50 percent of the additional cost to appropriately balance the incentives. This limit would provide hospitals an incentive for continued cost-effective behavior in relation to the overall costs of the case. In addition, hospitals would face an incentive to balance the desirability of using the new technology versus the old; otherwise, there would be a large and perhaps inappropriate incentive to use the new technology. For example, in the late 1980s, we considered whether to establish a special payment adjustment for tissue plasminogen activator (TPA), a thrombolytic agent used in treating blockages of coronary arteries, reflecting the high costs of the drug. We did not establish such an adjustment because we believed that the updates to the standardized amounts, combined with the potential for continuing improvements in hospital

productivity, would be adequate to finance appropriate care of Medicare patients. In fact, the costs of the drug were offset by shorter hospital stays and an overall reduction in costs per case. As clinical experience with TPA accumulated, furthermore, it appeared that the drug was not as widely beneficial as its original proponents expected. Establishing an add-on payment for this drug might have actually led to more extensive use of this drug for patients who would not have benefited, and might have even been harmed, by its blood-thinning characteristics.

#### 4. Budget Neutrality

The report language accompanying section 533 of Public Law 106-554 directs that the Secretary implement the new mechanism on a budget neutral basis (H.R. Conf. Rep. No. 106-1033, 106th Cong., 2d Sess. at 897 (2000)). Section 1886(d)(4)(C)(iii) of the Act requires that the adjustments to annual DRG classifications and relative weights must be made in a manner that ensures that aggregate payments to hospitals are not affected. Therefore, we would simulate projected payments under this provision for new technology during the upcoming fiscal year at the same time we estimate the payment effect of changes to the DRG classifications and recalibration. The impact of those additional payments would then be factored into the budget neutrality factor, which is applied to the standardized amounts.

Because any additional payments directed toward new technology under this provision would be offset to ensure budget neutrality, it is important to carefully consider the extent of this provision and ensure that only technologies representing substantial advances are recognized for additional payments. In that regard, we would discuss in the annual proposed and final regulations implementing changes to the inpatient hospital prospective payment system those technologies that were considered under this provision; our determination as to whether a particular new technology meets our criteria for a new technology; whether it is determined further that cases involving the new technology would be inadequately paid under the existing DRG payment; and any assumptions that went into the budget neutrality calculations related to additional payments for that new technology, including the expected number, distribution, and costs of these cases.

The payments made under this provision would be redistributed from all other payments made under the

inpatient prospective payment system; DRG payments would be reduced by amounts we estimate to be necessary to pay for the estimated aggregate new technology payments. Our projections of the aggregate payments for new technology would involve not only estimates of the effect of the new technology on the entire cost per case but also estimates of the volume of cases expected to involve the new technology during the upcoming year. Given the uncertainty in both of these aspects of the projections, we believe it is important to expose our estimates to public comment before implementing them.

#### 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 in part 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 1886(h)(2) of the Act, as amended by section 9202 of the Consolidated Omnibus Reconciliation Act (COBRA) of 1985 (Public Law 99-272), and implemented in regulations at § 413.86(e), establishes a methodology for determining payments to hospitals for the costs of approved GME programs. Section 1886(h)(2) of the Act, as amended by COBRA, 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 FTE residents working in all areas of the hospital complex (or nonhospital 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 updated for inflation 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 and obstetrics and gynecology residents and nonprimary care residents have two separate PRAs beginning in FY 1994: one for primary care and one for nonprimary care.

Section 1886(h)(2) of the Act was further amended by section 311 of Public Law 106-113 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 1886(h)(2) of the Act 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. PRAs that are below the floor, that is, 70 percent of the locality-adjusted, updated, weighted average PRA, would be revised to equal 70 percent of the locality-adjusted, updated, weighted average PRA. PRAs that exceed the ceiling, that is, 140 percent of the locality-adjusted, updated, weighted average PRA, would, depending on the fiscal year, either be frozen and not increased for inflation, or increased by a reduced inflation factor. We implemented section 311 of Public Law 106-113 in the hospital inpatient prospective payment system final rule published on August 1, 2000 (65 FR 47090). In that final rule, we set forth the methodology for calculating the weighted average PRA and outlined the steps for determining whether a hospital's PRA would be revised.

##### 2. Amendments Made by Section 511 of Public Law 106-554 (§ 413.86(e)(4)(ii)(C) and (e)(5)(iv))

Section 511 of Public Law 106-554 amended section 1886(h)(2)(D)(iii) of the Act by increasing the floor to 85 percent of the locality-adjusted national average PRA. In general, section 511 provides that, effective for cost reporting periods beginning on or after October 1, 2001, and before October 1, 2002, PRAs that are below 85 percent of the respective locality-adjusted national average PRA would be increased to equal 85 percent of that locality-adjusted national average PRA. Accordingly, we are proposing to implement section 511 by revising § 413.86(e)(4)(ii)(C)(1) to incorporate this change and by outlining the methodology for determining whether a hospital's PRA(s) will be adjusted in FY 2002 relative to the increased floor of the locality-adjusted national average PRA.

In the August 1, 2000 final rule (65 FR 47091 and 47092), as implemented at

§ 413.86(e)(4), we determined, in accordance with section 311 of Public Law 106-113, that the weighted average PRA for cost reporting periods ending during FY 1997 is \$68,464. We described the procedures for updating the weighted average PRA of \$68,464 for inflation to FY 2001 and for adjusting this average for the locality of each individual hospital. We then outlined the steps for comparing each hospital's PRA(s) to the locality-adjusted national average PRA to determine if, for cost reporting periods beginning on or after October 1, 2000, and before October 1, 2001, the PRAs should be revised to equal the 70-percent floor.

In accordance with section 511 of Public Law 106-554, in this proposed rule, we are proposing that, for cost reporting periods beginning during FY 2002, the FY 2002 PRAs of hospitals that are below 85 percent of the respective locality-adjusted national average PRA for FY 2002 be increased to equal 85 percent of that locality-adjusted national average PRA. Specifically, to determine which PRAs (primary care and nonprimary care separately) for each hospital are below the 85-percent floor, each hospital's locality-adjusted national average PRA for FY 2002 is multiplied by 85 percent. This resulting number is then compared to each hospital's PRA that is updated for inflation to FY 2002. If the hospital's PRA would be less than 85 percent of the locality-adjusted national average PRA, the individual PRA is *replaced* with 85 percent of the locality-adjusted national average PRA for that cost reporting period, and in future years the new PRA would be updated for inflation by the Consumer Price Index for All Urban Consumers (CPI-U) as compiled by the Bureau of Labor Statistics.

There may be some hospitals with both primary care and nonprimary care PRAs that are below the floor, and both PRAs are, therefore, replaced with 85 percent of the locality-adjusted national average PRA. In these situations, the hospitals would receive a single PRA; a distinction between PRAs would no longer be made for differences in inflation (under § 413.86(e)(3)(ii)). On the other hand, hospitals may have primary care PRAs that are above the floor, and nonprimary care PRAs that are below the floor. In these situations, only the nonprimary care PRAs would be revised to equal 85 percent of the locality adjusted national average PRA, and the prior year primary care PRAs would be updated for inflation by the CPI-U.

For example, if the FY 2002 locality-adjusted national average PRA for Area X is \$100,000, then 85 percent of that

amount is \$85,000. If, in Area X, Hospital A has a primary care FY 2002 PRA of \$84,000 and a nonprimary care FY 2002 PRA of \$82,000, both of Hospital A's FY 2002 PRAs are replaced by the \$85,000 floor. Thus, \$85,000 is the amount that would be used to determine Hospital A's direct GME payments for both primary care and nonprimary care FTEs in its cost reporting period beginning in FY 2002, and the \$85,000 PRA would be updated for inflation by the CPI-U in subsequent years. However, Hospital B, also located in Area X, has a primary care FY 2002 PRA of \$86,000 and a nonprimary care FY 2002 PRA of \$84,000. Thus, for Hospital B, only the nonprimary care PRA of \$84,000 is replaced by the \$85,000 floor. This new PRA of \$85,000 would be updated for inflation by the CPI-U in subsequent years. Hospital B's primary care PRA of \$86,000 and its nonprimary care PRA of \$85,000 would be used to determine its direct GME payments in its cost reporting period beginning in FY 2002.

We note that section 511 of Public Law 106-554 only affects hospitals with PRAs below the 85-percent floor, and does not affect hospitals with PRAs that are either between the floor and ceiling or exceed the ceiling. Thus, with the exception of the change in the floor as provided by section 511, the policy regarding the use of a national average PRA for making direct GME payments remains as implemented in the regulations at § 413.86(e)(4).

We are proposing to amend § 413.86(e)(4)(ii)(C)(1) to add the rules implementing section 1886(h)(2)(D)(iii) of the Act as amended by section 511 of Public Law 106-554.

We also are proposing to amend § 413.86(e)(5) regarding the determination of base year PRAs for new teaching hospitals for cost reporting periods beginning during FYs 2001 through 2005. In the August 1, 2000 final rule, we made a conforming change to § 413.86(e)(5) to account for situations in which hospitals do not have a 1984 base year PRA and establish a PRA in a cost reporting period beginning on or after October 1, 2000. Existing § 413.86(e)(5)(iv) specifies that the new base year PRAs of such hospitals are subject to the regulations regarding the floor and the ceiling of the locality-adjusted national average PRA. Although the determination of new base year PRAs is subject to the national average methodology, it is not necessary to include this provision in the regulations. Therefore, we are proposing to remove § 413.86(e)(5)(iv).

We would like to clarify that, for purposes of calculating a base year PRA

for a new teaching hospital, when calculating the weighted mean value of PRAs of hospitals located in the same geographic area or the weighted mean value of the PRAs in the hospital's census region (as defined in § 412.62(f)(1)(i)), the PRAs used in the weighted average calculation must not be less than the floors for cost reporting periods beginning during FY 2001 or FY 2002, or if they exceed the ceiling, they must either be frozen for FYs 2001 and 2002 or updated with the CPI-U minus 2 percent for FYs 2003 through 2005. In addition, existing § 413.86(e)(5) provides that the PRA for a new teaching hospital is based on the *lower* of the hospital's actual costs incurred in connection with the GME program or the weighted mean value of PRAs. For cost reporting periods beginning during FYs 2001 and 2005, the PRA for a new teaching hospital also would be subject to the floor and the ceiling of the national average PRA methodology. If a hospital's actual costs of the GME program during its cost reporting period beginning during FY 2001 or FY 2002 are *less* than the floors, the hospital's PRA would *not* be based on the actual costs. Instead, it would be equal to 70 percent in FY 2001, or 85 percent during FY 2002, of the locality-adjusted national average PRA. The floor applies to hospitals with existing PRAs in FYs 2001 and 2002, or to hospitals that are establishing new base year PRAs in FYs 2001 and 2002. We are proposing to clarify that if a hospital establishes a new base year PRA in a cost reporting period beginning *after* FY 2002, its PRA would *not* be increased to equal the floor if it is less than the floor. Similarly, the ceiling applies to hospitals with existing PRAs in FYs 2001 through 2005, or to hospitals that are establishing new base year PRAs in FYs 2001 through 2005.

### 3. Determining the 3-Year Rolling Average for Direct GME Payments (§ 413.86(g)(4) and (g)(5))

Section 1886(h)(4)(G)(iii) of the Act, as added by section 4623 of Public Law 106-33, provides that for the hospital's first cost reporting period beginning on or after October 1, 1997, the hospital's weighted FTE count for direct GME payment purposes equals the average of the weighted FTE count for that cost reporting period and the preceding cost reporting period. For cost reporting periods beginning on or after October 1, 1998, section 1886(h)(4)(G) of the Act requires that hospitals' direct medical education weighted FTE count for payment purposes equal the average of the actual weighted FTE count for the payment year cost reporting period and

the preceding two cost reporting periods (rolling average). This provision phases in the associated reduction in payment over a 3-year period for hospitals that are reducing their number of residents.

In the August 29, 1997 final rule with comment period (62 FR 46004), we revised § 413.86(g)(5) accordingly, and outlined the methodology for determining a hospital's direct GME payment. Based on what we explained in the 1997 final rule, for cost reporting periods beginning on or after October 1, 1997, we would determine a hospital's direct GME payment as follows:

*Step 1.* Determine the average of the weighted FTE counts for the payment year cost reporting period and the prior two immediately preceding cost reporting periods (with exception of the hospital's first cost reporting period beginning on or after October 1, 1997, which will be based on the average of the weighted average for that cost reporting period and the immediately preceding cost reporting period).

*Step 2.* Determine the hospital's direct GME amount without regard to the FTE cap (before determining Medicare's share). That is, take the sum of (a) the product of the primary care PRA and the primary care weighted FTE count in the current payment year, and (b) the product of the nonprimary care PRA and the nonprimary care weighted FTE count in the current payment year.

*Step 3.* Divide the hospital's direct GME amount by the total number of FTE residents (including the effect of weighting factors) for the cost reporting period to determine the weighted average PRA (this amount reflects the FTE weighted average of the primary and nonprimary care PRAs) for the cost reporting period.

*Step 4.* Multiply the weighted average PRA for the cost reporting period by the 3-year average weighted count to determine the hospital's allowable direct GME costs. This product is then multiplied by the hospital's Medicare patient load for the cost reporting period to determine Medicare's direct GME payment to the hospital.

Steps 2 and 3 above describe the methodology for combining a hospital's primary care PRA and nonprimary care PRA to determine the hospital's single weighted average PRA for the payment year cost reporting period. (This step accounts for hospitals that were training residents in both primary care and nonprimary care residency programs in FYs 1994 and 1995, when, as described in § 413.86(e)(3)(ii), each hospital's PRA for the previous cost reporting period was not adjusted for any resident FTEs who were not either a primary care resident or an obstetrics or a gynecology

resident. As a result, such hospitals have two PRAs for direct GME payment; one for primary care and obstetrics and gynecology residents, and one for all other, or nonprimary care, residents. Hospitals that train either only primary care (including obstetrics and gynecology) residents or only nonprimary care residents follow the methodology described above, with the exception of combining two PRAs). Step 4 then dictates that the resulting average PRA is multiplied by the 3-year rolling average, which, in turn, is multiplied by the hospital's Medicare patient load in the current year to determine Medicare's direct GME payment to the hospital for that cost reporting period.

In implementing this provision in the August 29, 1997 final rule with comment period, we believed that the methodology described above was appropriate because it was consistent with the methodology described under section 1886(h)(3)(B) of the Act. This section specifies that, in order to arrive at the average PRA, or "aggregate approved amount," HCFA must multiply a hospital's PRA by the "weighted average number of [FTE] residents \* \* \* in the hospital's approved medical residency training programs *in that period*" (emphasis added).

We also believed the methodology outlined above and in the August 29, 1997 rule was appropriate because it was consistent with the intent of the statute that, after October 1, 1997, direct GME payments should be based on a rolling average. Specifically, section 4623 of Public Law 106-33 provides that, "For cost reporting periods beginning on or after October 1, 1997 \* \* \* *the total number of full-time equivalent residents for determining a hospital's graduate medical education payment shall equal the average of the actual full-time equivalent resident counts for the cost reporting period and the preceding two cost reporting periods*" (emphasis added). Thus, while the statute does not include a specific methodology for computing the direct GME payments, it clearly indicates that the payment should be based on a 3-year average of the weighted number of residents, *not* the weighted number of residents in the current payment year cost reporting period.

As stated above, Congress provided that the direct GME payments should be made based on a 3-year average of the weighted number of residents in order to phase in the associated reduction in payment over a 3-year period for hospitals that are reducing the number of residents they are training. However, in steps 2 and 3 above, when combining

a hospital's primary care PRA and nonprimary care PRA, we weight the respective PRAs by *current year* residents. This introduces the number of residents that a hospital is training in the *current cost reporting period* into the payment formula. A payment formula that incorporates the number of current year residents "dilutes" the effect of the rolling average as related to direct GME payments. After further consideration, we believe that, consistent with the statute, the formula should be based on rolling average counts of residents. We are proposing an alternative methodology in which the direct GME payment would be the sum of (a) the product of the primary care PRA and the primary care and obstetrics and gynecology rolling average, and (b) the product of the nonprimary care PRA and the nonprimary care rolling average. (This sum would then be multiplied by the Medicare patient load.) We note that IME payments would not be affected because, although they also are based on a 3-year rolling average, there is no distinction between primary care and nonprimary care residents.

The new methodology would be effective for cost reporting periods beginning on or after October 1, 2001. The proposed methodology for determining a hospital's direct GME payment is as follows:

*Step 1.* Determine that the hospital's total unweighted FTE counts in the payment year cost reporting period and the prior two immediately preceding cost reporting periods for all residents in allopathic and osteopathic medicine do not exceed the hospital's FTE cap for these residents in accordance with § 413.86(g)(4). If the hospital's total unweighted FTE count in a cost reporting period exceeds its cap, the hospital's weighted FTE count, for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced in the same proportion that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. The proportional reduction is calculated *for primary care and obstetrics and gynecology residents and nonprimary care residents separately* in the following manner:

(FTE cap/unweighted total FTEs in the cost reporting period) × (weighted primary care and obstetrics and gynecology FTEs in the cost reporting period)  
 plus  
 (FTE cap/unweighted total FTEs in the cost reporting period) × (weighted nonprimary care FTEs in the cost reporting period).

Add the two products to determine the hospital's reduced cap.

*Step 2.* Determine the 3-year average of the weighted FTE count for primary care and obstetrics and gynecology residents in the payment year cost reporting period and the two immediately preceding cost reporting periods. Determine the 3-year average of the weighted FTE count for nonprimary care residents in the payment year cost reporting period and the two immediately preceding cost reporting periods.

*Step 3.* Determine the product of the primary care PRA and the primary care and obstetrics and gynecology 3-year average from step 2. Determine the product of the nonprimary care PRA and the nonprimary care 3-year average from step 2.

*Step 4.* Sum the products of step 3.

*Step 5.* Multiply the sum from step 4 by the hospital's Medicare patient load for the cost reporting period to determine Medicare's direct GME payment to the hospital.

Existing § 413.86(g)(5) specifies that residents in new programs are excluded from the rolling average calculation for a period of years equal to the minimum accredited length for the type of program, and are added to the payment formula after applying the averaging rules. Accordingly, for hospitals that qualify for an adjustment to their FTE caps for residents training in new programs under § 413.86(g)(6), primary care and obstetrics and gynecology residents in new programs would be added to the quotient of the primary care and obstetrics and gynecology 3-year average, and nonprimary care residents in new programs would be added to the quotient of the nonprimary care 3-year average. The sums of the respective 3-year averages and new residents would then be multiplied by the respective PRAs.

The following example illustrates the determination of direct GME payment under the proposed rolling average methodology for an existing teaching hospital with no new programs:

*Example:* Assume a hospital with a cost reporting period ending September 30, 1996 (beginning October 1, 1995) had 100 unweighted FTE residents and 90 weighted FTE residents. The hospital's FTE cap is 100 unweighted residents.

*Step 1.* In its cost reporting period beginning in FY 2000, it had 100 unweighted residents and 90 weighted residents (50 primary care and 40 nonprimary care).

- The hospital had 90 unweighted residents and 85 weighted residents (50 primary care and 35 nonprimary care)

for its cost reporting period beginning in FY 2001.

- In its cost reporting period beginning in FY 2002, the hospital had 80 unweighted residents and 80 weighted residents (50 primary care and 30 nonprimary care).

*Step 2.* The 3-year average of weighted primary care and obstetrics and gynecology residents is  $(50 + 50 + 50)/3 = 50$ . The 3-year average of weighted nonprimary care residents is  $(40 + 35 + 30)/3 = 35$ .

*Step 3.* Primary care:  $\$80,000 \text{ PRA} \times 50 \text{ weighted primary care and obstetrics and gynecology FTEs} = \$4,000,000$ . Nonprimary care:  $\$78,000 \times 35 \text{ weighted nonprimary care FTEs} = \$2,730,000$ .

*Step 4.*  $\$4,000,000 + \$2,730,000 = \$6,730,000$ .

*Step 5.* If the hospital's Medicare patient load for the payment cost reporting period is .20, Medicare's direct GME payment would be  $\$6,730,000 \times .20 = \$1,346,000$ .

Whether the proposed methodology results in a payment difference for a hospital is dependent upon whether or not the number and mix (primary care and nonprimary care) of FTEs changes in a 3-year period. If the number and mix of FTEs does not change in a 3-year period, there would be no difference in a direct GME payment amount derived using the proposed methodology versus the existing methodology. For example, if a hospital has 90 weighted FTEs (50 primary care and 40 nonprimary care) in the current year and the 2 previous years (using the PRAs and the Medicare patient load from the example above), the payment amounts derived from the existing methodology and the proposed methodology would be equal.

If the number and mix of FTEs varies from year to year, there will be a difference in the results of the two methodologies. In some instances the existing methodology would result in a higher payment, and in other instances the proposed methodology would result in a higher payment. In the example above, the hospital has reduced its number of weighted residents by 5 FTEs in FYs 2001 and 2002. Calculating this hospital's direct GME payment amount using the existing methodology (using the PRAs and the Medicare patient load from the example) would result in a payment of \$1,347,250, which is \$1,250 more than \$1,346,000, the amount calculated in the example using the proposed methodology.

In a scenario where a hospital makes larger reductions to the number of FTEs, the proposed methodology may be more beneficial. For example, using the PRAs and the Medicare patient load from the example above, assume a hospital has

90 weighted FTEs (50 primary care and 40 nonprimary care) in FY 2000, 85 weighted FTEs (50 primary care and 35 nonprimary care) in FY 2001, and 70 weighted FTEs (35 primary care and 35 nonprimary care) in FY 2002. If the proposed methodology is used, the payment amount of \$1,292,050 would be calculated, which is \$1,666 more than \$1,290,386, the amount calculated if the existing methodology is used.

We are proposing to revise § 413.86(g)(4) to specify that, effective for cost reporting periods beginning on or after October 1, 2001, if the hospital's total unweighted FTE count in a cost reporting period exceeds its cap, the hospital's weighted FTE count, for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced in the same proportion that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. We also are proposing to revise § 413.86(g)(5) to specify that, effective for cost reporting periods beginning on or after October 1, 2001, the direct GME payment will be calculated using two separate rolling averages, one for primary care and obstetrics and gynecology residents and one for nonprimary care residents.

#### 4. Counting Research Time as Direct and Indirect GME Costs (§§ 412.105 and 413.86)

It has come to our attention that there appears to be some confusion in the provider community as to whether the time that residents spend performing research is countable for the purposes of direct and indirect GME reimbursement. Although we are not proposing to make any policy changes in this proposed rule, we would like to reiterate our longstanding policy regarding time that residents spend in research and propose to incorporate this policy in the IME regulations.

Section 413.86(f) specifies that, for the purposes of determining the total number of FTE residents for the direct GME payment, residents in an approved program working in all areas of the hospital complex may be counted. Accordingly, the time the residents spend performing research as part of an approved program anywhere in the hospital complex may be counted for direct GME payment purposes. If the requirements listed at §§ 413.86(f)(3) and (f)(4) are met, a hospital may also count the time residents spend doing research in non-hospital settings for direct GME payment.

For purposes of determining the IME payment, § 412.105(f)(ii) specifies that

the time residents spend training in parts of the hospital that are subject to the inpatient prospective payment system, in the outpatient departments, or (effective on or after October 1, 1997, in accordance with §§ 413.86(f)(3) and (f)(4)) in nonhospital settings, may be counted. Section 2405.3.F.2. of the Provider Reimbursement Manual (PRM) further states that a resident must not be counted for the IME adjustment if the resident is engaged exclusively in research. Resident time spent “exclusively” in research means that the research is not associated with the treatment or diagnosis of a particular patient of the hospital. Therefore, although the research component may be part of an approved program, *the time that residents devote specifically to performing research that is not related to delivering patient care*, whether it occurs in the hospital complex or in non-hospital settings, *may not be counted for IME payment purposes*. “Exclusively research” time is not allowable for IME purposes irrespective of whether the resident is engaged only in research or spends only part of his or her time on research. Accordingly, time spent exclusively in research over the course of a program year should be subtracted from the total FTE for that year. For example, if a resident is required to spend 3 months in a particular program year engaged in research activities unrelated to delivering patient care, that amount of time should be subtracted from the total FTE, whether or not the research time is fulfilled in one block of time, or is distributed throughout the training year.

We note that in order to count residents for both direct GME and IME payment purposes, the residents’ training must be part of an approved program. *This applies whether or not the residents are doing work that is clinical in nature*. There are situations where residents have completed their residency program requirements but remain for an additional period of time to continue their training (that is, to conduct research or other activities) outside the context of a formally organized approved program. As we explained in the September 29, 1989 final rule (54 FR 40306), these residents are *not* countable for direct GME or IME reimbursement. Rather, patient care services provided by these residents should be paid as Part B services.

We are proposing to amend § 412.105(f)(1)(iii) to add a paragraph (B) to incorporate language that reflects this policy.

#### 5. Temporary Adjustments to FTE Cap To Reflect Residents Affected by Residency Program Closure

In the July 30, 1999 hospital inpatient prospective payment system final rule (64 FR 41522), we indicated that we would allow a temporary adjustment to a hospital’s FTE resident cap under limited circumstances and if certain criteria are met when a hospital assumes the training of additional residents because of another hospital’s closure. We made this change because hospitals had indicated a reluctance to accept additional residents from a closed hospital without a temporary adjustment to their caps. When we proposed this change 2 years ago, we received several comments suggesting that we include lost accreditation of a program (that is, a program’s closure) in the temporary adjustment policy. We explained in our response to these comments (64 FR 41522) that we did not believe it was appropriate to expand our policy to cover any acts other than a hospital’s closure. We made this decision because, unless the hospital terminates its Medicare agreement, the hospital would retain its statutory FTE cap and could affiliate with other hospitals to enable the residents to finish their training.

It has come to our attention that, despite a hospital’s ability to affiliate with other hospitals when it shuts down a residency program, some hospitals for various reasons do not affiliate before their programs close, particularly when the program closes abruptly towards the end of the program year (the deadline to submit Medicare affiliation agreements is July 1 of the upcoming program year). Therefore, we are proposing that if a hospital that closes its residency training program agrees to temporarily reduce its FTE cap, another hospital(s) may receive a temporary adjustment to its FTE cap to reflect residents added because of the closure of the former hospital’s residency training program. For purposes of this proposed policy on closed programs, we are proposing to define “closure of a hospital residency training program” as when the hospital ceases to offer training for residents in a particular approved medical residency training program (proposed § 413.86(g)(8)(i)(B)). The methodology for adjusting the caps for the “receiving hospital” and the “hospital that closed its program” is described below.

a. *Receiving hospital*. We are proposing that a hospital(s) may receive a temporary adjustment to its (or their) FTE cap to reflect residents added because of the closure of another

hospital’s residency training program if—

- The hospital is training additional residents from the residency training program of a hospital that closed its program; and
- No later than 60 days after the hospital begins to train the residents, the hospital submits to its fiscal intermediary a request for a temporary adjustment to its FTE cap, documents that the hospital is eligible for this temporary adjustment by identifying the residents who have come from another hospital’s closed program and have caused the hospital to exceed its cap, specifies the length of time the adjustment is needed, and submits to its fiscal intermediary a copy of the FTE cap reduction statement by the hospital closing the program, as specified in paragraph (g)(8)(iii)(B)(2).

In general, the above criteria we are proposing for the temporary adjustment are reflective of the criteria for the temporary adjustment for taking on the training of displaced residents from closed hospitals. We note that we are proposing that more than one hospital would be eligible to apply for the temporary adjustment, because residents from one closed program may go to different hospitals, or they may finish their training at more than one hospital. We also note that only to the extent a hospital would exceed its FTE cap by training displaced residents would it be eligible for the temporary adjustment.

Finally, we note that we are proposing that hospitals that meet the above proposed criteria would be eligible to receive temporary adjustments (for cost reporting periods beginning on or after October 1, 2001, for direct GME and with discharges beginning on or after October 1, 2001 for IME) for training the displaced residents from programs that closed even before the effective date of this policy. We mention this because hospitals may have closed programs in the recent past and the residents from the closed programs may not have completed their training as of the effective date of this policy. For instance, if a 5-year residency program, such as surgery, closed on July 1, 1997, the 5th program year residents may still be training during this residency year (2001). We are proposing that if both the receiving hospital(s) and the hospital that closed the program in this example follow the criteria described in this preamble, the receiving hospital may receive a temporary adjustment to its FTE cap for 9 months (October 1, 2001 through June 30, 2002) to accommodate the 5th year surgery residents. However, we note that hospitals would not be

eligible to receive a temporary adjustment for training the residents until the effective date of this rule.

b. *Hospital that closed its program(s).* We are proposing that a hospital that agrees to train residents who have been displaced by the closure of another hospital's program may receive a temporary FTE cap adjustment only if the hospital with the closed program(s)—

- Temporarily reduces its FTE cap by the number of FTE residents in each program year training in the program at the time of the program's closure. The yearly reduction would be determined by deducting the number of those residents who would have been training in the program year during each year had the program not closed; and
- No later than 60 days after the residents who were in the closed program begin training at another hospital, submits to its fiscal intermediary a statement signed and dated by its representative that specifies that it agrees to the temporary reduction in its FTE cap to allow the hospital training the displaced residents to obtain a temporary adjustment to its cap; identifies the residents who were training at the time of the program's closure; identifies the hospitals to which the residents are transferring once the program closes; and specifies the reduction for the applicable program years.

Unlike the closed hospital policy at § 413.86(g)(8), we are proposing under this closed program policy (which we are proposing to amend § 413.86(g)(8) to include), that in order for the receiving hospital(s) to qualify for a temporary adjustment to its FTE cap, the hospitals that are closing their programs would need to reduce their FTE cap for the duration of time the displaced residents would need to finish their training. We are proposing this change because, as explained below, the hospital that closes the program still has the FTE slots in its cap, even if the hospital chooses not to fill the slots with residents. We believe it is inappropriate to allow an increase to the receiving hospital's cap without an attendant decrease to the cap of the hospital with the closed program, even if the increase is only temporary. We note that even under this proposed closed program policy, the hospital that closes its program may choose instead to affiliate with another hospital by July 1 of the next residency year so that the residents can more easily finish their training.

We are proposing that the cap reduction for the hospital with the closed program would be based on the number of FTE residents in each

program year who were in the program at the program's closure, and who began training at another hospital, rather than the count of residents each year at the hospital(s) receiving the temporary adjustment(s). We believe it would be too burdensome administratively to require the hospital closing the program to keep track of the status of the residents when they are training at other hospitals. For instance, Joe Smith, a resident who is a PGY 1 when Hospital X closes its pathology residency program, may then finish his training at Hospital Y. The resident trains for one year at Hospital Y as a PGY 2, but decides to drop out of the program before finishing. It would be burdensome to require Hospital X to keep track of Joe Smith's status while he is training at Hospital Y for purposes of the reduction in Hospital X's cap. Therefore, we are proposing to "freeze" the basis for the reduction of the FTE cap of the hospital that closed the program based on the count and status of the residents when the hospital closes the program.

*Example:* Hospital A, which has a direct GME FTE cap of 20 FTEs and an IME FTE cap of 18 FTEs, is experiencing financial difficulties and decides to close down its internal medicine residency training program effective June 30, 2002. As of June 30, 2002, Hospital A is training 2 PGY 1s, 4 PGY 2s, and 6 PGY 3s in its internal medicine program. Hospitals B, C, and D take on the training of the displaced residents. These hospitals are eligible to receive temporary adjustments to their FTE caps if they follow the proposed criteria stated above. In order for Hospitals B, C, and D to receive the temporary adjustments, however, Hospital A must agree to reduce its FTE cap. According to the proposed criteria stated above, Hospital A's reduction would be:

*July 1, 2002 through June 30, 2003*

Direct GME FTE cap: 14 FTEs, (20 FTEs cap—2 PGY 2s—4 PGY 3s)

IME FTE cap: 12 FTEs (18 FTEs—2 PGY 2s—4 PGY 3s)

We note that no downward adjustment for the 6 PGY 3s for either cap is necessary since these residents will have completed their training in that program by the July 1, 2000 through June 30, 2003 program year.

*July 1, 2003 through June 30, 2004*

Direct GME FTE cap: 18 FTEs (20 FTEs cap—2 PGY 3s)

IME FTE cap: 16 FTEs (18 FTEs cap—2 PGY 3s)

*July 1, 2004 through June 30, 2005*

Direct GME FTE cap: 20 FTEs  
IME FTE cap: 18 FTEs

We also are proposing to revise § 412.105(f)(1)(ix) to make the provision relating to the adjustment to FTE caps to reflect residents affected by closure of hospitals' medical residency training programs applicable to determining the IME payment.

#### 6. Conforming Change to Regulations Governing Payment to Federally Qualified Health Centers (§ 405.2468(f))

We have discovered a technical error in the regulations at § 405.2468(f) regarding payment to federally qualified health centers (FQHCs) and rural health centers (RHCs) for the costs of graduate medical education. Specifically, § 405.2468(f)(6)(ii)(D) provides that "The costs associated with activities described in § 413.85(d) of this chapter" are not allowable graduate medical education costs. We recently amended § 413.85 in a final rule (66 FR 3358, January 12, 2001) regarding Medicare pass-through payment for approved nursing and allied health education programs. However, we inadvertently did not make a conforming change to § 405.2468(f)(6)(ii)(D). Section 405.2468(f)(6)(ii)(D) should read "The costs associated with activities described in § 413.85(h) of this chapter." We are proposing to revise § 405.2468(f)(6)(ii)(D) to reflect this change.

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

#### A. End of the Transition Period

Federal fiscal year (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 in this proposed rule, 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 cost reporting periods beginning on or after October 1, 1991 (FY 1992) and before October 1, 2001 (FY 2002). Beginning in FY 2001, the last year of the 10-year transition period for the prospective payment system for hospital capital-related costs, capital prospective payment system payments are based solely on the Federal rate for the vast majority of hospitals. Since FY 2001 is the final year of the capital transition period, we will no longer determine a hospital-specific rate for FY 2002 in section IV. of the Addendum of this proposed rule. For cost reporting periods beginning on or after October 1, 2001, payment for capital-related costs for all hospitals, except those defined as new hospitals under § 412.30(b), will be determined based solely on the capital standard Federal rate.

Generally, during the transition period, inpatient capital-related costs are paid on a per discharge basis, and the amount of payment depended 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.

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 were 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.

Hospitals that are defined as "new" for the purposes of capital payments during the transition period (see § 412.300(b)) will continue to be paid according to the applicable payment methodology outlined in § 412.324. 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 capital-related costs 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 will be 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:

$$\begin{aligned} & (\text{Standard Federal Rate}) \times (\text{DRG Weight}) \\ & \times (\text{GAF}) \times (\text{Large Urban Add-on, if} \\ & \text{applicable}) \times (\text{COLA Adjustment for} \\ & \text{Hospitals Located in Alaska and} \\ & \text{Hawaii}) \times (1 + \text{DSH Adjustment} \\ & \text{Factor} + \text{IME Adjustment Factor}) \end{aligned}$$

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.

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 as specified in the regulations at § 412.374. 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 (56 FR 43409), we established a capital exceptions policy, which provided 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 the 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 have received 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 has been subject to the capital prospective payment transition rules. The minimum payment percentages throughout the transition period for regular capital exceptions payments by class of hospitals 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 expires at the end of the transition period, that is, on September 30, 2001. Capital prospective payment system payments are no longer adjusted to reflect regular exceptions payments at § 412.348 after that date. Accordingly, for cost reporting periods beginning on or after October 1, 2001, all hospitals other than those defined as "new" under § 412.300(b) 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).

#### B. Special Exceptions Process

In the August 30, 1991 final rule (56 FR 43409), we established a capital exceptions policy at § 412.348, which provided for *regular* exception payments during the transition period. In the September 1, 1994 final rule (59 FR 45385), we added the *special* exceptions process, describing it as " \* \* \* narrowly defined, focusing on a small group of hospitals who found themselves in a disadvantaged position. The target hospitals were those who had an immediate and imperative need to begin major renovations or replacements just after the beginning of the capital prospective payment system. These hospitals would not be eligible for protection under the old capital and obligated capital provisions, and would not have been allowed any time to accrue excess capital prospective payments to fund these projects."

Under the special exceptions provisions at § 412.348(g), an additional payment may be made through the 10th year beyond the end of the capital prospective payment system transition period for eligible hospitals that meet (1) a project need requirement as described at § 412.348(g)(2), which, in the case of certain urban hospitals, includes an excess capacity test; and (2) a project size requirement as described at § 412.348(g)(5). Eligible hospitals include sole community hospitals, urban hospitals with at least 100 beds that have a disproportionate share percentage of at least 20.2 percent, and hospitals with a combined Medicare and Medicaid inpatient utilization of at least 70 percent.

When we established the special exceptions process, we selected the hospital's cost reporting period beginning before October 1, 2001, as the project completion date in order to limit cost-based exceptions payments to a period of not more than 10 years beyond the end of the transition to the fully Federal capital prospective payment system. Therefore, hospitals are eligible to receive special exceptions payments for the 10 years after the cost reporting year in which they complete their project. Generally, if a project is completed in the hospital cost reporting period ending September 29, 2002, exceptions payments would continue through September 29, 2012. In addition, we believe that, for projects completed after the deadline, hospitals would have had the opportunity to reserve their prior years' capital prospective payment system payments for financing projects. We note that the August 1, 2000 final rule (65 FR 47095) incorrectly stated that special exceptions payments could extend through September 30, 2011; the date should have been September 29, 2012.

For each cost reporting period, the amount of the special exceptions payment is determined by comparing the cumulative payments made to the hospital under the capital payment system to the cumulative minimum payment levels applicable to the hospital for each cost reporting period subject to the prospective payment system. This comparison is offset or reduced by (1) any amount by which the hospital's cumulative payments exceed its cumulative minimum payments under the regular exceptions process for all cost reporting periods during which the hospital has been subject to the capital prospective payment system; and (2) any amount by which the hospital's current year Medicare inpatient operating and capital prospective payment system payments (excluding 75 percent of its operating DSH payments) exceed its Medicare inpatient operating and capital costs (or its Medicare inpatient margin). During the capital prospective payment system transition period, the minimum payment level under the regular exceptions process varied by class of hospital as set forth in § 412.348(c) and described in section V.A. of this preamble. After the transition period and for the duration of the special exceptions provision, the minimum payment level is 70 percent as set forth in § 412.348(g)(6).

In the July 31, 1998 final rule (63 FR 40999), we stated that a few hospitals had expressed concern with the required completion date of October 1,

2001, and other qualifying criteria for the special exceptions payment. Therefore, we solicited certain information from hospitals on major capital construction projects that might qualify for the capital special exceptions payments so we could determine if any changes in the special exceptions criteria or process were necessary. In the May 7, 1999 proposed rule (64 FR 24736), we reported that four hospitals had responded timely to our solicitation with information on their major capital construction projects. The hospitals submitted information about their location, the cost of the project, the date that the certificate of need approval was received, the start date of the project, and the anticipated completion date. Some hospitals also suggested changing a number of the requirements of the special exception provision.

When we issued the May 7, 1999 proposed rule, we had no specific proposal to revise the special exceptions process. However, we invited comments and suggestions from hospitals and other interested parties on the revision to the special exceptions process (64 FR 24738). We noted that, because the capital special exceptions process is budget neutral, any liberalization of the policy would require a commensurate reduction in the capital rate paid to all hospitals. That is, 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, just as we have for regular exceptions during the transition period. We also stated that, based on the comments we received, we may make changes to the special exceptions criteria in the final regulation or propose changes in the FY 2001 proposed rule.

In the July 30, 1999 final rule (64 FR 41526), we responded to the six comments we received on potential changes to the special exceptions process. In that same final rule, we also described our attempt to obtain information on hospital projects that might qualify for special exceptions payments in order to assess the impact of the recommended changes to the existing policy. In conjunction with the most recent cost report data readily available at that time (FY 1996), we attempted to estimate which of the hospital construction projects might qualify for special exception payments under the existing policy and how that universe of hospitals might change as a result of the recommended revisions to the special exceptions criteria.

Because exception payments to a hospital for a given cost reporting period are based on a percentage of the

capital costs incurred during the cost reporting period, we were unable to determine a precise estimate of the amount of payments to hospitals that might be eligible for special exceptions. In addition, hospitals are not eligible for special exception payments until the assets are put into use for patient care. Once eligibility for special exceptions payment has been demonstrated, it is some time before completed and settled cost reports are available to determine these payments.

Based on our research, we determined that it is difficult to predict whether particular hospitals will be able to meet all of the special exceptions eligibility criteria (DSH percentage, completion date, project size, and project need requirements) as well as qualify to receive special exception payments after taking into account the appropriate offsets, such as inpatient operating and capital margins. However, we believe that any changes to the special exceptions policy may affect a significant number of hospitals.

Based on our belief that these changes may have an impact on a significant number of hospitals, our evaluation of the comments, and careful consideration of all the issues, we stated in the July 30, 1999 final rule that the more appropriate forum for addressing changes to the capital special exceptions policy is the legislative process in Congress rather than the regulation process (64 FR 41528).

As we also indicated in the July 30, 1999 final rule (64 FR 41526), we have little information about the number of hospitals that may qualify for special exceptions payments or the projected dollar amount of special exception payments, because no hospitals are currently being paid under the special exceptions process. Until FY 2002, the special exceptions provision pays either the same as the regular exceptions process or less for high DSH and sole community hospitals. In accordance with § 412.348(g)(7), a qualifying hospital may receive additional payments for up to 10 years from the year in which it completes a project that meets the project need and project size requirements of the special exception provision in §§ 412.348(g)(2) through (g)(5). Because a qualifying project under the special exceptions provision at § 412.348(g) must be completed (put into use for patient care) by the end of the hospital's last cost reporting period beginning before the end of the transition period (September 30, 2001), a hospital may receive special exception payments for 10 years through September 30, 2012. For example, an eligible hospital that completes a

qualifying project in October 1993 (FY 1994) will be eligible to receive special exception payments up through FY 2003 (September 30, 2003).

In order to assist our fiscal intermediaries in determining the end of the 10-year period in which an eligible hospital will no longer be entitled to receive special exception payments, we are proposing to add a new § 412.348(g)(9) to require that hospitals eligible for special exception payments under § 412.348(g) submit documentation to the intermediary indicating the completion date of their project (the date the project was put into use for patient care) that meets the project need and project size requirements outlined in §§ 412.348(g)(2) through (g)(5). We are proposing that, in order for an eligible hospital to receive special exception payments, this documentation would have to be submitted in writing to the intermediary by the later of October 1, 2001, or within 3 months of the end of the hospital's last cost reporting period beginning before October 1, 2001, during which a qualifying project was completed. For example, if a hospital completed a qualifying project in March 1995, it would be required to submit documentation to the intermediary by October 1, 2001. If a hospital with a 12-month cost reporting period beginning on July 1 completed a qualifying project in November 2001, it would be required to submit documentation to the intermediary no later than September 30, 2002, which is 3 months after the end of its 12-month cost reporting period that began on July 1, 2001.

#### *C. Exceptions Minimum Payment Level*

Section 412.348(h) limits the estimated aggregate amount of exceptions payments under both the regular exceptions and special exceptions process to no more than 10 percent of the total estimated capital prospective payment system payments in a given fiscal year. Consistent with the requirements for regular exceptions at § 412.348(c), we are proposing that if we estimate that special exception payments would exceed 10 percent of total capital prospective payment system payments for a given fiscal year, we will adjust the minimum payment level of 70 percent by one percentage point increments until the estimated payments are within the 10-percent limit. For example, we could set the minimum payment level at 69 percent to ensure that estimated aggregate special exceptions payments do not exceed 10 percent of estimated total capital prospective payment system payments. If the estimate of aggregate

special exceptions payments were still projected to exceed 10 percent of total capital prospective payment system payments, we would continue reducing the minimum payment level by one percentage point increments until the requirements in § 412.348(h) were satisfied. We are proposing to revise § 412.348(g)(6) accordingly to reflect this policy.

#### *D. Exceptions Adjustment Factor*

Section 412.308(c)(3) requires that the standard capital Federal rate be reduced by an adjustment factor equal to the estimated proportion of additional payments for both regular exceptions and special exceptions under § 412.348 relative to total capital prospective payment system payments. In estimating the proportion of regular exceptions payments to total capital prospective payment system payments during the transition period, we used the model originally developed for determining budget neutrality (described in Appendix B of this proposed rule) to determine the exception adjustment factor, which was applied to both the Federal and hospital-specific rates. Below we describe our proposed methodology for determining the special exceptions adjustment used in establishing the Federal capital rate.

Under the special exceptions provision specified at § 412.348(g)(1), eligible hospitals include SCHs, urban hospitals with at least 100 beds that have a disproportionate share percentage of at least 20.2 percent or qualify for DSH payments under § 412.106(c)(2), and hospitals with a combined Medicare and Medicaid inpatient utilization of at least 70 percent. An eligible hospital may receive special exception payments if it meets (1) a project need requirement as described at § 412.348(g)(2), which, in the case of certain urban hospitals, includes an excess capacity test; (2) an age of assets test as described at § 412.348(g)(3); and (3) a project size requirement as described at § 412.348(g)(5).

In order to determine the estimated proportion of special exceptions payments to total capital payments, we attempted to identify the universe of eligible hospitals that may potentially qualify for special exception payments. First, we identified hospitals that met the eligibility requirements at § 412.348(g)(1). Then we determined each hospital's average fixed asset age in the earliest available cost report starting in FY 1992 and later. For each of those hospitals, we calculated the average fixed asset age by dividing the

accumulated depreciation by the current year's depreciation. In accordance with § 412.348(g)(3), a hospital must have an average age of buildings and fixed assets above the 75th percentile of all hospitals in the first year of capital prospective payment system. In the September 1, 1994 final rule (59 FR 45385), we stated that, based on the June 1994 update of the cost report files in HCRIS, the 75th percentile for buildings and fixed assets for FY 1992 was 16.4 years. However, we noted that we would make a final determination of that value on the basis of more complete cost report information at a later date. In the August 29, 1997 final rule (62 FR 46012), based on the December 1996 update of HCRIS and the removal of outliers, we finalized the 75th percentile for buildings and fixed assets for FY 1992 as 15.4 years. Thus, we eliminated any hospitals from the potential universe of hospitals that may qualify for special exception payments if its average age of fixed assets did not exceed 15.4 years.

For the hospitals remaining in the potential universe, we estimated project-size by using the fixed capital acquisitions shown on Worksheet A7 from the following HCRIS cost reports updated through December 2000.

PPS year	Cost reports periods beginning in
IX .....	FY 1992
X .....	FY 1993
XI .....	FY 1994
XII .....	FY 1995
XIII .....	FY 1996
XIV .....	FY 1997

PPS year	Cost reports periods beginning in
XV .....	FY 1998
XVI .....	FY 1999

Because the project phase-in may overlap 2 cost reporting years, we added together the fixed acquisitions from sequential pairs of cost reports to determine project size. Under § 412.348(g)(5), the project-size must meet the following requirements: (1) \$200 million; or (2) 100 percent of its operating cost during the first 12-month cost reporting period beginning on or after October 1, 1991. We calculated the operating costs from the earliest available cost report starting in FY 1992 and later by subtracting inpatient capital costs from inpatient costs (for all payers). We did not subtract the direct medical education costs as those costs are not available on every update of the HCRIS minimum data set. If the hospital met the project size requirement, we assumed that it also met the project need requirements at § 412.348(g)(2) and the excess capacity test for urban hospitals at § 412.348(g)(4).

Because we estimate that so few hospitals will qualify for special exceptions, projecting costs, payments, and margins would result in high statistical variance. Consequently, we decided to model the effects of special exceptions using historical data based on hospitals' actual cost experiences. If we determined that a hospital may qualify for special exceptions, we modeled special exceptions payments

from the project start date through the last available cost report (FY 1999). For purposes of modeling we used the cost and payment data on the cost reports from HCRIS assuming that special exceptions would begin at the start of the qualifying project. In other words, when modeling costs and payment data, we ignored any regular exception payments that these hospitals may otherwise have received as if there had not been regular exceptions during the transition period. In projecting an eligible hospital's special exception payments, we applied the 70-percent minimum payment level, the cumulative comparison of current year capital prospective payment system payments and costs, and the cumulative operating margin offset (excluding 75 percent of operating DSH payments).

Because hospitals may receive regular exception payments up through the end of their last cost reporting period beginning before October 1, 2001, hospitals with cost reporting periods beginning on a day other than October 1 will continue to receive regular exception payments until the end of their FY 2002 cost reporting period. Therefore, these hospitals will only receive special exception payments for the remainder of Federal FY year 2002. Consequently, the special exceptions payments made in FY 2002 will be less than for subsequent years since they are only being paid a special exception payment for a portion of FY 2002.

Our modeling of special exception payments produced the following results:

Cost report	Number of hospitals eligible for special exceptions	Special exceptions as a fraction of capital payments to all hospitals	Special exceptions as a fraction of capital payments to all hospitals weighted by portion of FY 2002 for which special exceptions are paid
PPS IX .....	.....	.....	.....
PPS X .....	.....	.....	.....
PPS XI .....	3	.....	.....
PPS XII .....	6	0.0002	0.0001
PPS XIII .....	8	0.0001	0.0000
PPS XIV .....	14	0.0002	0.0001
PPS XV .....	18	0.0016	0.0002
PPS XVI .....	22	0.0011	0.0008

Currently, the PPS XVI cost reports in HCRIS are incomplete because there is a 2-year lag time between the end of a hospital's cost reporting period and the submission and processing of the cost reports for HCRIS. In particular,

hospitals whose cost reporting periods begin July 1 are missing. We expect more hospitals to qualify for special exceptions once data from later HCRIS updates are available. In addition, hospitals still have two more cost

reporting periods (PPS XVII and PPS XVIII) to complete their projects in order to be eligible for special exceptions. We estimate that about 30 additional hospitals could qualify for special exceptions. Thus, we project

that special exception payments as a fraction of capital payments to all hospitals could be approximately 0.0025. However, after weighting this amount to account for the FY 2002 phase-in of special exception payments, we project that this factor would be approximately 0.0012. Because special exceptions are budget neutral, we propose to offset the Federal capital rate by 0.12 percent for special exceptions for FY 2002. Therefore, the proposed exceptions adjustment factor would equal 0.9988 (1 minus 0.0012) to account for special exception payments in FY 2002. We will revise this projection of the special exception adjustment factor in the final rule based on the latest available data.

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

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

#### 1. Updated Caps for Existing Hospitals and Units

Section 1886(b)(3) of the Act (as amended by section 4414 of Public Law 105-33) established caps on the target amounts for certain existing hospitals and units excluded from the prospective payment system 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.

In addition, section 4416 of Public Law 105-33 limited payments for psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals that first received payments on or after October 1, 1997. Payment for these hospitals and units is limited to the lesser of the hospital's operating costs per case or 110 percent of the national median of target amounts for the same class of hospitals for cost reporting periods ending during FY 1996, updated and adjusted for differences in area wage levels.

A discussion of how the caps on the target amounts and the payment limitation 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 for existing facilities, the statute required the Secretary to estimate 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 without adjusting for differences in area wage levels. 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.

Section 121 of Public Law 106-113 amended section 1886(b)(3)(H) of the Act to also provide for an appropriate wage adjustment to the caps on the target amounts for existing 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. On August 1, 2000, we published an interim final rule with comment period that implemented this provision for cost reporting periods beginning on or after October 1, 1999 and before October 1, 2000 (65 FR 47026) and a final rule that implemented this provision for cost reporting periods beginning on or after October 1, 2000 (65 FR 47054). This proposed rule addresses the wage adjustment to the caps and payment limitations for cost reporting periods beginning on or after October 1, 2001.

For purposes of calculating the caps, 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 also provide for existing hospitals "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."

Consistent with the broad authority conferred on the Secretary by section 1886(b)(3)(H)(iii) of the Act to determine the appropriate wage adjustment, we account for differences in wage-related costs by adjusting the caps to account for the following:

First, we adjust each hospital's target amount to account for area differences in wage-related costs. For each class of hospitals (psychiatric, rehabilitation, and long-term care), we determine the labor-related portion of each hospital's FY 1996 target amount by multiplying its target amount by the actuarial estimate of the labor-related portion of costs (or 0.71553). Similarly, we determine 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, we account for wage differences among hospitals within each class by dividing the labor-related portion of each hospital's target amount by the hospital's wage index under the hospital inpatient prospective payment system. Within each class, each hospital's wage-neutralized target amount was calculated by adding the wage-neutralized labor-related portion of its target amount and the nonlabor-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 75th percentile caps on the target amounts for each class.

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 for FY 2001, in the August 1, 2000 final rule (65 FR 47096), we established the FY 2001 caps on the target amounts 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

In reviewing our methodology for wage neutralizing the hospital specific target amounts, it appears that we incorrectly used the FY 2000 hospital inpatient prospective payment system wage index published in Tables 4A and 4B of the July 30, 1999 final rule (64 FR 41585 through 41593), which is based on wage data after taking into account geographic reclassification under section 1886(d)(8) of the Act. We are proposing to revise the methodology of wage neutralizing the hospital-specific target amounts using pre-reclassified wage data. We propose to recalculate the limit for new excluded hospitals and units, as well as calculate the cap for existing excluded hospitals and units, using the pre-reclassification wage index. The pre-reclassification wage index is the same wage index used under the prospective payment system for skilled nursing facilities (SNFs) and was included in Table 7 of the July 30, 1999 SNF final rule (64 FR 41690). (We note that both SNFs and ambulatory surgical centers use the prospective payment system inpatient wage index

without regard to the prospective payment system reclassification as a proxy for variations in local costs.)

As we stated in the August 1, 2000 final rule, long-term care hospitals, rehabilitation hospitals and units, and psychiatric hospitals and units that are exempt from the prospective payment system are not subject to the prospective payment system hospital reclassification system 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 mandate for HCFA to develop an alternative board for long-term care hospitals, psychiatric hospitals and units, and rehabilitation hospitals and units. In addition, while it would be feasible to allow units physically located in prospective payment system 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 freestanding excluded providers. There are approximately 1,000 freestanding excluded providers. 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 they are physically located (MSA or rural area) and the prospective payment system reclassification under section 1886(d)(10) of the Act is not applicable. This policy is also consistent with the policy for SNFs and ambulatory surgical centers that use the acute care, inpatient hospital prospective payment system wage index and that does not allow for reclassifications since there is no analogous determinations process to the MGCRB. The MGCRB only has authority over the prospective payment system for acute care hospitals.

Therefore, based on the broad authority conferred on the Secretary by section 1886(b)(3)(H)(iii) of the Act to determine the appropriate wage adjustment to the caps, we have determined the labor-related and nonlabor-related portions of the proposed caps on the target amounts for FY 2002 using the methodology outlined above.

Class of excluded hospital or unit	FY 2002 proposed labor-related share	FY 2002 proposed nonlabor-related share
Long-Term Care	31,399	12,483

These labor-related and nonlabor-related portions of the proposed caps on the target amounts for FY 2002 are based on the current estimate of the market basket increase for excluded hospitals and units for FY 2002 of 3.0 percent and reflect the change in applying the pre-reclassified hospital inpatient prospective payment system wage index as discussed above. Furthermore, in accordance with section 307(a) of Public Law 106-554, which amended section 1886(b)(3) of the Act, the labor-related and nonlabor-related portions of the proposed cap for long-term care hospitals for FY 2002 are increased by 2 percent. We are providing a further discussion of this provision in an interim final rule with comment period that will implement provisions of Public Law 106-554 for FY 2001 and for periods in FY 2001 from April 1, 2001 through September 30, 2001 (HCFA-1178-IFC).

Finally, to determine payments described in § 413.40(c), the cap on the hospital's target amount per discharge is determined by adding the hospital's nonlabor-related portion of the national 75th percentile cap to its wage-adjusted, labor-related portion of the national 75th percentile cap. A hospital's wage-adjusted, labor-related portion of the target amount is calculated by multiplying the labor-related portion of the national 75th percentile cap for the hospital's class by the hospital's applicable wage index. For FY 2002, a hospital's applicable wage index is the pre-reclassified wage index under the hospital inpatient prospective payment system (see § 412.63). The proposed wage index values are computed based on the same data used to compute the proposed FY 2002 wage index values for the hospital inpatient prospective payment system without taking into account changes in geographic reclassification under section 1886(d)(8)(B) of the Act for certain rural hospitals or reclassifications based on MGCRB decisions or the Secretary's decisions under sections 1886(d)(8) through (d)(10) of the Act. For cost reporting periods beginning on or after October 1, 2001 and before October 1, 2002, the pre-reclassified wage index is in Tables 4G and 4H of this proposed rule. A hospital's applicable wage index corresponds to the area in which the hospital or unit is physically located (MSA or rural area).

Class of excluded hospital or unit	FY 2002 proposed labor-related share	FY 2002 proposed nonlabor-related share
Psychiatric .....	\$8,404	\$3,341
Rehabilitation ....	15,689	6,237

2. New Excluded Hospitals and Units

a. Updated Caps (§ 413.40(f))

Section 1886(b)(7) of the Act establishes a payment methodology for new psychiatric hospitals and units, new rehabilitation hospitals and units, and new long-term care hospitals. Under the statutory methodology, for a hospital that is within a class of hospitals specified in the statute and first receives payments as a hospital or unit excluded from the prospective payment system on or after October 1, 1997, the amount of payment will be determined as follows: For the first two 12-month cost reporting periods, the amount of payment is the lesser of (1) the operating costs per case; or (2) 110 percent of the national median of target amounts for the same class of hospitals for cost reporting periods ending during FY 1996, updated to the first cost reporting period in which the hospital receives payments as adjusted for differences in area wage levels.

As discussed earlier, in reviewing our methodology for wage neutralizing the hospital-specific target amounts, it appears we incorrectly used the FY 2000 hospital inpatient prospective payment system wage index published in Tables 4A and 4B of the July 30, 1999 final rule, which is based on wage data after taking into account geographic reclassifications under section 1886(d)(8) of the Act. Therefore, we also are proposing to revise the methodology of wage neutralizing the hospital-specific target amounts using pre-reclassified wage data in our calculation of the limit for new excluded hospitals and units.

The proposed amounts included in the following table reflect the updated and recalculated 110 percent of the wage neutralized national median target amounts for each class of excluded hospitals and units for cost reporting periods beginning during FY 2002. These figures are updated to reflect the projected market basket increase of 3.0 percent. For a new provider, the labor-related share of the target amount is multiplied by the appropriate geographic area wage index, without regard to prospective payment system reclassifications, and added to the nonlabor-related share in order to determine the per case limit on payment under the statutory payment methodology for new providers.

Class of excluded hospital or unit	FY 2002 proposed labor-related share	FY 2002 proposed nonlabor-related share
Psychiatric .....	\$6,795	\$2,701
Rehabilitation ....	13,425	5,337

Class of excluded hospital or unit	FY 2002 proposed labor-related share	FY 2002 proposed nonlabor-related share
Long-Term Care	16,651	6,620

b. Changes in Type of Hospital Classification (§§ 412.23 and 412.25)

Section 1886(b)(3) of the Act (as amended by section 4414 of Public Law 105-33) establishes caps on the target amounts for existing psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals for cost reporting periods beginning on or after October 1, 1997 through September 30, 2002. Section 4416 of Public Law 105-33 amended section 1886(b)(7) of the Act to provide for a limitation on payment for new excluded psychiatric hospitals and units, new rehabilitation hospitals and units, and new long-term care hospitals. Since the establishment of the caps on target amounts and the payment limitations, there has been an increase in the number of hospitals requesting a change from one classification type to another (for example, from rehabilitation to long-term care). Regulations at § 412.22(d) state that "For purposes of exclusion from the prospective payment systems under this subpart, the status of each currently participating hospital (excluded or not excluded) is determined at the beginning of each cost reporting period and is effective for the entire cost reporting period. Any changes in the status of the hospital are made only at the start of a cost reporting period." Even though the existing regulations directly address only a hospital that changes from a prospective payment system hospital to an excluded hospital, our longstanding policy has been that a change of any classification type can be effective only at the beginning of the provider's cost reporting period. Although the existing regulations do not directly address changes in a classification type of excluded hospital, we believe that a change from one classification type of excluded hospital to another type of excluded hospital is analogous to a change from a prospective payment system hospital to an excluded hospital. Therefore, we believe it would be consistent with our longstanding policy to amend our regulations to specify that a change from one excluded hospital classification type to another type is allowed only at the beginning of the hospital's cost reporting period.

The rationale underlying our present policy of requiring that these types of changes should only be effective at the

beginning of the cost reporting period is the need to avoid any undue (and possibly significant) administrative burden that could result from doing otherwise (for example, cost allocation, cost reporting requirements, certification issues). If we were to accept changes in an excluded hospital's classification type from one type of classification to another, other than at the beginning of the cost reporting period, the hospital would need to file a terminating cost report with respect to its original classification as well as file a separate cost report for the remainder of the cost reporting period with respect to its new classification. Filing these cost reports would involve gathering the appropriate cost data, allocating the data, and apportioning the data between the two hospital classes. Additionally, we would have to validate the cost reports. To allow these types of changes in the middle of a cost reporting period would result in a significant administrative burden. We would point out that this burden is applicable equally for either a change from a prospective payment system hospital to an excluded hospital, or a change from one excluded hospital classification type to another classification type. Therefore, we are proposing to amend the regulations to provide that the effective date of any of these classification changes is only at the beginning of a provider's cost reporting period (proposed § 412.23(i), for excluded hospitals, and proposed § 412.25(f), for excluded units).

3. Effective Date of Exclusion of Long-Term Care Hospitals

Existing regulations at § 412.23(e) require a newly established long-term care hospital to operate for at least 6 months with an average length of stay in excess of 25 days in order to qualify for exclusion from the inpatient hospital prospective payment system as a long-term care hospital. Other regulations at § 412.22(d) allow changes in a hospital's status from not excluded to excluded to occur only at the start of a cost reporting period. These two regulations, taken together, typically require a hospital to operate for at least 6 months under the prospective payment system before becoming eligible for payment at the more favorable rate under section 1886(b)(3) of the Act.

These regulations were challenged in litigation by a chain organization that operates a large number of long-term care hospitals (*Transitional Hospital Corporation of Louisiana, Inc. v. Shalala*, 222 F.3d 1019 (D.C. Cir. 2000) (*THC*)). Although the court of appeals in this case found that the Secretary has

ample authority to adopt current regulatory provisions, it also concluded that the Secretary has not adequately considered other policy options. Consequently, it remanded the case to the agency for the agency to consider whether it wanted to continue its existing policy or adopt a policy of either "self-certification" or "retroactive adjustment." Generally, under a self-certification approach, hospitals that have not yet demonstrated the required average length of stay would be excluded from the prospective payment system based on a commitment to maintain such a length of stay. Under a retroactive adjustment approach, a hospital's long-term care classification would be made effective with the beginning of the 6-month period in which it demonstrated the required average length of stay. Payments for that period initially would be made under the prospective payment system and then adjusted retroactively to amounts payable for an excluded long-term care hospital once length of stay was successfully established.

As directed by the court of appeals, we are reviewing the issues raised in this case in light of the court's decision, and are specifically considering the options of self-certification and retroactive adjustment. Our current proposals and the alternatives we considered before arriving at them are set forth below. To assist us in completing the review process, we are requesting public comment on our proposals, taking into account the following considerations.

a. Demonstrating Required Average Length of Stay

Although we understand that we have discretion to select other policy options, we are proposing to continue our policy of requiring hospitals seeking long-term care hospital classification to demonstrate the required average length of stay based on 6 months of data, instead of permitting these hospitals to "self-certify" the required average length of stay.

We note that the statute provides the agency with broad authority to determine the methodology by which facilities can qualify for exclusion as long-term care hospitals (section 1886(d)(1)(B)(iv)(I) of the Act specifies that "a hospital which has an average inpatient length of stay (as determined by the Secretary) of greater than 25 days" qualifies for exclusion as a long-term care hospital). As the court of appeals decided, the parenthetical phrase *as determined by the Secretary* "gives the Secretary considerable leeway to determine whether to require

prospective, contemporaneous, or retrospective evaluation and payment.” (*THC* at 1026.)

Although we have considered the self-certification option, we do not believe that it is appropriate to permit long-term care hospitals to self-certify. Long-term care hospitals “are licensed as acute care hospitals in the States in which they operate [and] their only distinguishing characteristic is their long average length of stay” (ProPAC March 1, 1997 Report and Recommendations to the Congress, Recommendation 30). For this reason, and because average length of stay can be difficult, if not impossible, to forecast when a new hospital first opens its doors for service, it would not be appropriate to allow new hospitals to self-certify that they will have an average length of stay exceeding 25 days.

Requiring newly participating hospitals to collect at least 6 months of length of stay data before permitting them to qualify as long-term care hospitals is consistent with treatment of other types of excluded hospitals in the regulations. Like long-term care hospitals, children’s hospitals, which by statute are also excluded from the prospective payment system, also have just one distinguishing characteristic from acute care hospitals; namely, having inpatients who are predominantly individuals under 18 years of age (section 1886(d)(1)(B)(iii) of the Act). As with long-term care hospitals, we do not permit children’s hospitals to self-certify that they will meet this requirement as to a future cost reporting period (§ 412.23(d)).

Although we permit rehabilitation hospitals to self-certify that they meet certain elements of the definition for such a hospital, important differences between rehabilitation hospitals and long-term care hospitals render such a scheme inappropriate for the latter. The differences in the two types of excluded hospitals begin with the statute, which excludes from the prospective payment system “a rehabilitation hospital (as defined by the Secretary)” and “a hospital which has an average inpatient length of stay (as defined by the Secretary) of greater than 25 days”; that is, a long-term care hospital (sections 1886(d)(1)(B)(ii) and 1886(d)(1)(B)(iv)(I) of the Act). Thus, Congress delegated broad authority to the Secretary to define rehabilitation hospitals, but provided the definition of long-term care hospitals in the statute itself (and then, as discussed above, gave the agency broad authority to determine how to apply that definition).

In exercising our authority to define a rehabilitation hospital, we promulgated regulations that contain several defining features that a facility must possess to be considered such a hospital, as opposed to the one statutorily mandated feature (average length of stay) that defines long-term care hospitals (§ 412.23(b)). The requirements that a rehabilitation hospital must meet include a showing that 75 percent of its patients are of a certain type, the existence of a preadmission screening process, assurance that patients will receive close medical supervision and that the hospital will furnish certain types of therapy through the use of qualified personnel, the presence of a director of rehabilitation with certain qualifications, evidence of a plan of treatment for each inpatient that is established and monitored by a physician, and the use of a coordinated interdisciplinary team approach in the rehabilitation of each patient (§ 412.23(b)(1) through (b)(7)). With the exception of the “75 percent rule,” all of these requirements are “characteristics of the patients and types of services that the facility furnishes” that “can be assessed at a given point in time” (ProPAC March 1, 1997 Report and Recommendations to the Congress, Recommendation 30).

Thus, rehabilitation hospitals are defined primarily by static and observable features, most of which can be accurately assessed when a new rehabilitation hospital is first certified under the Medicare program. As a result, the regulations permit a new rehabilitation hospital to provide written certification that it will meet the 75 percent rule, provided we find that it also meets the six other elements of the definition of a rehabilitation facility (§ 412.23(b)(8)). The hospital’s demonstrated ability to meet the six remaining requirements provides an adequate level of assurance that the hospital will also meet the 75-percent requirement if it so certifies. No such assurance is available, however, regarding whether a hospital might, during a future period, meet the sole requirement for qualification as a long-term care hospital—the average length of stay of its patients.

#### b. Effective Date of Exclusion From the Prospective Payment System

Because we propose to continue our policy of not allowing a hospital to self-certify the required average length of stay in order to be paid as an excluded long-term care hospital, it is necessary to consider the effective date of excluded status for a hospital that has demonstrated the required average

length of stay. We considered making long-term care classification effective retroactively with the beginning of the 6-month period in which the hospital demonstrated the required average length of stay. Doing so would mean, for example, that a hospital that admitted its first patient on January 1, 2001, and demonstrated that its average length of stay exceeded 25 days for the period January 1 through June 30, and that was approved for long-term care classification on July 15, would be paid for its discharges from January 1, 2001 forward as an excluded long-term care hospital rather than under the prospective payment system, as long as it continued to demonstrate the requisite average length of stay. However, we believe that such retroactive application of excluded status is inappropriate.

For the reasons below, we are proposing to continue our policy that a hospital’s payment as a long-term care hospital would be effective with the beginning of the hospital’s cost reporting period that follows the determination to classify the hospital as a long-term care hospital. From the first rulemaking implementing the inpatient acute hospital prospective payment system payment methodology, the agency has generally applied decisions regarding various elements of the prospective payment system payment methodology prospectively only, and the courts have upheld that action. (*THC* at 1022 (“status” decisions regarding whether a hospital is subject to or excluded from the prospective payment system); *County of Los Angeles v. Shalala* 192 F.3d 1005 (D.C. Cir. 1999) (decisions regarding criteria for receipt of “outlier” payments); *Methodist Hospital of Sacramento v. Shalala*, 38 F.3d 1225 (D.C. Cir. 1994) (decisions to revise “wage index” component of the prospective payment system payment rate); *Hennepin County v. Sullivan*, 883 F.2d 85, 91 (D.C. Cir. 1989) (“there is nothing inherently arbitrary or capricious about an agency’s decision to apply new data prospectively only”); 57 FR 39746 and 39798 (1992).)

For the same reasons that existed in the cases cited above, we believe that prospective implementation of the statutory exclusion for long-term care hospitals is fully consistent with Congress’ goals in enacting the prospective payment system. It allows both the hospital and us to know with certainty at the beginning of each cost reporting period of the hospital whether the hospital is subject to or excluded from the prospective payment system for that cost reporting period and thus

promotes certainty and predictability of payment for both providers and the agency. *County of Los Angeles* at 1019; *Methodist Hospital of Sacramento* at 1232 (“because the Secretary’s prospectivity policy permits hospitals to rely with certainty on one additional element in the PPS calculation rate \* \* \* the Secretary could reasonably conclude that it will promote efficient and realistic cost saving targets”).

Moreover, retroactive application of a prospective payment system excluded status decision would entail a significant administrative burden as it would require reprocessing of large numbers of a hospital’s claims for hospital inpatient services. See 49 FR 234 and 271 (1984) (making retroactive changes in decisions regarding providers’ status as “sole community hospitals” would require us “to reprocess every inpatient hospital claim submitted for the hospital and make adjustment payments at the new rate). It is reasonable to conclude that such a burden outweighs any “increase in accuracy that would result” from retroactive application of decisions regarding long-term care hospital exclusions (*Methodist Hospital of Sacramento* at 1233).

Finally, we apply our prospective-only policy evenhandedly, regardless of whether it results in a hospital’s being subject to, or excluded from, the prospective payment system. Thus, retroactive adjustments in hospitals’ status are as likely to hurt providers that slip below the required average length of stay during a cost reporting period as they are to help them by furnishing reimbursement for a past period in which they met that requirement (*Methodist Hospital of Sacramento* at 1232, 1233). Any adverse effect of the prospective only policy that might be perceived by new long-term care facilities is also lessened by the availability of a short initial cost reporting period and outlier payments for extraordinarily lengthy cases during the initial period when the hospital is subject to the prospective payment system.

In addition to believing that it is appropriate to make payment as a long-term care hospital effective prospectively rather than retroactively, we believe it is also appropriate to continue our policy of making payment effective with the beginning of the hospital’s next cost reporting period rather than as of the date of approval of long-term care status. This policy is consistent with how we treat changes in status (that is, from excluded to nonexcluded or from nonexcluded to excluded) for all types of hospitals. As

we explain in more detail in section VI.A.2.b of this proposed rule, the rationale for requiring changes in a hospital’s status, or changes in a hospital’s classification (that is, from one type of excluded hospital to another), only at the start of the hospital’s cost reporting period is to alleviate the administrative burden and potential confusion that would result from doing otherwise.

As noted earlier, we request public comments on the proposals described above.

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

Section 1886(j) of the Act, as added by section 4421 of Public Law 105–33, provided 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, with a fully implemented system for cost reporting periods beginning on or after October 1, 2002. Section 1886(j) of the Act 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. Section 305 of Public Law 106–554 further amended section 1886(j) of the Act to allow hospitals to elect to be paid the full Federal prospective payment rather than the transitional period payments specified in the Act.

On November 3, 2000, we issued a notice of proposed rulemaking in the **Federal Register** (65 FR 66303) on the proposed establishment of the prospective payment system for inpatient rehabilitation facilities, to be effective on April 1, 2001. Due to the scope and complexity of the proposed system and requests from the public for more time to comment on the proposed rule, we extended the public comment period for an additional 30 days, from January 3, 2001 to February 1, 2001. As a result of the extension of the comment period, it would have been technically impossible to publish a final rule 60 days prior to implementing the prospective payment system for rehabilitation facilities by April 1. We anticipate publication of a final rule in May 2001 and intend to announce our plans for implementation at that time.

#### B. Critical Access Hospitals (CAHs)

##### 1. Exclusion of CAHs From Payment Window Requirements

Section 1886 of the Act specifies the requirements governing payment to full-service hospitals for the operating costs of inpatient hospital services under both the inpatient hospital prospective payment system and the limits on the target amounts for hospitals excluded from the prospective payment system. “Operating costs of inpatient hospital services” are defined in section 1886(a)(3) of the Act, which provides in part that costs of certain services provided to a beneficiary during the 3 days (or in the case of an excluded hospital or unit, during the 1 day) immediately preceding the patient’s admission are to be included in the payments for costs under the inpatient hospital prospective payment system, or the target amount for excluded hospitals and units. This part of the definition is sometimes referred to as the “payment window” requirement. Regulations implementing the payment window requirement are found at § 412.2(c)(5) for hospitals subject to the prospective payment system, and § 413.40(c)(2) for hospitals excluded from the prospective payment system.

Payment to CAHs for inpatient services is not made under section 1886 of the Act, nor are CAHs considered to be hospitals excluded from the inpatient hospital Prospective Payment System. Instead, payment is made on a reasonable cost basis, as mandated by section 1814(l) of the Act. Neither section 1814(l) nor section 1861(v) of the Act (which defines “reasonable cost”) requires application of the payment window to services furnished on an outpatient basis immediately before admission to a CAH. Therefore, we have determined that the payment window provision does not apply to CAHs. To clarify this point and avoid possible misapplication of the payment window, we are proposing to amend § 413.70(a)(1) to provide that the requirements of §§ 412.2(c)(5) and 413.40(c)(2) do not apply to CAHs.

##### 2. Availability of CRNA Pass-Through for CAHs

Generally, anesthesia services furnished to a hospital patient by a certified registered nurse anesthetist (CRNA) must be billed to the Part B carrier and payment is made under the applicable fee schedule provisions of § 414.60. However, certain rural hospitals that furnish no more than 500 surgical procedures requiring anesthesia per year and meet other specified requirements are exempted from the fee

schedule. These hospitals are paid on a reasonable cost basis for their costs of anesthesia services furnished by a qualified nonphysician anesthetists. The exemption is provided in accordance with section 9320(k) of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) (as added by section 608(c)(2) of the Family Support Act of 1988 (Public Law 100-185), as amended by section 6132 of the Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239)). HCFA has codified this exemption at § 412.113(c).

Although § 412.113(c) does not specifically extend eligibility for the pass-through payment for CRNAs to CAHs, some CAHs have pointed out that they are similar to the rural hospitals that are eligible for this payment, in that they also furnish low volumes of surgical procedures requiring anesthesia and could face the same problem of potentially inadequate payment for CRNA services if they are not allowed to qualify for the pass-through payment. We share this concern.

We recognize that the legislation cited above, which provides the legal basis for the pass-through payments, refers only to "hospitals," not to CAHs. Moreover, section 1861(e) of the Act states that "the term 'hospital' does not include, unless the context otherwise requires, a critical access hospital \* \* \*." It is clear from section 1861(e) of the Act that CAHs are not to be considered hospitals under the Medicare law for most purposes. However, the reference to "context" in the provision indicates that CAHs may be classified as hospitals where, in specific contexts, it would be consistent with the purpose of the legislation to do so.

We believe this is the case with the statutory provisions authorizing pass-through payments for CRNA costs. The purpose of the pass-through legislation is to provide small rural hospitals with low surgical volumes with relief from the difficulties they might otherwise have in furnishing CRNA services for their patients. CAHs are by definition limited service facilities located in rural areas and, as such, they serve a population much like those served by hospitals eligible for the pass-through payments. In some cases, an institution that now participates as a CAH may even have been eligible for the pass-through payments when it participated as a hospital. Such an institution would clearly be disadvantaged if it were to lose this status. Thus, in accordance with section 1861(e) of the Act and in light of the context of the pass-through legislation cited above, we consider CAHs to be "hospitals" for purposes of

extending eligibility for the CRNA pass-through payments to them.

Therefore, we are proposing to add a new § 413.70(a)(3) and revise §§ 413.70(a)(2), (b)(1), and (b)(6) to permit CAHs that meet the criteria for the pass-through payments in § 412.113(c) to qualify for pass-through payments for the costs of anesthesia services for both inpatient and outpatient surgeries, on the same basis as full service rural hospitals. As an unrelated technical correction, we are proposing to revise § 413.70(b)(2)(i)(C) to delete the incorrect reference to § 413.130(j)(2) and replace it with a reference to reduction in capital costs under § 413.130(j). We also are proposing to revise § 412.113(c) by changing the term "hospital" to "hospital or CAH".

### 3. Payment to CAHs for Emergency Room On-Call Physicians (Proposed § 413.70(b)(4))

Under section 1834(g) of the Act, Medicare payment to a CAH for facility services to Medicare outpatients is the reasonable costs of the CAH in providing such services. The term "reasonable cost" is defined in section 1861(v) of the Act and in regulations at 42 CFR Part 413, including, with specific reference to CAHs, § 413.70. Consistent with the general policies stated in section 2109 of the Medicare Provider Reimbursement Manual (PRM), Part I (HCFA Publication 15-1), the reasonable cost of CAH services to outpatients may include reasonable costs of compensating physicians who are on standby status in the emergency room (that is, physicians who are present and ready to treat patients if necessary). However, under existing policy, the reasonable cost of CAH services to outpatients may not include any costs of compensating physicians who are not present in the facility but are on call.

Section 204 of Public Law 106-554 further amended section 1834(g) of the Act (as amended by section 201 of Public Law 106-554) by adding a new paragraph (5). New section 1834(g)(5) of the Act provides that, in determining the reasonable costs of outpatient CAH services under sections 1834(g)(1) and 1834(g)(2)(A) of the Act, the Secretary shall recognize as allowable costs amounts (as defined by the Secretary) for reasonable compensation and related costs for emergency room physicians who are on call (as defined by the Secretary) but who are not present on the premises of the CAH involved, are not otherwise furnishing physicians' services, and are not on call at any other provider or facility. The provisions of

section 204 of Public Law 106-554 are effective for cost reporting periods beginning on or after October 1, 2001.

To implement the provisions of section 1834(g)(5) of the Act, we are proposing to add a new paragraph (4) to § 413.70(b). The proposed § 413.70(b)(4) would permit the reasonable costs of CAH outpatient services to include the reasonable compensation and related costs of emergency room on-call physicians under the terms and conditions specified in the statute. As directed in the statute, under § 413.70(b)(4)(ii)(A) of this proposed rule, we are defining "amounts for reasonable compensation and related costs" as those allowable costs of compensating emergency room physicians for being on call, to the extent these costs are found to be reasonable under the rules in § 413.70(b)(2).

In addition, as specified under § 413.70(b)(4)(ii)(A) of this proposed rule, we are defining an "emergency room physician who is on call" as a doctor of medicine or osteopathy with training or experience in emergency care who is immediately available by telephone or radio contact, and who is available on site within the timeframes specified in our existing regulations under § 485.618(d). Existing § 485.618(d) specifies that the physician must be available on site (1) within 30 minutes, on a 24-hour a day basis, if the CAH is located in an area other than an area described in item (2); or (2) within 60 minutes, on a 24-hour a day basis, if all of the following requirements are met:

- The CAH is located in an area designated as a frontier area (that is, an area with fewer than six residents per square mile based on the latest population data published by the Bureau of the Census) or in an area that meets criteria for a remote location adopted by the State in its rural health care plan, and approved by HCFA, under section 1820(b) of the Act.
- The State has determined under criteria in its rural health care plan that allowing an emergency response time longer than 30 minutes is the only feasible method of providing emergency care to residents of the area served by the CAH.
- The State maintains documentation showing that the response time of up to 60 minutes at a particular CAH it designates is justified because other available alternatives would increase the time needed to stabilize a patient in an emergency.

We also believe that it is essential that physicians who are paid to be in on-call status in fact come to the facility when

summoned. Therefore, we are proposing to specify that costs of on-call emergency room physicians are allowable only if the costs are incurred under written contracts that require them to come to the CAH when their presence is medically required.

#### 4. Treatment of Ambulance Services Furnished by Certain Critical Access Hospitals (Proposed § 413.70(b)(5))

Under section 1861(s)(7) of the Act, Medicare Part B covers and pays for ambulance services, to the extent prescribed in regulations, when the use of other methods of transportation would be contraindicated. Various Congressional reports indicate that Congress intended that (1) the ambulance benefit cover transportation services only if other means of transportation are contraindicated by the beneficiary's medical condition; and (2) only ambulance services to local facilities be covered unless necessary services are not available locally, in which case, transportation to the nearest facility furnishing those services is covered. (H.R. Rept. No. 89-213, 89th Cong., 1st Sess. at 37 (1995) and S. Rept. No. 89-404, 89th Cong., 1st Sess., Pt. I, at 43 (1995).)

The Medicare program currently pays for ambulance services on a reasonable cost basis when furnished by a provider and on a reasonable charge basis when furnished by a supplier. (The term "provider" includes all Medicare-participating institutional providers that submit claims for Medicare ambulance services (hospitals, CAHs, SNFs, and home health agencies). The term "supplier" means an entity that is independent of any provider. The reasonable charge methodology that is the basis of payment for ambulance services is determined by the lowest of the customary, prevailing, actual, or inflation indexed charge.)

Section 4531(a)(1) of Public Law 105-33 amended section 1861(v)(1) of the Act and imposed an additional per trip limitation on reasonable cost payment to hospitals and CAHs for ambulance service. As amended, the statute provides that, in determining the reasonable cost of ambulance services furnished by a provider of services, the Secretary shall not recognize the cost per trip in excess of the prior year's reasonable cost per trip updated by an inflation factor. This trip limit provision was first effective for services furnished during Federal fiscal year 1998 (October 1, 1997 through September 30, 1998).

Section 205 of Public Law 106-554 amended section 1834(l) of the Act by adding a new paragraph (8) to that section. New section 1834(l)(8) provides

that the Secretary is to pay the reasonable costs incurred in furnishing ambulance services if such services are furnished by a CAH (as defined in section 1861(mm)(1) of the Act), or by an entity owned or operated by the CAH. This provision in effect eliminates any trip limit that CAHs had been subject to as a result of section 1861(v)(1) of the Act, as amended by Public Law 105-33. However, section 205 further states that in order to receive reasonable cost reimbursement for the furnishing of ambulance services, the CAH or entity must be the only provider or supplier of ambulance services located within a 35-mile drive of the CAH. Section 205 is effective for services furnished on or after December 21, 2000, the date of enactment of Public Law 106-554.

To implement the provisions of section 1834(l)(8) of the Act, we are proposing to add a new paragraph (5) to § 413.70(b). Proposed § 413.70(b)(5) would permit a CAH, or an entity owned or operated by a CAH, to be paid for furnishing ambulance services on a reasonable cost basis if the CAH or entity is the only provider or supplier of ambulance services within a 35-mile drive of the CAH. In determining whether there is any other provider or supplier of ambulance services within a 35-mile drive of a CAH or entity, we would first identify the site where the nearest other ambulance provider or supplier garages its vehicles, and then determine whether that site is within 35 miles, calculated as the shortest distance in miles measured over improved roads. An improved road for this purpose would be defined as any road that is maintained by a local, State, or Federal government entity, and is available for use by the general public. Consistent with the change we are proposing in § 412.92(c)(1) relating to SCH determinations (as explained in section IV. of this preamble), we would consider improved roads to include the paved surface up to the front entrance of the hospital and, for purposes of § 413.70(b)(5), the front entrance of the garage.

#### 5. Qualified Practitioners for Preanesthesia and Postanesthesia Evaluation in CAHs

Section 1820 of the Act sets forth the conditions for designating certain hospitals as CAHs. Implementing regulations for section 1820 of the Act are located in 42 CFR part 485, Subpart F. Among the conditions of participation regulations for CAHs in subpart F is the condition for surgical services (§ 485.639). Existing § 485.639 specifies that preanesthesia and

postanesthesia services in a CAH can only be performed by a doctor of medicine or an osteopathic practitioner; a doctor of dental surgery or dental medicine; or a doctor of podiatric medicine. This Medicare condition of participation requirement regarding preanesthesia and postanesthesia evaluations for CAHs differs from, and is more restrictive than, the current requirement for acute care hospitals in general. In an acute care hospital, the CRNA is listed among the practitioners who may perform the preanesthesia and postanesthesia evaluations.

Our principal consideration in regulating providers is to ensure patient safety and high quality patient outcomes. As circumstances and health care environments change, we reassess regulations and propose changes accordingly.

When the regulations for the initial Rural Primary Care Hospital (RPCH) program (which later became the CAH program) were adopted, RPCHs were limited to patient stays of no more than 72 hours and to bed counts of no more than 6 acute care beds. We initially viewed RPCHs as very limited-service facilities that would be unlikely to perform any surgery beyond what might be done in a physician's office; therefore, we did not have a condition of participation for surgery. Section 102(a)(1) of the Social Security Amendments of 1994, Public Law 103-432, specifically authorized surgical care in RPCHs. In June 1995, we proposed a surgical condition of participation that incorporated the ambulatory surgery center (ASC) standards. We expected that the types of procedures done in a RPCH would most likely be those that could be done in ASCs. At the time, we received no comments in response to the proposed standards and therefore adopted them in the final RPCH conditions of participation that were published on September 1, 1995 (60 FR 45851).

In 1997, the RPCH (now CAH) program was expanded through a statutory change to include all States and to allow for an increase in bed size and length of stay (August 29, 1997 final rule, 62 FR 46035). Since that time, the program's original conditions of participation have been revised to remove possible barriers to access to care. One example of this effort is the final rule to eliminate the Federal requirement for physician supervision of CRNAs in CAHs as well as acute care hospitals and ASCs that was published in the **Federal Register** on January 18, 2001 (66 FR 96570).

Recently, provider and medical groups have suggested that CAHs may

be at risk of losing the ability to provide access to appropriate surgical services without the full support of available CRNAs. They indicated that the existing regulations place the responsibility of the preanesthesia and postanesthesia evaluations on the operating practitioner, thereby creating a higher standard for CAHs than for other hospitals.

In an effort to eliminate or minimize potential access issues in rural areas and to recognize the CAH's program expansion, we are proposing to revise § 485.639(b) to allow CRNAs to perform preanesthesia and postanesthesia evaluations in a CAH. As with any licensed independent health care provider, the proposed change would not permit CRNAs to practice beyond his or her licensed scope of practice or the approved policies and procedures of the CAH.

#### 6. Clarification of Location Requirements for CAHs

Under section 1820(c)(2)(B)(i) of the Act, a facility seeking designation by the State as a CAH must meet two distinct types of location requirements. First, the facility must either be actually located in a county or equivalent unit of local government in a rural area, as defined in section 1886(d)(2)(D) of the Act, or it must be located in an urban area as defined in section 1886(d)(2)(D) of the Act, but be treated as being located in a rural area under section 1886(d)(8)(E) of the Act. Second, the facility must also be located more than a 35-mile drive (or, in the case of mountainous terrain or in areas with only secondary roads available, a 15-mile drive) from a hospital or similar facility described in section 1820(c) of the Act, or it must be certified by the State as being a necessary provider of health care services to residents in the area. Implementing regulations for these provisions were published in an interim final rule with comment period in the **Federal Register** on August 1, 2000 (65 FR 47026) and are set forth at § 485.610(b).

Recently, concern has been expressed that § 485.610(b) does not accurately reflect the fact that a facility may satisfy the "rural location" requirement either by actually being located in a rural area or by being located in an urban area but qualifying for treatment as rural under section 1886(d)(8)(E) of the Act. In addition, we have received questions as to whether a potential CAH must meet both the rural location requirement and the requirement for location relative to other facilities (or certification by the State as a "necessary provider").

To avoid any further confusion, and ensure that our regulations reflect the provisions of the law accurately, we are proposing to revise § 485.610(b) to clarify that a potential CAH must either be actually located in a rural area, or be treated as being rural under section 1886(d)(8)(E) of the Act. In addition, we are proposing to place the provisions of the existing § 485.610(b)(5) in a newly created paragraph (c) entitled, "Location relative to other facilities or necessary provider certification". We are proposing to relocate this provision in order to clarify that these criteria are separate from the rural location criteria. These proposed changes do not reflect any change in policy; they are merely an attempt to improve the clarity of the regulations.

#### VII. MedPAC Recommendations

We have reviewed the March 1, 2001 report submitted by MedPAC to Congress and have given it careful consideration in conjunction with the proposals set forth in this document. Recommendation 5A concerning the update factor for inpatient hospital operating costs and for hospitals and hospital distinct-part units excluded from the prospective payment system are discussed in Appendix D to this proposed rule. Other MedPAC recommendations and our responses are set forth below.

##### A. Accounting for New Technology in Hospital Prospective Payment Systems (Recommendations 3D and 3E)

*Recommendation 3D:* For the inpatient payment system, the Secretary should develop formalized procedures for expeditiously assigning codes, updating relative weights, and investigating the need for patient classification changes to recognize the costs of new and substantially improved technologies.

*Response:* Section 533 of Public Law 106-554 directs the Secretary to develop a mechanism for ensuring adequate payment under the hospital inpatient prospective payment system for new medical services and technologies, and to report to Congress on ways to more expeditiously incorporate new services and technologies into that system. The discussion relating to new medical services and technologies is found in section II.D. of this proposed rule and addresses MedPAC's concern regarding the process of assigning new codes. In addition, MedPAC acknowledges, and we agree, that the process of updating the relative weights has an established track record.

MedPAC states that a more formal system for assigning codes and

investigating the need for DRG changes would have enabled the current system to more adequately respond to new technology. Although we believe the current process for assigning new codes has the advantage of being well-understood, the proposed new process we described in section II. of this proposed rule should improve the ability of the system to respond to the introduction of new technology.

*Recommendation 3E:* Additional payments in the inpatient payment system should be limited to new or substantially improved technologies that add significantly to the cost of care in a diagnosis related group and should be made on a budget-neutral basis.

*Response:* Section 533 of Public Law 106-554 directed the Secretary to establish a mechanism to make these payments beginning with discharges on or after October 1, 2001, and we are proposing implementation of this provision under section IV.F. of this proposed rule.

##### B. Occupational-Mix Adjusted Wage Index for FY 2005 (Recommendation 4)

*Recommendation:* To implement an occupation-mix adjusted wage index in FY 2005, the Secretary should collect data on wage rates by occupation in the fiscal year 2002 Medicare cost reports. Hospital-specific wage rates for each occupation should be supplemented by data on the mix of occupations for each provider type. The Secretary also should continue to improve the accuracy of the wage index by investigating differences in wages across areas for each type of provider and in the substitution of one occupation for another.

*Response:* We are proposing to collect occupational mix data from hospitals through a supplemental survey to the cost report for cost reporting periods beginning during FY 2001. A more complete discussion of our proposed methodology can be found in section III. of this proposed rule.

##### C. Financial Performance and Inpatient Payment Issues (Recommendations 5B, 5C, and 5D)

*Recommendation 5B:* In collecting sample patient-level data, HCFA should seek to balance the goals of minimizing payment errors and furthering understanding of the effects of coding on case-mix change.

*Response:* The sample data referred to by MedPAC is the Payment Error Prevention Program (PEPP) Surveillance Sample. These data are collected to monitor the payment error rate for Medicare inpatient prospective payment system services and provide outcome data to measure PROs' performance in

reducing payment errors in their respective States. This information can be appropriately weighted to reflect the true distribution of DRGs nationally. The sample data supplant the DRG validation sample that MedPAC used in its original 1996 through 1998 estimates. The current PEPP Surveillance Sample doubles the size of the earlier DRG validation sample. It is comprised of approximately 60,000 cases per year. We believe this is a sufficient number of cases to both monitor case-mix index changes and PRO performance on payment error reduction.

*Recommendation 5C:* Although the Benefits Improvement and Protection Act of 2000 improved the equity of the hospital disproportionate share adjustment, Congress still needs to reform this adjustment by:

- Including the costs of all poor patients in calculating low-income shares used to distribute disproportionate share payments; and
- Using the same formula to distribute payments to all hospitals covered by prospective payment.

*Response:* HCFA is participating a Medicare Technical Advisory Group workgroup concerning technical issues related to the collection of uncompensated care data relative to the Medicare disproportionate share formula. A worksheet and instructions to collect these data will be sent out for prior consultation this summer for revisions to the cost reports applicable for cost reporting periods beginning on or after October 1, 2001.

*Recommendation 5E:* The Congress should protect urban hospitals from the adverse effect of nearby hospitals being reclassified to areas with higher wage indexes by computing each area's wage index as if none of the hospitals located in the area had been reassigned.

*Response:* With this rule, HCFA has proposed to include the wage data for a reclassified hospital in both the area to which it is reclassified and the area where the hospital is physically located. We agree with MedPAC and believe that this will provide consistency and predictability in hospital reclassification and wage indices.

#### *D. Specialties With Training Beyond the Initial Residency Period (Recommendation 10)*

*Recommendation:* The Congress should eliminate the weighting factors that currently determine Medicare's direct graduate medical education payments and count all residencies equally through completion of residents' first specialty or combined program and subspecialty if one is pursued. Residents training longer than the

minimum number of years required for board eligibility in a specialty, combined program, or subspecialty should not be included in hospitals' direct graduate medical education resident counts. These policy changes should be implemented in a budget-neutral manner through adjustments to the per resident payment amounts.

*Response:* Currently, Medicare payments to hospitals for direct GME is dependent, in part, on the initial residency period of the residents. Generally, the initial residency period is defined at § 413.86(g)(1) as the minimum number of years required for board eligibility, not to exceed 5 years. For purposes of determining the direct GME payment, residents are weighted at 1.0 FTE within the initial residency period, and at .5 FTE beyond the initial residency period. The limitation on the initial residency period was designed by Congress to limit full Medicare direct GME payment to the time required to train in a single specialty.

MedPAC states that Medicare's current direct GME payment policy of limiting full funding to the first specialty in which a resident trains provides a disincentive for hospitals to offer training in subspecialties or combined programs, and therefore, may influence hospitals' decisions on the types of residents that they train. MedPAC believes that Medicare should not influence workforce policy and recommends that the disincentive be removed to make Medicare payments policies neutral with regard to programs with prerequisites, subspecialties, and combined programs. Accordingly, MedPAC recommends that Congress eliminate the weighting factors associated with direct GME payment so that all residents would be counted for full direct GME payment through the completion of their first specialty, combined program, or subspecialty. Residents training beyond the minimum number of years required for board eligibility in a specialty, combined program, or subspecialty should not be counted for purposes of the direct GME payment.

MedPAC also believes that eliminating the weighting factors could potentially increase Medicare's direct GME payments by approximately 5 to 8 percent. Therefore, MedPAC recommends that hospitals' per resident amounts (PRAs), which are used to calculate the direct GME payment, be reduced so that this change can be implemented, to the extent possible, in a budget-neutral manner. MedPAC explains that, although further research is needed, it appears that hospitals with substantial subspecialty training (that is,

at least 15 percent of the resident mix) would likely see a small net increase in payments, despite the reduction to the PRAs, while hospitals that do not have subspecialty training would likely see a small decrease in payments.

In response to MedPAC's recommendation, we question MedPAC's estimate that eliminating the weighting factors could increase Medicare direct GME payments by only 5 to 8 percent. We believe that subspecialty training constitutes a significant portion of all GME programs, and, consequently, the elimination of the weighting factors could potentially increase payments by far more than 8 percent. If budget neutrality is to be maintained, this could mean that the attendant reductions to the PRAs could be much greater than MedPAC might assume. For those teaching hospitals that have substantial subspecialty training, there is no guarantee that the decreases in the PRAs will be offset by the increases in the direct GME payments due to the elimination of the weighting factors.

While the recommendation would remove the existing disincentive for training in subspecialties, we believe the reductions to the PRAs, whether they are minimal or more significant, will be far more detrimental to the smaller teaching hospitals that have little or no subspecialty training. Many of these hospitals provide care to beneficiaries in rural, underserved areas and in nonhospital settings. We believe these conditions may discourage the expansion of residency training in these areas. It may be inappropriate to limit the direct GME funding to such hospitals, considering Congress' initiatives to encourage residency training in rural, underserved areas and in nonhospital settings. We also are unclear as to how MedPAC would implement the proposed reduction to the PRAs. MedPAC did not explain in its recommendation how it would propose to do this.

## **VIII. Other Required Information**

### *A. Requests for Data From the Public*

In order to respond promptly to public requests for data related to the prospective payment system, we have established a process under which commenters can gain access to raw data on an expedited basis. Generally, the data are available in computer tape or cartridge format; however, some files are available on diskette as well as on the Internet at <http://www.hcfa.gov/stats/pubfiles.html>. Data files, and the cost for each, are listed below. Anyone wishing to purchase data tapes, cartridges, or

diskettes should submit a written request along with a company check or money order (payable to HCFA-PUF) to cover the cost to the following address: Health Care Financing Administration, Public Use Files, Accounting Division, P.O. Box 7520, Baltimore, Maryland 21207-0520, (410) 786-3691. Files on the Internet may be downloaded without charge.

1. Expanded Modified MedPAR-Hospital (National)

The Medicare Provider Analysis and Review (MedPAR) file contains records for 100 percent of Medicare beneficiaries using hospital inpatient services in the United States. (The file is a Federal fiscal year file, that is, discharges occurring October 1 through September 30 of the requested year.) The records are stripped of most data elements that would permit identification of beneficiaries. The hospital is identified by the 6-position Medicare billing number. The file is available to persons qualifying under the terms of the Notice of Proposed New Routine Uses for an Existing System of Records published in the **Federal Register** on December 24, 1984 (49 FR 49941), and amended by the July 2, 1985 notice (50 FR 27361). The national file consists of approximately 11 million records. Under the requirements of these notices, an agreement for use of HCFA Beneficiary Encrypted Files must be signed by the purchaser before release of these data. For all files requiring a signed agreement, please write or call to obtain a blank agreement form before placing an order. Two versions of this file are created each year. They support the following:

- Notice of Proposed Rulemaking (NPRM) published in the **Federal Register**. This file, scheduled to be available by the end of April, is derived from the MedPAR file with a cutoff of 3 months after the end of the fiscal year (December file).

- Final Rule published in the **Federal Register**. The FY 2000 MedPAR file used for the FY 2002 final rule will be cut off 6 months after the end of the fiscal year (March file) and is scheduled to be available by the end of April.

Media: Tape/Cartridge  
File Cost: \$3,655.00 per fiscal year  
Periods Available: FY 1988 through FY 2000

2. Expanded Modified MedPAR-Hospital (State)

The State MedPAR file contains records for 100 percent of Medicare beneficiaries using hospital inpatient services in a particular State. The records are stripped of most data

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

- NPRM published in the **Federal Register**. This file, scheduled to be available by the end of April, is derived from the MedPAR file with a cutoff of 3 months after the end of the fiscal year (December file).

- Final Rule published in the **Federal Register**. The FY 2000 MedPAR file used for the FY 2002 final rule will be cut off 6 months after the end of the fiscal year (March file) and is scheduled to be available by the end of April.

Media: Tape/Cartridge  
File Cost: \$1,130.00 per State per year  
Periods Available: FY 1988 through FY 2000

3. HCFA Wage Data

This file contains the hospital hours and salaries for FY 1998 used to create the proposed FY 2002 prospective payment system wage index. The file will be available by the beginning of February for the NPRM and the beginning of May for the final rule.

Processing year	Wage data year	PPS fiscal year
2001 .....	1998	2002
2000 .....	1997	2001
1999 .....	1996	2000
1998 .....	1995	1999
1997 .....	1994	1998
1996 .....	1993	1997
1995 .....	1992	1996
1994 .....	1991	1995
1993 .....	1990	1994
1992 .....	1989	1993
1991 .....	1988	1992

These files support the following:

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

Media: Diskette/most recent year on the Internet  
File Cost: \$165.00 per year  
Periods Available: FY 2002 PPS Update

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

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

Media: Diskette/most recent year on the Internet  
File Cost: \$165.00 per year  
Periods Available: FY 2002 PPS Update

5. PPS SSA/FIPS MSA State and County Crosswalk

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

Media: Diskette/Internet  
File Cost: \$165.00 per year  
Periods Available: FY 2002 PPS Update

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

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

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

Media: Diskette/Internet  
File Cost: \$165.00 per year  
Periods Available: FY 2002 PPS Update

7. PPS-IV to PPS-XII Minimum Data Set

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

Media: Tape/Cartridge  
File Cost: \$770.00 per year

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

**Note:** The PPS–XIII, PPS–XIV, PPS–XV, and PPS–XVI Minimum Data Sets are part of the PPS–XIII, PPS–XIV, PPS–XV, and PPS–XVI Hospital Data Set Files.

8. PPS–IX to PPS–XII Capital Data Set

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

Media: Tape/Cartridge  
File Cost: \$770.00 per year

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

**Note:** The PPS–XIII, PPS–XIV, PPS–XV, and PPS–XVI Capital Data Sets are part of the PPS–XIII, PPS–XIV, PPS–XV, and PPS–XVI Hospital Data Set Files.

9. PPS–XIII to PPS–XVI Hospital Data Set

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

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

	Periods beginning on or after	And before
PPS–XIII .....	10/01/95	10/01/96
PPS–XIV .....	10/01/96	10/01/97
PPS–XV .....	10/01/97	10/01/98
PPS–XVI .....	10/01/98	10/01/99

10. Provider-Specific File

This file is a component of the PRICER program used in the fiscal intermediary’s system to compute DRG payments for individual bills. The file contains records for all prospective payment system eligible hospitals,

including hospitals in waiver States, and data elements used in the prospective payment system recalibration processes and related activities. Beginning with December 1988, the individual records were enlarged to include pass-through per diems and other elements.

Media: Diskette/Internet  
File Cost: \$265.00  
Periods Available: FY 2002 PPS Update

11. HCFA Medicare Case-Mix Index File

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

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

Media: Diskette/most recent year on Internet  
Price: \$165.00 per year/per file  
Periods Available: FY 1985 through FY 2000

12. DRG Relative Weights (Formerly Table 5 DRG)

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

- NPRM.
- Final rule.

Media: Diskette/Internet  
File Cost: \$165.00  
Periods Available: FY 2002 PPS Update

13. PPS Payment Impact File

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

Media: Diskette/Internet  
File Cost: \$165.00  
Periods Available: FY 2002 PPS Update  
14. AOR/BOR Tables

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

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

Media: Diskette/Internet  
File Cost: \$165.00  
Periods Available: FY 2002 PPS Update

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

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

*B. Information Collection Requirements*

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comments on each of these issues for the sections that contain information collection requirements.

*Proposed New § 412.230(e)(2)(ii) Criteria for an Individual Hospital Seeking Redesignation to Another Rural Area or an Urban Area; Proposed New § 412.232(d)(2)(ii) Criteria for All Hospitals in a Rural County Seeking Urban Redesignation; Proposed New § 412.235 Criteria for All Hospitals in a State Seeking a Statewide Wage Index; and Proposed Revised § 412.273 Withdrawing an Application or Terminating an Approved 3-Year Reclassification*

Proposed §§ 412.230(e)(2)(ii) and 412.232(d)(2)(ii) specify that, for hospital-specific data for wage index changes for redesignations effective beginning FY 2003, the hospital must provide a 3-year average of its average hourly wages using data from the HCFA hospital wage survey used to construct the wage index in effect for prospective payment purposes. For other data, the hospital must provide a weighted 3-year average of the average hourly wage in the area in which the hospital is located and a weighted 3-year average of the average hourly wage in the area to which the hospital seeks reclassification. Proposed new § 412.235 specifies that in order for all prospective payment system hospitals in a State to use a statewide wage index, the hospitals as a group must submit an application to the MGCRB for a decision for reclassifications for wage index purposes. The proposed changes to § 412.273 would incorporate proposed revised procedures for hospitals that request withdraw of their wage index application or termination of their wage index reclassification. These proposed changes, discussed in detail in section IV.E. of this proposed rule, implement sections 304(a) and (b) of Public Law 106-554.

The information collection requirements associated with a hospital's application to the MGCRB for geographic reclassifications, including reclassifications for wage index purposes and the required submittal of wage data, that are codified in Part 412 are currently approved by OMB under OMB Approval Number 0938-0573, with an expiration date of September 30, 2002.

*Proposed § 412.348(g)(9) Exception Payments*

As discussed in section V. of this proposed rule, Medicare makes special exceptions payments for capital-related costs through the 10th year beyond the end of the capital prospective payment system transition period for eligible hospitals that complete a project that meets certain requirements specified in

§ 412.348. In order to assist our fiscal intermediaries in determining the end of the 10-year period in which an eligible hospital will no longer be entitled to receive special exception payments, we are proposing to add a new § 412.348(g)(9) to require that hospitals eligible for special exception payments under § 412.348(g) submit documentation to the intermediary indicating the completion date of their project (the date the project was put in use for patient care) that meets the project need and project size requirements outlined in §§ 412.348(g)(2) through (g)(5). We are proposing that, in order for an eligible hospital to receive special exception payments, this documentation would have to be submitted in writing to the intermediary by the later of October 1, 2001, or within 3 months of the end of the hospital's last cost reporting period beginning before October 1, 2001, during which a qualifying project was completed.

We estimate that the information collection requirement of preparing and submitting the documentation on a hospital's capital project would impose a burden of approximately 1 hour for approximately 30 hospitals.

If you comment on these information collection and recordkeeping requirements, please mail copies directly to the following addresses: Health Care Financing Administration, Office of Information Services, Security and Standards Group, Division of HCFA Enterprise Standards Room N2-14-26, 7500 Security Boulevard, Baltimore, Maryland 21244-1850, Attn: John Burke HCFA-1158-P; and Office of Information and Regulatory Affairs, Office of Management and Budget, Room 3001, New Executive Office Building, Washington, DC 20503, Attn: Allison Herron Eydt, HCFA Desk Officer.

These new information collection and recordkeeping requirements have been submitted to the Office of Management and Budget (OMB) for review under the authority of PRA. We have submitted a copy of the proposed rule to OMB for its review of the information collection requirements. These requirements will not be effective until they have been approved by OMB.

#### *C. Public Comments*

Because of the large number of items of correspondence we normally receive on a proposed rule, we are not able to acknowledge or respond to them individually. However, in preparing the final rule, we will consider all

comments concerning the provisions of this proposed rule that we receive by the date and time specified in the DATES section of this preamble and respond to those comments in the preamble to that rule. We emphasize that section 1886(e)(5) of the Act requires the final rule for FY 2002 to be published by August 1, 2001, and we will consider only those comments that deal specifically with the matters discussed in this proposed rule.

#### **List of Subjects**

##### *42 CFR Part 405*

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

##### *42 CFR Part 412*

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

##### *42 CFR Part 413*

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

##### *42 CFR Part 485*

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

##### *42 CFR Part 486*

Health professions, Medicare, Organ procurement, X-rays.

42 CFR Chapter IV is proposed to be amended as set forth below:

#### **PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED**

A. Part 405 is amended as set forth below:

1. The authority citation for Part 405 continues to read as follows:

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

2. In § 405.2468, paragraph (f)(6)(ii) is republished and paragraph (f)(6)(ii)(D) is revised to read as follows.

##### **§ 405.2468 Allowable costs.**

\* \* \* \* \*

(f) Graduate medical education.

\* \* \*

(6) \* \* \*

(ii) The following costs are not allowable graduate medical education costs:

\* \* \* \* \*

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

\* \* \* \* \*

**PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES**

B. Part 412 is amended as follows:

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

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

2. Section 412.2 is amended as follows:

- a. The introductory text of paragraph (e) is republished.
b. Paragraph (e)(4) is revised.
c. The introductory text of paragraph (f) is republished.
d. A new paragraph (f)(9) is added.

**§ 412.2 Basis of payment.**

\* \* \* \* \*

(e) *Excluded costs.* The following inpatient hospital costs are excluded from the prospective payment amounts and are paid on a reasonable cost basis:

\* \* \* \* \*

(4) The acquisition costs of hearts, kidneys, livers, lungs, pancreas, and intestines (or multivisceral organs) incurred by approved transplantation centers.

\* \* \* \* \*

(f) *Additional payments to hospitals.* In addition to payments based on the prospective payment system rates for inpatient operating and inpatient capital-related costs, hospitals receive payments for the following:

\* \* \* \* \*

(9) Special additional payment for certain new technology as specified in § 412.87 and 412.88 of Subpart F.

3. Section 412.23 is amended by adding a new paragraph (i) to read as follows:

**§ 412.23 Excluded hospitals: Classifications.**

\* \* \* \* \*

(i) *Changes in classification of hospitals.* For purposes of exclusions from the prospective payment system, the classification of a hospital is effective for the hospital's entire cost reporting period. Any changes in the classification of a hospital are made only at the start of a cost reporting period.

4. Section 412.25 is amended by adding a new paragraph (f) to read as follows:

**§ 412.25 Excluded hospital units: Common requirements.**

\* \* \* \* \*

(f) *Changes in classification of hospital units.* For purposes of exclusions from the prospective payment system under this section, the classification of a hospital unit is effective for the unit's entire cost reporting period. Any changes in the classification of a hospital unit is made only at the start of a cost reporting period.

5. Section 412.63 is amended by revising paragraphs (t) and (u) to read as follows:

**§ 412.63 Federal rates for inpatient operating costs for fiscal years after Federal fiscal year 1984.**

\* \* \* \* \*

(t) *Applicable percentage change for fiscal years 2002 and 2003.* The applicable percentage change for fiscal years 2002 and 2003 is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this subchapter) minus 0.55 percentage points for hospitals in all areas.

(u) *Applicable percentage change for fiscal year 2004 and for subsequent fiscal years.* The applicable percentage change for fiscal year 2004 and for subsequent years is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this subchapter) for hospitals in all areas.

\* \* \* \* \*

6. The title of Subpart F is revised to read as follows:

**Subpart F—Payment for Outlier Cases and Special Treatment Payment for New Technology**

7. A new undesignated center heading is added after the Subpart F heading and before § 412.80; the section heading of § 412.80 is revised; and a new paragraph (a)(3) is added to read as follows:

**Payment for Outlier Cases**

**§ 412.80 Outlier cases: General provisions.**

\* \* \* \* \*

(a) *Basic rule.*

\* \* \* \* \*

(3) *Discharges occurring on or after October 1, 2001.* For discharges occurring on or after October 1, 2001, except as provided in paragraph (b) of this section concerning transfers, HCFA provides for additional payment, beyond standard DRG payments and beyond additional payments for new

medical services or technology specified in §§ 412.87 and 412.88, to a hospital for covered inpatient hospital services furnished to a Medicare beneficiary if the hospital's charges for covered services, adjusted to operating costs and capital costs by applying cost-to-charge ratios as described in § 412.84(h), exceed the DRG payment for the case (plus payments for indirect costs of graduate medical education (§ 412.105), payments for serving a disproportionate share of low-income patients (§ 412.106), and additional payments for new medical services or technologies) plus a fixed dollar amount (adjusted for geographic variation in costs) as specified by HCFA.

\* \* \* \* \*

8. A new undesignated center heading and §§ 412.87 and 412.88 are added immediately following § 412.86, to read as follows:

**Additional Special Payment for Certain New Technology**

**§ 412.87 Additional payment for new medical services and technologies: General provisions.**

(a) *Basis.* Sections 412.87 and 412.88 implement sections 1886(d)(5)(K) and 1886(d)(5)(L) of the Act, which authorizes the Secretary to establish a mechanism to recognize the costs of new medical services and technologies under the hospital inpatient prospective payment system.

(b) *Eligibility criteria.* For discharges occurring on or after October 1, 2001, HCFA provides for additional payments (as specified in § 412.88) beyond the standard DRG payments and outlier payments to a hospital for discharges involving covered inpatient hospital services that are new medical services and technologies, if the following conditions are met:

(1) A new medical service or technology represents an advance that substantially improves, relative to technologies previously available, the diagnosis or treatment of Medicare beneficiaries. HCFA will determine whether a new medical service or technology meets this criterion and announce the results of its determinations in the **Federal Register** as a part of its annual updates and changes to the hospital inpatient prospective payment system.

(2) A medical service or technology may be considered new within 2 or 3 years after it becomes available on the market (depending on when a new code is assigned and data on the new service or technology become available for DRG recalibration). After HCFA has recalibrated the DRGs, based on

available data, to reflect the costs of an otherwise new medical service or technology, the medical service or technology will no longer be considered "new" under the criterion of this section.

(3) The DRG prospective payment rate otherwise applicable to discharges involving the medical service or technology is determined to be inadequate, based on application of a threshold amount to estimated costs incurred with respect to such discharges. To determine whether the payment would be adequate, HCFA will determine whether the costs of the cases involving a new medical service or technology will exceed a threshold amount set at one standard deviation beyond the mean standardized charge for all cases in the DRG to which the new medical service or technology is assigned (or the case-weighted average of all relevant DRGs if the new medical service or technology occurs in many different DRGs). Standardized charges reflect the actual charges of a case adjusted by the prospective payment system payment factors applicable to an individual hospital, such as the wage index, the indirect medical education adjustment factor, and the disproportionate share adjustment factor.

**§ 412.88 Additional payment for new medical service or technology.**

(a) For discharges involving new medical services or technologies that meet the criteria specified in § 412.87, Medicare payment will be:

- (1) The standard DRG payment; plus
- (2) If the costs of the discharge (determined by applying cost-to-charge ratios as described in § 412.84(h)) exceed the standard DRG payment, an additional amount equal to the lesser of—

- (i) 50 percent of the costs of the new medical service or technology; or
- (ii) 50 percent of the amount by which the costs of the case exceed the standard DRG payment.

(b) Unless a discharge case qualifies for outlier payment under § 412.84, Medicare will not pay any additional amount beyond the DRG payment plus 50 percent of the estimated costs of the new medical service or technology.

9. Section 412.92 is amended as follows:

a. Paragraph (b)(1)(iii)(A) is amended by revising the phrase "50 mile radius" to read "35 mile radius."

b. Paragraph (c)(1) is revised.

**§ 412.92 Special treatment: Sole community hospitals.**

\* \* \* \* \*

(c) *Terminology.* \* \* \*

(1) The term *miles* means the shortest distance in miles measured over improved roads. An improved road for this purpose is any road that is maintained by a local, State, or Federal government entity and is available for use by the general public. An improved road includes the paved surface up to the front entrance of the hospital.

\* \* \* \* \*

10. Section 412.105 is amended as follows:

- a. The introductory text of paragraph (a) is republished.
- b. Paragraph (a)(1) is revised.
- c. Paragraph (d)(3)(vi) is revised.
- d. A new paragraph (d)(3)(vii) is added.
- e. Paragraph (f)(1)(ii)(C) is revised.
- f. Paragraph (f)(1)(iii) is revised.
- g. Paragraph (f)(1)(v) is amended by adding four sentences at the end.
- h. Paragraph (f)(1)(ix) is revised.

**§ 412.105 Special treatment: Hospitals that incur indirect costs for graduate medical education programs.**

\* \* \* \* \*

(a) *Basic data.* HCFA determines the following for each hospital:

(1) The hospital's ratio of full-time equivalent residents, except as limited under paragraph (f) of this section, to the number of beds (as determined under paragraph (b) of this section). Except for the special circumstances for affiliated groups and new programs described in paragraphs (f)(1)(vi) and (f)(1)(vii) of this section, for a hospital's cost reporting periods beginning on or after October 1, 1997, this ratio may not exceed the ratio for the hospital's most recent prior cost reporting period after accounting for the cap on the number of full-time equivalent residents as described in paragraph (f)(1)(iv) of this section. The exception for new programs described in paragraph (f)(1)(vii) of this section applies for the period of years equal to the minimum accredited length for that type of program.

\* \* \* \* \*

(d) *Determination of education adjustment factor.*

\* \* \* \* \*

(3) \* \* \*

(vi) For discharges occurring during fiscal year 2002, 1.6.

(vii) For discharges occurring on or after October 1, 2002, 1.35.

\* \* \* \* \*

(f) *Determining the total number of full-time equivalent residents for cost reporting periods beginning on or after July 1, 1991.*

(1) \* \* \*

(ii) \* \* \*

(C) Effective for discharges occurring on or after October 1, 1997, the time spent by a resident in a non-hospital setting in patient care activities under an approved medical residency training program is counted towards the determination of full-time equivalency if the criteria set forth in § 413.86(f)(3) or § 413.86 (f)(4), as applicable, are met.

(iii) (A) Full-time equivalent status is based on the total time necessary to fill a residency slot. No individual may be counted as more than one full-time equivalent. If a resident is assigned to more than one hospital, the resident counts as a partial full-time equivalent based on the proportion of time worked in any of the areas of the hospital listed in paragraph (f)(1)(ii) of this section, to the total time worked by the resident. A part-time resident or one working in an area of the hospital other than those listed under paragraph (f)(1)(ii) of this section (such as a freestanding family practice center or an excluded hospital unit) would be counted as a partial full-time equivalent based on the proportion of time assigned to an area of the hospital listed in paragraph (f)(1)(ii) of this section, compared to the total time necessary to fill a full-time residency slot.

(B) The time spent by a resident in research that is not associated with the treatment or diagnosis of a particular patient of the hospital is not countable.

\* \* \* \* \*

(v) \* \* \* If a hospital qualified for an adjustment to the limit established under paragraph (f)(1)(iv) of this section for new medical residency programs created under paragraph (f)(1)(vii) of this section, the count of residents participating in new medical residency training programs above the number included in the hospital's FTE count for the cost reporting period ending during calendar year 1996 is added after applying the averaging rules in this paragraph for a period of years. Residents participating in new medical residency training programs are included in the hospital's FTE count before applying the averaging rules after the period of years has expired. For purposes of this paragraph, the period of years equals the minimum accredited length for the type of program. The period of years begins when the first resident begins training.

\* \* \* \* \*

(ix) A hospital may receive a temporary adjustment to its full-time equivalent cap to reflect residents added because of another hospital's closure if the hospital meets the criteria specified in §§ 413.86(g)(8)(i) and (g)(8)(ii) of this

subchapter. If a hospital that closes its residency training program agrees to temporarily reduce its FTE cap according to the criteria specified in §§ 413.86(g)(8)(i) and (g)(8)(iii)(B) of this subchapter, another hospital(s) may receive a temporary adjustment to its FTE cap to reflect residents added because of the closure of the residency training program if the criteria specified in §§ 413.86(g)(8)(i) and (g)(8)(iii)(A) of this subchapter are met.

\* \* \* \* \*

11. Section 412.106 is amended by revising the heading of paragraph (e) and paragraph (e)(5) to read as follows:

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

\* \* \* \* \*

(e) *Reduction in payments beginning FY 1998.* \* \* \*

(5) For FY 2002, 3 percent.

\* \* \* \* \*

**§ 412.113 [Amended]**

12. In § 412.113(c), including the heading for paragraph (c), the term "hospital", wherever it appears, is revised to read "hospital or CAH" (16 times).

13. Section 412.230 is amended by revising paragraph (e)(2) to read as follows:

**§ 412.230 Criteria for an individual hospital seeking redesignation to another rural area or an urban area.**

\* \* \* \* \*

(e) *Use of urban or other rural area's wage index.*

\* \* \* \* \*

(2) *Appropriate wage data.* For a wage index change, the hospital must submit appropriate wage data as follows:

(i) For redesignations effective through FY 2002:

(A) For hospital-specific data, the hospital must provide data from the HCFA hospital wage survey used to construct the wage index in effect for prospective payment purposes during the fiscal year prior to the fiscal year for which the hospital requests reclassification.

(B) For data for other hospitals, the hospital must provide data concerning the average hourly wage in the area in which the hospital is located and the average hourly wage in the area to which the hospital seeks reclassification. The wage data are taken from the HCFA hospital wage survey used to construct the wage index in effect for prospective payment purposes during the fiscal year prior to the fiscal year for which the hospital requests reclassification.

(C) If the hospital is requesting reclassification under paragraph (e)(1)(iv)(B) of this section, the hospital must provide occupational-mix data to demonstrate the average occupational mix for each employment category in the area to which it seeks reclassification. Occupational-mix data can be obtained from surveys conducted by the American Hospital Association.

(ii) For redesignations effective beginning FY 2003:

(A) For hospital-specific data, the hospital must provide a weighted 3-year average of its average hourly wages using data from the HCFA hospital wage survey used to construct the wage index in effect for prospective payment purposes.

(B) For data for other hospitals, the hospital must provide a weighted 3-year average of the average hourly wage in the area in which the hospital is located and a weighted 3-year average of the average hourly wage in the area to which the hospital seeks reclassification. The wage data are taken from the HCFA hospital wage survey used to construct the wage index in effect for prospective payment purposes.

\* \* \* \* \*

14. Section 412.232 is amended by revising paragraph (d)(2) to read as follows:

**§ 412.232 Criteria for all hospitals in a rural county seeking urban redesignation.**

\* \* \* \* \*

(d) *Appropriate data.*

\* \* \* \* \*

(2) *Appropriate wage data.* The hospitals must submit appropriate data as follows:

(i) For redesignations effective through FY 2002:

(A) For hospital-specific data, the hospitals must provide data from the HCFA wage survey used to construct the wage index in effect for prospective payment purposes during the fiscal year prior to the fiscal year for which the hospitals request reclassification.

(B) For data for other hospitals, the hospitals must provide the following:

(1) The average hourly wage in the adjacent area, which is taken from the HCFA hospital wage survey used to construct the wage index in effect for prospective payment purposes during the fiscal year prior to the fiscal year for which the hospitals request reclassification.

(2) Occupational-mix data to demonstrate the average occupational mix for each employment category in the adjacent area. Occupational-mix data can be obtained from surveys conducted by the American Hospital Association.

(ii) For redesignations effective beginning FY 2003:

(A) For hospital-specific data, the hospital must provide a weighted 3-year average of its average hourly wages using data from the HCFA hospital wage survey used to construct the wage index in effect for prospective payment purposes.

(B) For data for other hospitals, the hospital must provide a weighted 3-year average of the average hourly wage in the area in which the hospital is located and a weighted 3-year average of the average hourly wage in the area to which the hospital seeks reclassification. The wage data are taken from the HCFA hospital wage survey used to construct the wage index in effect for prospective payment purposes.

15. Section 412.235 is added to read as follows:

**§ 412.235 Criteria for all hospitals in a State seeking a statewide wage index redesignation.**

(a) *General criteria.* For all prospective payment system hospitals in a State to be redesignated to a statewide wage index, the following conditions must be met:

(1) All prospective payment system hospitals in the State must apply as a group for reclassification to a statewide wage index through a signed single application.

(2) All prospective payment system hospitals in the State must agree to the reclassification to a statewide wage index through a signed affidavit on the application.

(3) All prospective payment system hospitals in the State must agree, through an affidavit, to withdrawal of an application or to termination of an approved statewide wage index reclassification.

(4) All hospitals in the State must waive their rights to any wage index classification that they would otherwise receive absent the statewide wage index classification, including a wage index that any of the hospitals might have received through individual geographic reclassification.

(5) New hospitals that open within the State prior to the deadline for submitting an application for a statewide wage index reclassification (September 1), regardless of whether a group application has already been filed, must agree to the use of the statewide wage index as part of the group application. New hospitals that open within the State after the deadline for submitting a statewide wage index reclassification application or during the approved reclassification period will be considered a party to the statewide

wage index application and reclassification.

(b) *Effect on payments.* (1) An individual hospital within the State may receive a wage index that could be higher or lower under the statewide wage index reclassification in comparison to its otherwise redesignated wage index.

(2) Any new prospective payment system hospital that opens in the State during the effective period of an approved statewide wage index reclassification will be designated to receive the statewide wage index for the duration of that period.

(3) A hospital located in an area outside a State in which all participating hospitals have received an approved statewide wage index reclassification may apply to be reclassified into the statewide wage index area. In that case, such a hospital that is reclassified into a statewide wage index area will receive a wage index calculated based on the statewide wage index reclassification.

(c) *Terms of the decision.* (1) A decision by the MGCRB on an application for a statewide wage index reclassification will be effective for 3 years beginning with discharges occurring on the first day (October 1) of the second Federal fiscal year following the Federal fiscal year in which the hospitals filed a complete application.

(2) The procedures and timeframes specified in § 412.273 apply to withdrawals of applications for redesignation to a statewide wage index and terminations of approved statewide wage index reclassifications, including the requirement that, to withdraw an application or terminate an approved reclassification, the request must be made in writing by all hospitals that are party to the application, except hospitals reclassified into the State for purposes of receiving the statewide wage index.

16. Section 412.273 is amended as follows:

- a. The title of the section is revised.
- b. Paragraphs (b) and (c) are redesignated as paragraphs (c) and (d), respectively.
- c. A new paragraph (b) is added.
- d. Redesignated paragraph (c) is revised.

**§ 412.273 Withdrawing an application or terminating an approved 3-year reclassification.**

\* \* \* \* \*

(b) *Request for termination of approved 3-year wage index reclassifications.*

(1) A hospital, or a group of hospitals, that has been issued a decision on its

application for a 3-year reclassification for wage index purposes only or for redesignation to a statewide wage index and has not withdrawn that application under the procedures specified in paragraph (a) of this section may request termination of its approved 3-year wage index reclassification under the following conditions:

(i) The request to terminate must be received by the MGCRB within 45 days of the publication of the annual notice of proposed rulemaking concerning changes to the inpatient hospital prospective payment system and proposed payment rates for the fiscal year for which the termination is to apply.

(ii) A request to terminate a 3-year reclassification will be effective only for the full fiscal year(s) remaining in the 3-year period at the time the request is received. Requests for terminations for part of a fiscal year will not be considered.

(2) *Reapplication within the approved 3-year period.*

(i) If a hospital elects to withdraw its wage index application after the MGCRB has issued its decision, it may terminate its withdrawal in a subsequent fiscal year and request the MGCRB to reinstate its wage index reclassification for the remaining fiscal year(s) of the 3-year period.

(ii) A hospital may apply for reclassification for purposes of the wage index to a different area (that is, an area different from the one to which it was originally reclassified for the 3-year period). If the application is approved, the reclassification will be effective for 3 years.

(c) *Written request only.* A request to withdraw an application or terminate an approved reclassification must be made in writing to the MGCRB by all hospitals that are party to the application or reclassification.

\* \* \* \* \*

17. Section 412.274 is amended by revising paragraph (b) to read as follows:

**§ 412.274 Scope and effect of an MGCRB decision.**

\* \* \* \* \*

(b) *Effective date and term of the decision.* (1) A standardized amount classification change is effective for one year beginning with discharges occurring on the first day (October 1) of the second Federal fiscal year following the Federal fiscal year in which the complete application is filed and ending effective at the end of that Federal fiscal year (the end of the next September 30).

(2) A wage index classification change is effective for 3 years beginning with discharges occurring on the first day

(October 1) of the second Federal fiscal year in which the complete application is filed.

\* \* \* \* \*

18. Section 412.348 is amended by revising paragraph (g)(6) and adding a new paragraph (g)(9) to read as follows:

**§ 412.348 Exception payments.**

\* \* \* \* \*

(g) *Special exceptions process.* \* \* \*

(6) *Minimum payment level.*

(i) The minimum payment level for qualifying hospitals will be 70 percent.

(ii) HCFA will adjust the minimum payment level in one percentage point increments as necessary to satisfy the requirement specified in paragraph (h) of this section that total estimated payments under the exceptions process not exceed 10 percent of the total estimated capital prospective payment system payments for the same fiscal year.

\* \* \* \* \*

(9) *Notification requirement.* Eligible hospitals must submit documentation to the intermediary indicating the completion date of a project that meets the project need requirement under paragraph (g)(2) of this section, the project size requirement under paragraph (g)(5) of this section, and, in the case of certain urban hospitals, an excess capacity test under paragraph (g)(4) of this section, by the later of October 1, 2001 or within 3 months of the end of the hospital's last cost reporting period beginning before October 1, 2001, during which a qualifying project was completed.

\* \* \* \* \*

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

C. Part 413 is amended as follows:

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

**Authority:** Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395hh, 1395rr, 1395tt, and 1395ww).

2. Section 413.70 is amended as follows:

- a. Paragraph (a)(1) introductory text is republished.
- b. A new paragraph (a)(1)(iv) is added.
- c. Paragraph (a)(2) is revised.
- d. A new paragraph (a)(3) is added.
- e. Paragraph (b)(1) is revised.

f. Paragraph (b)(2)(i)(C) is revised.  
g. New paragraphs (b)(4), (b)(5) and (b)(6) are added.

**§ 413.70 Payment for services of a CAH.**

(a) *Payment for inpatient services furnished by a CAH.*

(1) Payment for inpatient services of a CAH is the reasonable costs of the CAH in providing CAH services to its inpatients, as determined in accordance with section 1861(v)(1)(A) of the Act and the applicable principles of cost reimbursement in this part and in Part 415 of this chapter, except that the following payment principles are excluded when determining payment for CAH inpatient services:

\* \* \* \* \*

(iv) The payment window provisions for preadmission services, specified in § 412.2(c)(5) of this subchapter and § 413.40(c)(2).

(2) Except as specified in paragraph (a)(3) of this section, payment to a CAH for inpatient services does not include any costs of physician services or other professional services to CAH inpatients, and is subject to the Part A hospital deductible and coinsurance, as determined under subpart G of part 409 of this chapter.

(3) If a CAH meets the criteria in § 412.113(c) of this subchapter for pass-through of costs of anesthesia services furnished by qualified nonphysician anesthesiologists employed by the CAH or obtained under arrangements, payment to the CAH for the costs of those services is made in accordance with § 412.113(c).

(b) *Payment for outpatient services furnished by CAH.—*(1) *General.* (i) Unless the CAH elects to be paid for services to its outpatients under the method specified in paragraph (b)(3) of this section, the amount of payment for outpatient services of a CAH is the amount determined under paragraph (b)(2) of this section.

(ii) Except as specified in paragraph (b)(6) of this section, payment to a CAH for outpatient services does not include any costs of physician services or other professional services to CAH outpatients.

\* \* \* \* \*

(2) *Reasonable costs for facility services.*

(i) \* \* \*

(C) Any type of reduction to operating or capital costs under § 413.124 or § 413.130(j).

\* \* \* \* \*

(4) *Costs of emergency room on-call physicians.* (i) Effective for cost reporting periods beginning on or after October 1, 2001, the reasonable costs of

outpatient CAH services under paragraph (b) of this section may include amounts for reasonable compensation and related costs for an emergency room physician who is on call but who is not present on the premises of the CAH involved, is not otherwise furnishing physicians' services, and is not on call at any other provider or facility.

(ii) For purposes of this paragraph (b)(4)—

(A) "Amounts for reasonable compensation and related costs" means all allowable costs of compensating emergency room physicians who are on call to the extent the costs are found to be reasonable under the rules specified in paragraph (b)(2) of this section and the applicable sections of Part 413.

Costs of compensating emergency room physicians are allowable only if the costs are incurred under written contracts that require the physician to come to the CAH when the physician's presence is medically required.

(B) An "emergency room physician who is on call" means a doctor of medicine or osteopathy with training or experience in emergency care who is immediately available by telephone or radio contact, and is available on site within the timeframes specified in § 485.618(d) of this chapter.

(5) *Costs of ambulance services.* (i) Effective for services furnished on or after December 21, 2000, payment for ambulance services furnished by a CAH or an entity that is owned and operated by a CAH is the reasonable costs of the CAH or the entity in furnishing those services, but only if the CAH or the entity is the only provider or supplier of ambulance services located within a 35-mile drive of the CAH or the entity.

(ii) For purposes of paragraph (b)(5) of this section, the distance between the CAH or the entity and the other provider or supplier of ambulance services will be determined as the shortest distance in miles measured over improved roads between the CAH or the entity and the site at which the vehicles of the closest provider or supplier of ambulance services are garaged. An improved road for this purpose is any road that is maintained by a local, State, or Federal government entity and is available for use by the general public. An improved road will be considered to include the paved surface up to the front entrance of the hospital and the front entrance of the garage.

(6) If a CAH meets the criteria in § 412.113(c) of this subchapter for pass-through of costs of anesthesia services furnished by nonphysician anesthesiologists employed by the CAH or obtained under

arrangement, payment to the CAH for the costs of those services is made in accordance with § 412.113(c).

\* \* \* \* \*

3. Section 413.86 is amended as follows:

- a. Paragraph (e)(4)(ii)(C)(1) is revised.
- b. Paragraph (e)(5)(iv) is removed.
- c. Paragraph (g)(4) is revised.
- d. Paragraph (g)(5) is revised.
- e. Paragraph (g)(8) is revised.

**§ 413.86 Direct graduate medical education payments.**

\* \* \* \* \*

(e) *Determining per residents amounts for the base period.* \* \* \*

(4) \* \* \*

(ii) \* \* \*

(C) *Determining necessary revisions to the per resident amount.* \* \* \*

(1) Floor. (i) For cost reporting periods beginning on or after October 1, 2000, and before October 1, 2001, if the hospital's per resident amount would otherwise be less than 70 percent of the locality-adjusted national average per resident amount for FY 2001 (as determined under paragraph (e)(4)(ii)(B) of this section), the per resident amount is equal to 70 percent of the locality-adjusted national average per resident amount for FY 2001.

(ii) For cost reporting periods beginning on or after October 1, 2001, and before October 1, 2002, if the hospital's per resident amount would otherwise be less than 85 percent of the locality-adjusted national average per resident amount for FY 2002 (as determined under paragraph (e)(4)(ii)(B) of this section), the per resident amount is equal to 85 percent of the locality-adjusted national average per resident amount for FY 2002.

(iii) For subsequent cost reporting periods beginning on or after October 1, 2002, the hospital's per resident amount is updated using the methodology specified under paragraph (e)(3)(i) of this section.

\* \* \* \* \*

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

(4) For purposes of determining direct graduate medical education payments—

(i) For cost reporting periods beginning on or after October 1, 1997, a hospital's unweighted FTE count for residents in allopathic and osteopathic medicine may not exceed the hospital's unweighted FTE count (or, effective for cost reporting periods beginning on or after April 1, 2000, 130 percent of the unweighted FTE count for a hospital located in a rural area) for these residents for the most recent cost reporting period ending on or before December 31, 1996.

(ii) If a hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 1997, and before October 1, 2001, exceeds the limit described in this paragraph (g), the hospital's total weighted FTE count (before application of the limit) will be reduced in the same proportion that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996.

(iii) If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this paragraph (g), the hospital's weighted FTE count (before application of the limit), for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced in the same proportion that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996.

(iv) Hospitals that are part of the same affiliated group may elect to apply the limit on an aggregate basis.

(v) The fiscal intermediary may make appropriate modifications to apply the provisions of this paragraph (g)(4) based on the equivalent of a 12-month cost reporting period.

(5) For purposes of determining direct graduate medical education payment—

(i) For the hospital's first cost reporting period beginning on or after October 1, 1997, the hospital's weighted FTE count is equal to the average of the weighted FTE count for the payment year cost reporting period and the preceding cost reporting period.

(ii) For cost reporting periods beginning on or after October 1, 1998, and before October 1, 2001, the hospital's weighted FTE count is equal to the average of the weighted FTE count for the payment year cost reporting period and the preceding two cost reporting periods.

(iii) For cost reporting periods beginning on or after October 1, 2001, the hospital's weighted FTE count for primary care and obstetrics and gynecology residents is equal to the average of the weighted primary care and obstetrics and gynecology counts for the payment year cost reporting period and the preceding two cost reporting periods, and the hospital's weighted FTE count for nonprimary care residents is equal to the average of the weighted nonprimary care FTE counts for the payment year cost reporting period and the preceding two cost reporting periods.

(iv) The fiscal intermediary may make appropriate modifications to apply the provisions of this paragraph (g)(5) based on the equivalent of 12-month cost reporting periods.

(v) If a hospital qualifies for an adjustment to the limit established under paragraph (g)(4) of this section for new medical residency programs created under paragraph (g)(6) of this section, the count of the residents participating in new medical residency training programs above the number included in the hospital's FTE count for the cost reporting period ending during calendar year 1996 is added after applying the averaging rules in this paragraph (g)(5) for a period of years. Residents participating in new medical residency training programs are included in the hospital's FTE count before applying the averaging rules after the period of years has expired. For purposes of this paragraph (g)(5), the period of years equals the minimum accredited length for the type of program. The period of years begins when the first resident begins training.

\* \* \* \* \*

(8) *Closure of hospital or hospital residency program.*

(i) *Definitions.* For purposes of this paragraph (g)(8)—

(A) "Closure of a hospital" means the hospital terminates its Medicare agreement under the provisions of § 489.52 of this chapter.

(B) "Closure of a hospital residency training program" means the hospital ceases to offer training for residents in a particular approved medical residency training program.

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

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

(B) No later than 60 days after the hospital begins to train the residents, the hospital submits a request to its fiscal intermediary for a temporary adjustment to its FTE cap, documents that the hospital is eligible for this temporary adjustment by identifying the residents who have come from the closed hospital and have caused the hospital to exceed its cap, and specifies the length of time the adjustment is needed.

(iii) *Closure of a hospital's residency training program.* If a hospital that closes its residency training program voluntarily agrees to temporarily reduce its FTE cap according to the criteria specified in paragraph (g)(8)(iii)(B) of

this section, another hospital(s) may receive a temporary adjustment to its FTE cap to reflect residents added because of the closure of the residency training program if the criteria specified in paragraph (g)(8)(iii)(A) of this section are met.

(A) *Receiving hospital(s).* A hospital may receive a temporary adjustment to its FTE cap to reflect residents added because of the closure of another hospital's residency training program if—

(1) The hospital is training additional residents from the residency training program of a hospital that closed a program; and

(2) No later than 60 days after the hospital begins to train the residents, the hospital submits to its fiscal intermediary a request for a temporary adjustment to its FTE cap, documents that it is eligible for this temporary adjustment by identifying the residents who have come from another hospital's closed program and have caused the hospital to exceed its cap, specifies the length of time the adjustment is needed, and submits to its fiscal intermediary a copy of the FTE reduction statement by the hospital that closed its program, as specified in paragraph (g)(8)(iii)(B)(2) of this section.

(B) *Hospital that closed its program(s).* A hospital that agrees to train residents who have been displaced by the closure of another hospital's program may receive a temporary FTE cap adjustment only if the hospital with the closed program—

(1) Temporarily reduces its FTE cap based on the FTE residents in each program year training in the program at the time of the program's closure. This yearly reduction in the FTE cap will be determined based on the number of those residents who would have been training in the program during that year had the program not closed; and

(2) No later than 60 days after the residents who were in the closed program begin training at another hospital, submit to its fiscal intermediary a statement signed and dated by its representative that specifies that it agrees to the temporary reduction in its FTE cap to allow the hospital training the displaced residents to obtain a temporary adjustment to its cap; identifies the residents who were in training at the time of the program's closure; identifies the hospitals to which the residents are transferring once the program closes; and specifies the reduction for the applicable program years.

\* \* \* \* \*

**PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS**

D. Part 485 is amended as follows:

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

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

2. Section 485.610 is amended by revising paragraph (b) and adding a new paragraph (c) to read as follows:

**§ 485.610 Condition of participation: Status and location.**

\* \* \* \* \*

(b) *Standard: Location in a rural area or treatment as rural.* The CAH meets the requirements of either paragraph (b)(1) or (b)(2) of this section.

(1) The CAH meets the following requirements:

(i) The CAH is located outside any area that is a Metropolitan Statistical Area, as defined by the Office of Management and Budget, or that has been recognized as urban under § 412.62(f) of this chapter;

(ii) The CAH is not deemed to be located in an urban area under § 412.63(b) of this chapter; and

(iii) The CAH has not been classified as an urban hospital for purposes of the standardized payment amount by HCFA or the Medicare Geographic Classification Review Board under § 412.230(e) of this chapter, and is not among a group of hospitals that have been redesignated to an adjacent urban area under § 412.232 of this chapter.

(2) The CAH is located within a Metropolitan Statistical Area, as defined by the Office of Management and Budget, but is being treated as being located in a rural area in accordance with § 412.103 of this chapter.

(c) *Standard: Location relative to other facilities or necessary provider certification.* The CAH is located more than a 35-mile drive (or, in the case of mountainous terrain or in areas with only secondary roads available, a 15-mile drive) from a hospital or another CAH, or the CAH is certified by the State as being a necessary provider of health care services to residents in the area.

3. Section 485.639 is amended by revising paragraph (b) to read as follows:

**§ 485.639 Condition of participation: Surgical services.**

\* \* \* \* \*

(b) *Anesthetic risk and evaluation.* (1) A qualified practitioner, as specified in paragraph (a) of this section, must examine the patient immediately before surgery to evaluate the risk of the procedure to be performed.

(2) A qualified practitioner, as specified in paragraph (c) of this section, must examine each patient before surgery to evaluate the risk of anesthesia.

(3) Before discharge from the CAH, each patient must be evaluated for proper anesthesia recovery by a qualified practitioner, as specified in paragraph (c) of this section.

\* \* \* \* \*

4. Section 485.643 is amended by revising paragraph (f) to read as follows:

**§ 485.643 Condition of participation: Organ, tissue, and eye procurement.**

\* \* \* \* \*

(f) For purposes of these standards, the term “organ” means a human kidney, liver, heart, lung, pancreas, or intestines (or multivisceral organs).

**PART 486—CONDITIONS FOR COVERAGE OF SPECIALIZED SERVICES FURNISHED BY SUPPLIERS**

F. Part 486 is amended as follows:

1. The authority citation for Part 486 continues to read as follows:

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

2. Section 486.302 is amended by revising the definition of “organ” to read as follows:

**§ 486.302 Definitions.**

\* \* \* \* \*

“Organ” means a human kidney, liver, heart, lung, pancreas, or intestines (or multivisceral organs).

\* \* \* \* \*

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

Dated: March 15, 2001.

**Michael McMullan,**

*Acting Deputy Administrator, Health Care Financing Administration.*

Dated: April 3, 2001.

**Tommy G. Thompson,**

*Secretary.*

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

**Addendum—Proposed Schedule of Standardized Amounts Effective With Discharges Occurring On or After October 1, 2001 and Update Factors and Rate-of-Increase Percentages Effective With Cost Reporting Periods Beginning On or After October 1, 2001**

**I. Summary and Background**

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

For discharges occurring on or after October 1, 2001, except for SCHs, MDHs, and hospitals located in Puerto Rico, each hospital’s payment per discharge under the prospective payment system will be based on 100 percent of the Federal national rate.

SCHs are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal national rate, the updated hospital-specific rate based on FY 1982 cost per discharge, the updated hospital-specific rate based on FY 1987 cost per discharge, or, if qualified, 50 percent of the updated hospital-specific rate based on FY 1996 cost per discharge, plus the greater of 50 percent of the updated FY 1982 or FY 1987 hospital-specific rate or 50 percent of the Federal DRG payment rate. Section 213 of Public Law 106-554 amended section 1886(b)(3) of the Act to allow all SCHs to rebase their hospital-specific rate based on their FY 1996 cost per discharge.

Under section 1886(d)(5)(G) of the Act, MDHs are paid based on the Federal national rate or, if higher, the Federal national rate plus 50 percent of the difference between the Federal national rate and the updated hospital-specific rate based on FY 1982 or FY 1987 cost per discharge, whichever is higher.

For hospitals in Puerto Rico, the payment per discharge is based on the sum of 50 percent of a Puerto Rico rate and 50 percent of a Federal national rate. (See section II.D.3. of this Addendum for a complete description.)

As discussed below in section II. of this Addendum, we are proposing to make changes in the determination of the prospective payment rates for Medicare inpatient operating costs for FY 2002. The changes, to be applied prospectively, would affect the calculation of the Federal rates. In section III. of this Addendum, we discuss our proposed changes for

determining the prospective payment rates for Medicare inpatient capital-related costs for FY 2002. Section IV. of this Addendum sets forth our proposed changes for determining the rate-of-increase limits for hospitals excluded from the prospective payment system for FY 2002. The tables to which we refer in the preamble to this proposed rule are presented at the end of this Addendum in section V.

## II. Proposed Changes to Prospective Payment Rates for Inpatient Operating Costs for FY 2002

The basic methodology for determining prospective payment rates for inpatient operating costs is set forth at § 412.63. The basic methodology for determining the prospective payment rates for inpatient operating costs for hospitals located in Puerto Rico is set forth at §§ 412.210 and 412.212. Below, we discuss the proposed factors used for determining the prospective payment rates. The Federal and Puerto Rico rate changes, once issued as final, will be effective with discharges occurring on or after October 1, 2001.

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

- Updates of 2.55 percent for all areas (that is, the market basket percentage increase of 3.1 percent minus 0.55 percentage points);
- An adjustment to ensure budget neutrality of hospital geographic reclassification, as provided for under sections 1886(d)(4)(C)(iii) and (d)(3)(E) of the Act, by applying new budget neutrality adjustment factors to the large urban and other standardized amounts;
- An adjustment to ensure budget neutrality as provided for in section 1886(d)(8)(D) of the Act by removing the FY 2001 budget neutrality factor and applying a revised factor;
- An adjustment to apply the revised outlier offset by removing the FY 2001 outlier offsets and applying a new offset; and
- An adjustment in the Puerto Rico standardized amounts to reflect the application of a Puerto Rico-specific wage index.

### A. Calculation of Adjusted Standardized Amounts

#### 1. Standardization of Base-Year Costs or Target Amounts

Section 1886(d)(2)(A) of the Act required the establishment of base-year cost data containing allowable operating costs per discharge of inpatient hospital services for each hospital. The preamble to the September 1, 1983 interim final

rule (48 FR 39763) contains a detailed explanation of how base-year cost data were established in the initial development of standardized amounts for the prospective payment system and how they are used in computing the Federal rates.

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

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

Under sections 1886(d)(2)(H) and (d)(3)(E) of the Act, in making payments under the prospective payment system, the Secretary estimates from time to time the proportion of costs that are wages and wage-related costs. Since October 1, 1997, when the market basket was last revised, we have considered 71.1 percent of costs to be labor-related for purposes of the prospective payment system. The average labor share in Puerto Rico is 71.3 percent. We are proposing to revise the discharge-weighted national standardized amount for Puerto Rico to reflect the proportion of discharges in large urban and other areas from the FY 2000 MedPAR file.

#### 2. Computing Large Urban and Other Area Averages

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

Puerto Rico are paid a blend of 50 percent of the applicable Puerto Rico standardized amount and 50 percent of a national standardized payment amount.

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

Based on 1999 population estimates published by the Bureau of the Census, 63 areas meet the criteria to be defined as large urban areas for FY 2002. These areas are identified in Table 4A.

#### 3. Updating the Average Standardized Amounts

Under section 1886(d)(3)(A) of the Act, we update the average standardized amounts each year. In accordance with section 1886(d)(3)(A)(iv) of the Act, we are proposing to update the large urban areas’ and the other areas’ average standardized amounts for FY 2002 using the applicable percentage increases specified in section 1886(b)(3)(B)(i) of the Act. Section 1886(b)(3)(B)(i)(XVII) of the Act as amended by section 301 of Public Law 106–554 specifies that the update factor for the standardized amounts for FY 2002 is equal to the market basket percentage increase minus 0.55 percentage points for hospitals in all areas. Section 301 also established that the update factor for FY 2003 is equal to the market basket percentage increase minus 0.55 percentage points. We are proposing to revise § 412.63 to reflect these changes.

The percentage change in the market basket reflects the average change in the price of goods and services purchased by hospitals to furnish inpatient care. The most recent forecast of the hospital

market basket increase for FY 2002 is 3.1 percent. Thus, for FY 2002, the proposed update to the average standardized amounts equals 2.55 percent for hospitals in all areas.

As in the past, we are adjusting the FY 2001 standardized amounts to remove the effects of the FY 2001 geographic reclassifications and outlier payments before applying the FY 2002 updates. That is, we are increasing the standardized amounts to restore the reductions that were made for the effects of geographic reclassification and outliers. We then apply the new offsets to the standardized amounts for outliers and geographic reclassifications for FY 2002.

Although the update factors for FY 2002 are set by law, we are required by section 1886(e)(3) of the Act to report to the Congress our initial recommendation of update factors for FY 2002 for both prospective payment hospitals and hospitals excluded from the prospective payment system. For general information purposes, we have included the report to Congress as Appendix C to this proposed rule. Our proposed recommendation on the update factors (which is required by sections 1886(e)(4)(A) and (e)(5)(A) of the Act) is set forth as Appendix D to this proposed rule.

#### 4. Other Adjustments to the Average Standardized Amounts

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

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

To comply with the requirement of section 1886(d)(4)(C)(iii) of the Act that DRG reclassification and recalibration of the relative weights be budget neutral, and the requirement in section 1886(d)(3)(E) of the Act that the updated wage index be budget neutral, we used

FY 2000 discharge data to simulate payments and compared aggregate payments using the FY 2001 relative weights and wage index to aggregate payments using the proposed FY 2002 relative weights and wage index. The same methodology was used for the FY 2001 budget neutrality adjustment. (See the discussion in the September 1, 1992 final rule (57 FR 39832).) Based on this comparison, we computed a budget neutrality adjustment factor equal to 0.992493. We also adjust the Puerto Rico-specific standardized amounts for the effect of DRG reclassification and recalibration. We computed a budget neutrality adjustment factor for Puerto Rico-specific standardized amounts equal to 0.994677. These budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the FY 2001 budget neutrality adjustments. We do not remove the prior budget neutrality adjustment because estimated aggregate payments after the changes in the DRG relative weights and wage index should equal estimated aggregate payments prior to the changes. If we removed the prior year adjustment, we would not satisfy this condition.

In addition, we are proposing to apply these same adjustment factors to the hospital-specific rates that are effective for cost reporting periods beginning on or after October 1, 2001. (See the discussion in the September 4, 1990 final rule (55 FR 36073).)

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

Under section 1886(d)(8)(D) of the Act, the Secretary is required to adjust the standardized amounts so as to ensure that aggregate payments under the prospective payment system after implementation of the provisions of sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act are equal to the aggregate prospective payments that would have been made absent these provisions. To calculate this budget neutrality factor, we used FY 2000 discharge data to simulate payments, and compared total prospective payments (including indirect medical education and disproportionate share

hospital payments) prior to any reclassifications to total prospective payments after reclassifications. Based on these simulations, we are applying an adjustment factor of 0.991054 to ensure that the effects of reclassification are budget neutral.

The adjustment factor is applied to the standardized amounts after removing the effects of the FY 2001 budget neutrality adjustment factor. We note that the proposed FY 2002 adjustment reflects wage index and standardized amount reclassifications approved by the MGCRB or the Administrator as of February 28, 2001, and the effects of section 304 of Public Law 106-554 to extend wage index reclassifications for 3 years. The effects of any additional reclassification changes resulting from appeals and reviews of the MGCRB decisions for FY 2002 or from a hospital's request for the withdrawal of a reclassification request will be reflected in the final budget neutrality adjustment published in the final rule for FY 2002.

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

*i. FY 2002 outlier thresholds.* For FY 2001, the fixed loss cost outlier threshold was equal to the prospective payment rate for the DRG plus the IME and DSH payments plus \$17,550 (16,036 for hospitals that have not yet entered the prospective payment system for capital-related costs). The marginal cost factor for cost outliers (the percent of costs paid after costs for the case exceed the threshold) was 80 percent. We applied an outlier adjustment to the FY 2001 standardized amounts of 0.948908 for the large urban and other areas rates and 0.9409 for the capital Federal rate.

For FY 2002, we propose to establish a fixed loss cost outlier threshold equal to the prospective payment rate for the

DRG plus the IME and DSH payments plus \$21,000. The capital prospective payment system is fully phased in, effective FY 2002. Therefore, we no longer are establishing a separate threshold for hospitals that have not yet entered the prospective payment system for capital-related costs. We propose to maintain the marginal cost factor for cost outliers at 80 percent.

To calculate FY 2002 outlier thresholds, we simulated payments by applying FY 2002 rates and policies to the December 2000 update of the FY 2000 MedPAR file and the December 2000 update of the provider-specific file. As we have explained in the past, to calculate outlier thresholds, we apply a cost inflation factor to update costs for the cases used to simulate payments. For FY 2000, we used a cost inflation factor of zero percent. For FY 2001, we used a cost inflation factor (or cost adjustment factor) of 1.8 percent. To set the proposed FY 2002 outlier thresholds, we are using a 2-year cost inflation factor of 5.5 percent (to inflate FY 2000 charges to FY 2002). This factor reflects our analysis of the best available cost report data as well as calculations (using the best available data) indicating that the percentage of actual outlier payments for FY 2000 is higher than we projected before the beginning of FY 2000, and that the percentage of actual outlier payments for FY 2001 will likely be higher than we projected before the beginning of FY 2001. The calculations of "actual" outlier payments are discussed further below.

ii. *Other changes concerning outliers.* In accordance with section 1886(d)(5)(A)(iv) of the Act, we calculated proposed outlier thresholds so that outlier payments are projected to equal 5.1 percent of total payments based on DRG prospective payment rates. In accordance with section 1886(d)(3)(E), we reduced the proposed FY 2002 standardized amounts by the same percentage to account for the projected proportion of payments paid to outliers.

As stated in the September 1, 1993 final rule (58 FR 46348), we establish outlier thresholds that are applicable to both inpatient operating costs and inpatient capital-related costs. When we modeled the combined operating and capital outlier payments, we found that using a common set of thresholds resulted in a higher percentage of outlier payments for capital-related costs than for operating costs. We project that the proposed thresholds for FY 2002 will result in outlier payments equal to 5.1 percent of operating DRG payments and 5.7 percent of capital payments based on the Federal rate.

The proposed outlier adjustment factors to be applied to the standardized amounts for FY 2002 are as follows:

	Operating standardized amounts	Capital federal rate
National .....	0.948910	0.974711
Puerto Rico .....	0.942593	0.970336

We apply the proposed outlier adjustment factors after removing the effects of the FY 2001 outlier adjustment factors on the standardized amounts.

Table 8A in section V. of this Addendum contains the updated Statewide average operating cost-to-charge ratios for urban hospitals and for rural hospitals to be used in calculating cost outlier payments for those hospitals for which the fiscal intermediary is unable to compute a reasonable hospital-specific cost-to-charge ratio. These Statewide average ratios would replace the ratios published in the August 1, 2000 final rule (65 FR 47054). Table 8B contains comparable statewide average capital cost-to-charge ratios. These average ratios would be used to calculate cost outlier payments for those hospitals for which the fiscal intermediary computes operating cost-to-charge ratios lower than 0.1908357 or greater than 1.3133937 and capital cost-to-charge ratios lower than 0.0120498 or greater than 0.1668928. This range represents 3.0 standard deviations (plus or minus) from the mean of the log distribution of cost-to-charge ratios for all hospitals. We note that the cost-to-charge ratios in Tables 8A and 8B would be used during FY 2002 when hospital-specific cost-to-charge ratios based on the latest settled cost report are either not available or outside the three standard deviations range.

iii. *FY 2000 and FY 2001 outlier payments.* In the August 1, 2000 final rule (65 FR 47054), we stated that, based on available data, we estimated that actual FY 2000 outlier payments would be approximately 6.2 percent of actual total DRG payments. This was computed by simulating payments using the March 2000 update of the FY 1999 bill data available at the time. That is, the estimate of actual outlier payments did not reflect actual FY 2000 bills but instead reflected the application of FY 2000 rates and policies to available FY 1999 bills. Our current estimate, using available FY 2000 bills, is that actual outlier payments for FY 2000 were approximately 7.4 percent of actual total DRG payments. We note that the MedPAR file for FY 2000 discharges continues to be updated. Thus, the data indicate that, for FY 2000, the

percentage of actual outlier payments relative to actual total payments is higher than we projected before FY 2000 (and thus exceeds the percentage by which we reduced the standardized amounts for FY 2000). In fact, the data indicate that the proportion of actual outlier payments for FY 2000 exceeds 6.0 percent. Nevertheless, consistent with the policy and statutory interpretation we have maintained since the inception of the prospective payment system, we do not plan to recoup money and make retroactive adjustments to outlier payments for FY 2000.

We currently estimate that actual outlier payments for FY 2001 will be approximately 5.9 percent of actual total DRG payments, 0.8 percent higher than the 5.1 percent we projected in setting outlier policies for FY 2001. This estimate is based on simulations using the December 2000 update of the provider-specific file and the December 2000 update of the FY 2000 MedPAR file (discharge data for FY 2000 bills). We used these data to calculate an estimate of the actual outlier percentage for FY 2001 by applying FY 2001 rates and policies to available FY 2000 bills.

#### 5. FY 2002 Standardized Amounts

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

#### B. Adjustments for Area Wage Levels and Cost of Living

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

1. Adjustment for Area Wage Levels

Sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act require that we make an adjustment to the labor-related portion of the prospective payment rates to account for area differences in hospital wage levels. This adjustment is made by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. In section III. of this preamble, we discuss the data and methodology for the proposed FY 2002 wage index. The proposed wage index is set forth in Tables 4A, 4B, 4C, and 4F of this Addendum.

2. Adjustment for Cost-of-Living in Alaska and Hawaii

Section 1886(d)(5)(H) of the Act authorizes an adjustment to take into account the unique circumstances of hospitals in Alaska and Hawaii. Higher labor-related costs for these two States are taken into account in the adjustment for area wages described above. For FY 2002, we propose to adjust the payments for hospitals in Alaska and Hawaii by multiplying the nonlabor portion of the standardized amounts by the appropriate adjustment factor contained in the table below. If the Office of Personnel Management releases revised cost-of-living adjustment factors before July 1, 2001, we will publish them in the final rule and use them in determining FY 2002 payments.

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

Alaska—All areas .....	1.25
Hawaii:	
County of Honolulu .....	1.1650
County of Hawaii .....	1.2325
County of Kauai .....	1.2325
County of Maui .....	1.2375
County of Kalawao .....	1.2375

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

C. DRG Relative Weights

As discussed in section II. of the preamble, we have developed a classification system for all hospital discharges, assigning them into DRGs, and have developed relative weights for each DRG that reflect the resource utilization of cases in each DRG relative to Medicare cases in other DRGs. Table 5 of section V. of this Addendum contains the relative weights that we are proposing to use for discharges occurring in FY 2002. These factors

have been recalibrated as explained in section II. of the preamble.

D. Calculation of Prospective Payment Rates for FY 2002

General Formula for Calculation of Prospective Payment Rates for FY 2002

The prospective payment rate for all hospitals located outside of Puerto Rico, except SCHs and MDHs, equals the Federal rate.

The prospective payment rate for SCHs equals whichever of the following rates yields the greatest aggregate payment: the Federal national rate, the updated hospital-specific rate based on FY 1982 cost per discharge, the updated hospital-specific rate based on FY 1987 cost per discharge, or, if qualified, 50 percent of the updated hospital-specific rate based on FY 1996 cost per discharge, plus the greater of 50 percent of the updated FY 1982 or FY 1987 hospital-specific rate or 50 percent of the Federal DRG payment rate. Section 213 of Public Law 106-554 amended section 1886(b)(3) of the Act to allow all SCHs to rebase their hospital-specific rate based on their FY 1996 cost per discharge.

The prospective payment rate for MDHs equals 100 percent of the Federal rate, or, if the greater of the updated FY 1982 hospital-specific rate or the updated FY 1987 hospital-specific rate is higher than the Federal rate, 100 percent of the Federal rate plus 50 percent of the difference between the applicable hospital-specific rate and the Federal rate.

The prospective payment rate for Puerto Rico equals 50 percent of the Puerto Rico rate plus 50 percent of a discharge-weighted average of the national large urban standardized amount and the Federal national other standardized amount.

1. Federal Rate

For discharges occurring on or after October 1, 2001 and before October 1, 2002, except for SCHs, MDHs, and hospitals in Puerto Rico, the hospital's payment is based exclusively on the Federal national rate.

The payment amount is determined as follows:

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

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

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

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

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

2. Hospital-Specific Rate (Applicable Only to SCHs and MDHs)

Section 1886(b)(3)(C) of the Act provides that SCHs are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal national rate, the updated hospital-specific rate based on FY 1982 cost per discharge, the updated hospital-specific rate based on FY 1987 cost per discharge, or, if qualified, 50 percent of the updated hospital-specific rate based on FY 1996 cost per discharge, plus the greater of 50 percent of the updated FY 1982 or FY 1987 hospital-specific rate or 50 percent of the Federal DRG payment rate.

Section 1886(d)(5)(G) of the Act provides that MDHs are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal rate or the Federal rate plus 50 percent of the difference between the Federal rate and the greater of the updated hospital-specific rate based on FY 1982 and FY 1987 cost per discharge.

Hospital-specific rates have been determined for each of these hospitals based on either the FY 1982 cost per discharge, the FY 1987 cost per discharge or, for qualifying SCHs, the FY 1996 cost per discharge. For a more detailed discussion of the calculation of the hospital-specific rates, we refer the reader to the September 1, 1983 interim final rule (48 FR 39772); the April 20, 1990 final rule with comment (55 FR 15150); the September 4, 1990 final rule (55 FR 35994); and the August 1, 2000 final rule (65 FR 47082).

a. *Updating the FY 1982, FY 1987, and FY 1996 Hospital-Specific Rates for FY 2002.* We are proposing to increase the hospital-specific rates by 2.55 percent (the hospital market basket percentage increase minus 0.55 percentage points) for SCHs and MDHs for FY 2002. Section 1886(b)(3)(C)(iv) of the Act provides that the update factor applicable to the hospital-specific rates for SCHs equal the update factor provided under section 1886(b)(3)(B)(iv) of the Act, which, for SCHs in FY 2002,

is the market basket rate of increase minus 0.55 percentage points. Section 1886(b)(3)(D) of the Act provides that the update factor applicable to the hospital-specific rates for MDHs equals the update factor provided under section 1886(b)(3)(B)(iv) of the Act, which, for FY 2002, is the market basket rate of increase minus 0.55 percentage points.

b. *Calculation of Hospital-Specific Rate.* For SCHs, the applicable FY 2002 hospital-specific rate would be based on the following: the hospital-specific rate calculated using the greater of the FY 1982 or FY 1987 costs, increased by the applicable update factor of 2.55 percent; or, if the hospital-specific rate based on cost per case in FY 1996 is greater than the hospital-specific rate using either the FY 1982 or the FY 1987 costs, the greater of 50 percent of the hospital-specific rate based on the FY 1982 or FY 1987 costs, increased by the applicable update factor, or 50 percent of the Federal rate plus 50 percent of its rebased FY 1996 hospital-specific rate updated through FY 2002. For MDHs, the applicable FY 2002 hospital-specific rate would be calculated by increasing the hospital's hospital-specific rate for the preceding fiscal year by the applicable update factor of 2.55 percent, which is the same as the update for all prospective payment hospitals. In addition, for both SCHs and MDHs, the hospital-specific rate would be adjusted by the budget neutrality adjustment factor (that is, by 0.992493) as discussed in section II.A.4.a. of this Addendum. The resulting rate is used in determining the payment under which rate an SCH or a MDH is paid for its discharges beginning on or after October 1, 2001.

3. General Formula for Calculation of Prospective Payment Rates for Hospitals Located in Puerto Rico Beginning On or After October 1, 2001 and Before October 1, 2002

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

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

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

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

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

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

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

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

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

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

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

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

### III. Proposed Changes to Payment Rates for Inpatient Capital-Related Costs for FY 2002

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

The basic methodology for determining Federal capital prospective rates is set forth at §§ 412.308 through 412.352. Below we discuss the factors that we used to determine the proposed Federal for FY 2002. The rates, which will be effective for discharges occurring on or after October 1, 2001. As we stated in section V of the preamble of this proposed rule, we are no longer determining an update to the capital hospital-specific rate, since FY 2001 is the last year of the 10-year transition period, and beginning in FY 2002 all hospitals (except those defined as "new" under § 412.300) will be paid based on 100 percent of the capital Federal rate.

For FY 1992, we computed the standard Federal payment rate for capital-related costs under the prospective payment system by updating the FY 1989 Medicare inpatient capital cost per case by an

actuarial estimate of the increase in Medicare inpatient capital costs per case. Each year after FY 1992, we update the standard Federal rate, as provided in § 412.308(c)(1), to account for capital input price increases and other factors. Also, § 412.308(c)(2) provides that the Federal rate is adjusted annually by a factor equal to the estimated proportion of outlier payments under the Federal rate to total capital payments under the Federal rate. In addition, § 412.308(c)(3) requires that the Federal rate be reduced by an adjustment factor equal to the estimated proportion of payments for (regular and special) exceptions under § 412.348. Furthermore, § 412.308(c)(4)(ii) requires that the Federal rate be adjusted so that the annual DRG reclassification and the recalibration of DRG weights and changes in the geographic adjustment factor are budget neutral. For FYs 1992 through 1995, § 412.352 required that the Federal rate also be adjusted by a budget neutrality factor so that aggregate payments for inpatient hospital capital costs were projected to equal 90 percent of the payments that would have been made for capital-related costs on a reasonable cost basis during the fiscal year. That provision expired in FY 1996. Section 412.308(b)(2) describes the 7.4 percent reduction to the rate that was made in FY 1994, and § 412.308(b)(3) describes the 0.28 percent reduction to the rate made in FY 1996 as a result of the revised policy of paying for transfers. In the FY 1998 final rule with comment period (62 FR 45966), we implemented section 4402 of Public Law 105-33, which requires that for discharges occurring on or after October 1, 1997, and before October 1, 2002, the unadjusted standard Federal rate is reduced by 17.78 percent. A small part of that reduction will be restored effective October 1, 2002.

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

In accordance with section 1886(d)(9)(A) of the Act, under the prospective payment system for inpatient operating costs, hospitals located in Puerto Rico are paid for operating costs under a special payment

formula. Prior to FY 1998, hospitals in Puerto Rico were paid a blended rate that consisted of 75 percent of the applicable standardized amount specific to Puerto Rico hospitals and 25 percent of the applicable national average standardized amount. However, effective October 1, 1997, as a result of 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.

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

In the August 1, 2000 final rule (65 FR 47122), we established a Federal rate of \$382.03 for FY 2001. In a separate interim final rule with comment, as a result of implementing section 301(a) of Public Law 106-554 we are establishing a Federal rate of \$380.85 for discharges occurring on or after April 1, 2001 and before October 1, 2001. In accordance with section 547 of Public Law 106-554, the special increases and adjustments provided by Public Law 106-554 effective between April and October 2001 do not apply for discharges occurring after FY 2001 and should not be included in determining the payment rates in subsequent years. Thus, the adjustments and rates published in the August 1, 2000 final rule were used in determining the proposed FY 2002 rates. As a result of the changes we are proposing to the factors used to establish the Federal rate in this addendum, the proposed FY 2002 Federal rate is \$389.09.

In the discussion that follows, we explain the factors that were used to determine the proposed FY 2002 Federal rate. In particular, we explain why the proposed FY 2002 Federal rate has increased 1.85 percent compared to the FY 2001 Federal rate (published in the August 1, 2000 final rule (65 FR

47122)). We also estimate aggregate capital payments will increase by 3.80 percent during this same period. This increase is primarily due to the increase in the number of hospital admissions and the increase in case-mix. This increase in capital payments is less than last year (5.48 percent) because with the end of the transition period the remaining hold harmless hospitals receiving "cost-based" payments will begin being paid based on 100 percent of the Federal rate.

Total payments to hospitals under the prospective payment system are relatively unaffected by changes in the capital prospective payments. Since capital payments constitute about 10 percent of hospital payments, a 1 percent change in the capital Federal rate yields only about 0.1 percent change in actual payments to hospitals. Aggregate payments under the capital prospective payment transition system are estimated to increase in FY 2002 compared to FY 2001.

#### 1. Standard Federal Rate Update

a. *Description of the Update Framework.* Under § 412.308(c)(1), the standard Federal rate is updated on the basis of an analytical framework that takes into account changes in a capital input price index and other factors. The update framework consists of a capital input price index (CIPI) and several policy adjustment factors. Specifically, we have adjusted the projected CIPI rate of increase as appropriate each year for case-mix index-related changes, for intensity, and for errors in previous CIPI forecasts. The proposed update factor for FY 2002 under that framework is 1.1 percent. This proposal is based on a projected 0.5 percent increase in the CIPI, a 0.3 percent adjustment for intensity, a 0.0 percent adjustment for case-mix, a 0.0 percent adjustment for the FY 2000 DRG reclassification and recalibration, and a forecast error correction of 0.3 percent. We explain the basis for the FY 2002 CIPI projection in section II.D. of this Addendum. Below we describe the policy adjustments that have been applied.

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

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

- The average resource use of Medicare patients changes ("real" case-mix change);

- Changes in hospital coding of patient records result in higher weight DRG assignments ("coding effects"); and
- The annual DRG reclassification and recalibration changes may not be budget neutral ("reclassification effect").

We define real case-mix change as actual changes in the mix (and resource requirements) of Medicare patients as opposed to changes in coding behavior that result in assignment of cases to higher weighted DRGs but do not reflect higher resource requirements. In the update framework for the prospective payment system for operating costs, we adjust the update upwards to allow for real case-mix change, but remove the effects of coding changes on the case-mix index. We also remove the effect on total payments of prior changes to the DRG classifications and relative weights, in order to retain budget neutrality for all case-mix index-related changes other than patient severity. (For example, we are adjusting for the effects of the FY 2000 DRG reclassification and recalibration as part of our FY 2002 update recommendation.) We have adopted this case-mix index adjustment in the capital update framework as well.

For FY 2002, we are projecting a 1.0 percent increase in the case-mix index. We estimate that real case-mix increase will equal 1.0 percent in FY 2002. Therefore, the proposed net adjustment for case-mix change in FY 2002 is 0.0 percentage points.

We estimate that FY 2000 DRG reclassification and recalibration will result in a 0.0 percent change in the case-mix when compared with the case-mix index that would have resulted if we had not made the reclassification and recalibration changes to the DRGs. Therefore, we are making a 0.0 percent adjustment for DRG reclassification and recalibration in the update recommendation for FY 2002.

The capital update framework contains an adjustment for forecast error. The input price index forecast is based on historical trends and relationships ascertainable at the time the update factor is established for the upcoming year. In any given year there may be unanticipated price fluctuations that may result in differences between the actual increase in prices and the forecast used in calculating the update factors. In setting a prospective payment rate under the framework, we make an adjustment for forecast error only if our estimate of the change in the capital input price index for any year is off by 0.25 percentage points or more. There is a 2-year lag between the forecast and the measurement of the forecast error. A

forecast error of 0.3 percentage points was calculated for the FY 2000 update. That is, current historical data indicate that the FY 2000 CIPI used in calculating the forecasted FY 2000 update factor (0.6 percent) understated the actual realized price increases (0.9 percent) by 0.3 percent. This under-prediction was due to prices from municipal bond yields declining slower than expected. Therefore, we are making a 0.3 percent adjustment for forecast error in the update for FY 2002.

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

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

For FY 2002, we have developed a Medicare-specific intensity measure based on a 5-year average using FY 1996 through 2000 data. In determining case-mix constant intensity, we found that observed case-mix increase was 1.6 percent in FY 1996, 0.3 percent in FY 1997, -0.4 percent in FY 1998, and -0.3 in FY 1999, and -0.7 percent in

FY 2000. Since we found an increase in case-mix of 1.6 for FY 1996, which was outside of the range of 1.0 to 1.4 percent, we estimate that real case-mix increase was 1.0 to 1.4 percent for that year. The estimate of 1.0 to 1.4 percent is supported by past studies of case-mix change by the RAND Corporation. The most recent study was "Has DRG Creep Crept Up? Decomposing the Case Mix Index Change Between 1987 and 1988" by G. M. Carter, J. P. Newhouse, and D. A. Relles, R-4098-HCFA/ProPAC (1991). The study suggested that real case-mix change was not dependent on total change, but was usually a fairly steady 1.0 to 1.4 percent per year. We use 1.4 percent as the upper bound because the RAND study did not take into account that hospitals may have induced doctors to document medical records more completely in order to improve payment. Following that study, we consider up to 1.4 percent of observed case-mix change as real for FY 1996 through FY 2000. Based on this analysis, we believe that all of the observed case-mix increase for FY 1997, FY 1998, and FY 1999, and FY 2000 is real. The increases for FY 1996 was in excess of our estimate of real case-mix increase.

We calculate case-mix constant intensity as the change in total charges per admission, adjusted for price level changes (the CPI for hospital and related services), and changes in real case-mix. Based upon an upper limit of 1.0 percent real case-mix increase, we estimate that case-mix constant intensity increased by an average 0.3 percent during FYs 1996 through 2000, for a cumulative increase of 1.4 percent given estimates of real case-mix of 1.0 percent for FY 1996, 0.3 percent for FY 1997, -0.4 for FY 1998, and -0.3 for FY 1999, and -0.7 percent for FY 2000. Based upon an upper limit of 1.4 percent real case-mix increase, we estimate that case-mix constant intensity increase by an average 0.2 percent during FYs 1996 through 2000, for a cumulative increase of 1.2 percent, given that real case-mix increase was 1.4 percent for FY 1996, 0.3 percent for FY 1997, -0.4 for FY 1998, -0.3 for FY 1999, and -0.7 percent for FY 2000. Since we estimate that intensity has increased during that period, we are recommending a 0.3 percent intensity adjustment for FY 2002.

b. *Comparison of HCFA and MedPAC Update Recommendations.* In its March 2001 Report to Congress, MedPAC presented a combined operating and capital update for hospital inpatient prospective payment system payments for FY 2002. Currently, section 1886(b)(3)(B)(i)(XVII) of the Act sets

forth the FY 2002 percentage increase in the prospective payment system operating cost standardized amounts. The prospective payment system capital update is set at the discretion of the Secretary under the framework outlined in § 412.308(c)(1).

For FY 2002, MedPAC's update framework supports a combined operating and capital update for hospital inpatient prospective payment system payments of 1.5 percent to 3.0 percent (or between the increase in the combined operating and capital market basket minus 1.3 percentage points and the increase in the combined operating and capital market basket plus 0.2 percentage points). MedPAC also notes that while the number of hospitals with negative inpatient hospital margins have increased in FY 1999 (from 33.7 percent in FY 1998 to 36.7 percent in FY 1999 (page 71)), overall high inpatient Medicare margins generally offset hospital losses on other lines of Medicare services. MedPAC continues to project substantially improved hospital total margins for FY 2000 based on performance in the first half of the fiscal year (page 72).

MedPAC's FY 2002 combined operating and capital update framework uses a weighted average of HCFA's forecasts of the operating (PPS Input Price Index) and capital (CIPI) market baskets. This combined market basket is used to develop an estimate of the change in overall operating and capital prices. MedPAC calculated a combined market basket forecast by weighting the operating market basket forecast by 0.92 and the capital market basket forecast by 0.08, since operating costs are estimated to represent 92 percent of total hospital costs (capital costs are estimated to represent the remaining 8 percent of total hospital costs). MedPAC's combined market basket for FY 2002 is estimated to increase by 2.8 percent, based on HCFA's December 2000 forecasted operating market basket increase of 3.0 percent and HCFA's December 2000 forecasted capital market basket increase of 0.8 percent.

*Response:* As we stated in the August 1, 2000 final rule (65 FR 47119), our long-term goal is 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 2003 (as amended by Public Law 106-554). 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.

Our recommendation for updating the prospective payment system capital Federal rate is supported by the following analyses that measure changes in scientific and technological advances, practice pattern changes, changes in case-mix, the effect of reclassification and recalibration, and forecast error correction. MedPAC recommends a 1.5 to 3.0 percent combined operating and capital update for hospital inpatient prospective payments. Under our existing capital update framework, we are recommending a 1.1 percent update to the capital Federal rate. For purposes of comparing HCFA's capital update recommendation and MedPAC's update recommendation for FY 2002, we have isolated the capital component of MedPAC's combined market basket forecast, which was based on HCFA's December 2000 CIPI forecast of 0.8 percent. As a result, MedPAC's update recommendation for FY 2002 for capital payments is between -0.9 percent and 0.6 percent (see Table 1).

There are some differences between HCFA's and MedPAC's update frameworks, which account for the difference in the respective update recommendations. In its combined FY 2002 update recommendation, MedPAC uses HCFA's capital input price index (the CIPI) as the starting point for estimating the change in prices since the previous year. HCFA's CIPI includes price measures for interest expense, which are an indicator of the interest rates facing hospitals during their capital purchasing decisions. Previously, MedPAC's capital market basket did not include interest expense; instead it included a financing policy adjustment when necessary to account for the prolonged changes in interest rates. HCFA's CIPI is vintage-weighted, meaning that it takes into account price changes from past purchases of capital when determining the current period update. In the past, MedPAC's capital market basket was not vintage-weighted, and only accounted for the current year price changes. Beginning last year, both HCFA's and MedPAC's FY 2002 update frameworks use HCFA's CIPI. MedPAC used HCFA's December 2000 CIPI in preparing its FY 2002 recommendation, which was forecast at 0.8 percent. Currently, the CIPI is forecast at 0.5 percent (March 2001).

MedPAC and HCFA also differ in the adjustments they make to their price indices. (See Table 1 for a comparison of HCFA and MedPAC's update recommendations.) MedPAC makes an adjustment for scientific and technological advances, which is offset

by a fixed standard for productivity growth and one-time factors. HCFA has not adopted a separate adjustment for capital science and technology or productivity and efficiency.

In addition, MedPAC includes, when appropriate, an adjustment for one-time factors expected to affect costs in FY 2002 and the removal of the adjustment for FY 2002 one-time factors in its science and technology adjustment. MedPAC concluded that a one-time adjustment of 0.5 percent for the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulatory requirements be reflected in its FY 2002 payment update. Additionally, since MedPAC believes that the costs associated with one-time factors should not be built permanently into the rates, it recommended that the FY 2002 payment rates be reduced by 0.5 percent to offset the increase it recommended in the FY 2000 update for the costs associated with year 2000 (Y2K) computer improvements. Thus, MedPAC's combined FY 2002 adjustment for science and technological advances is 0.0 percent to 0.5 percent.

Instead, we have identified a total intensity factor, which reflects scientific and technological advances, but we have not identified an adequate total productivity measure. MedPAC also includes a site-of-care substitution adjustment (unbundling of the payment unit) to account for the decline in the average length of Medicare acute inpatient stays. This adjustment is designed to shift funding along with associated costs when Medicare patients are discharged to postacute settings that replace acute inpatient days. Other factors, such as technological advances that allow for a decreased need in follow-up care and BBA mandated policy on payment for transfer cases that limits payments within certain DRGs, are reflected in the site-of-care substitution adjustment as well. We agree with MedPAC that the site-of-care substitution effect is real and believe that it is factored into our intensity recommendation.

For FY 2002, MedPAC recommends a -2.0 to -1.0 percent combined adjustment for site-of-care substitutions. MedPAC recommends a 0.0 to a 0.5 percent combined adjustment for scientific and technological advances, which was offset by a fixed productivity standard of 0.5 percent and a 0.0 percent adjustment for one-time factors for FY 2002. We recommend a 0.3 intensity adjustment.

Additionally, MedPAC includes an adjustment for Medicare policy changes affecting financial status in its section of

factors affecting current level of payments in its FY 2002 update recommendation. While MedPAC's update framework has not considered such costs in the past, MedPAC believes that it is appropriate to account for significant costs incurred as a result of new Medicare policy. For FY 2002, MedPAC believes that legislated updates will match cost growth and that the overall net effects of legislative changes (from Public Law 105-33, Public Law 106-113, and Public Law 106-554) will be small. Thus, it did not recommend any additional allowance for these costs for FY 2002. Accordingly, MedPAC recommended a 0.0 percent adjustment for Medicare policy changes.

MedPAC makes a two-part adjustment for case-mix changes, which takes into account changes in case-mix in the past year. It recommends a 0.0 percent combined adjustment for DRG coding change and a 0.0 percent combined adjustment for within-DRG complexity change. This results in a combined total case-mix adjustment of 0.0 percent. We recommend a 0.0 adjustment for case-mix, since we are projecting a 1.0 percent increase in case-mix index and we estimate that real case-mix increase will equal 1.0 percent in FY 2002.

We recommend a 0.3 percent adjustment for forecast error correction. MedPAC's combined FY 2002 update recommendation includes a 0.7 percent adjustment for forecast error correction. However, it noted that this forecast error adjustment is a result of the difference between the forecasted FY 2000 operating market basket of 2.9 percent and the actual FY 2000 operating market basket increase of 3.6 percent. The FY 2000 capital market basket was forecast at 0.6 percent, while the actual observed increase equaled 0.9 percent for capital costs. Therefore, we have included 0.3 percent adjustment for FY 2000 forecast error correction in the comparison of MedPAC's and HCFA's update recommendations for FY 2002 shown below in Table 1.

We applied MedPAC's ratio of hospital capital costs to total hospital costs (8 percent) to the adjustment factors in its update framework for comparison with HCFA's capital update framework. The net result of these adjustments is that MedPAC has recommended a -0.9 to 0.6 percent update to the capital Federal rate for FY 2002. MedPAC believes that the annual updates to the capital and operating payments under the prospective payment system should not differ substantially, even though they are determined separately, since they correspond to costs generated by providing the same inpatient hospital

services to the same Medicare patients. We describe the basis for our 1.1 percent total capital update for FY 2002 in the preceding section. Our recommendation of 1.1 percent is 0.5 percent higher than the upper limit of the range recommended by MedPAC due to MedPAC's -2.0 to -1.0 percent combined (operating and capital) adjustment for unbundling of the

payment unit for FY 2002. If we had applied only the portion of that adjustment attributable to capital-related services, our proposed update recommendation would most likely have fallen within the range of MedPAC's update recommendation for capital for FY 2002. While in previous years, our update recommendation has fallen within the range recommended by

MedPAC, since MedPAC has developed its combined operating and capital update recommendation beginning in FY 2001, we have only been outside of that range by 0.5 percent. For FY 2001, our update recommendation of 0.9 percent was only 0.5 percentage points below MedPAC's lower limit of its FY 2002 recommendation.

TABLE 1.—HCFA'S FY 2002 UPDATE FACTOR AND MEDPAC'S RECOMMENDATION

	HCFA's update factor	MedPAC's recommendation
Capital Input Price Index .....	0.5	0.8 <sup>1</sup>
Policy Adjustment Factors:		
Intensity .....	0.3	( <sup>2</sup> )
Science and Technology .....		0.0 to 0.5.
Real within DRG Change .....		( <sup>3</sup> )
Site-of-Care Substitution .....		-2.0 to -1.0.
One-Time Factors .....	( <sup>4</sup> )	0.0
Subtotal .....	0.3	-2.0 to -0.5.
Medicare Policy Change; .....		0.0
Case-Mix Adjustment Factors:		
Projected Case-Mix Change .....	-1.0	
Real Across DRG Change .....	1.0	
Coding Change .....		0.0
Real within DRG Change .....	( <sup>4</sup> )	0.0
Subtotal .....	0.0	0.0
Effect of FY 2000 Reclassification and Recalibration .....	0.0	
Forecast Error Correction .....	0.3	0.3
<b>Total Update .....</b>	<b>1.1</b>	<b>-0.9 to 0.6.</b>

<sup>1</sup> Used HCFA's December 2000 capital marker basket forecast in its combined update recommendation.  
<sup>2</sup> Included in MedPAC's productivity offset in its science and technology adjustment.  
<sup>3</sup> Included in MedPAC's case-mix adjustment.  
<sup>4</sup> Included in HCFA's intensity factor.

2. Outlier Payment Adjustment Factor

Section 412.312(c) establishes a unified outlier methodology for inpatient operating and inpatient capital-related costs. A single set of thresholds is used to identify outlier cases for both inpatient operating and inpatient capital-related payments. Section 412.308(c)(2) provides that the standard Federal rate for inpatient capital-related costs be reduced by an adjustment factor equal to the estimated proportion of capital-related outlier payments to total inpatient capital-related PPS payments. The outlier thresholds are set so that operating outlier payments are projected to be 5.1 percent of total operating DRG payments.

In the August 1, 2000 final rule, we estimated that outlier payments for capital in FY 2001 would equal 5.91 percent of inpatient capital-related payments based on the Federal rate (65 FR 47121). Accordingly, we applied an outlier adjustment factor of 0.9409 to the Federal rate. Based on the

thresholds as set forth in section II.A.4.d. of this Addendum, we estimate that outlier payments for capital will equal 5.74 percent of inpatient capital-related payments based on the Federal rate in FY 2002. Therefore, we are proposing an outlier adjustment factor of 0.9426 to the Federal rate. Thus, the projected percentage of capital outlier payments to total capital standard payments for FY 2002 is lower than the percentage for FY 2001.

The outlier reduction factors are not built permanently into the rates; that is, they are not applied cumulatively in determining the Federal rate. As explained previously, in accordance with section 547 of Public Law 106-554, the proposed FY 2002 rates are based on the FY 2001 adjustments and rates published in the August 1, 2000 final rule (65 FR 47122). Therefore, the proposed net change in the outlier adjustment to the Federal rate for FY 2002 is 1.0018 (0.9426/0.9409). The outlier adjustment increases the FY 2002 Federal rate by 0.18 percent

compared with the FY 2001 outlier adjustment.

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

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

these figures to compute the adjustment required to maintain budget neutrality for changes in DRG weights and in the GAF.

For FY 2001, we calculated a GAF/DRG budget neutrality factor of 0.9979. For FY 2002, we are proposing a GAF/DRG budget neutrality factor of 0.9913. The GAF/DRG budget neutrality factors are built permanently into the rates; that is, they are applied cumulatively in determining the Federal rate. This follows from the requirement that estimated aggregate payments each year be no more than they would have been in the absence of the annual DRG reclassification and recalibration and changes in the GAF. As explained previously, in accordance with section 547 of Public Law 106-554, the proposed FY 2002 adjustments and rates are based on the FY 2001 adjustment and rates published in the August 1, 2000 final rule (65 FR 47122). The proposed incremental change in the adjustment from FY 2001 to FY 2002 is 0.9913. The proposed cumulative change in the rate due to this adjustment is 0.9906 (the product of the incremental factors for FY 1993, FY 1994, FY 1995, FY 1996, FY 1997, FY 1998, FY 1999, FY 2000, FY 2001 and the proposed incremental factor for FY 2002:  $0.9980 \times 1.0053 \times 0.9998 \times 0.9994 \times 0.9987 \times 0.9989 \times 1.0028 \times 0.9985 \times 0.9979 \times 0.9913 = 0.9906$ ).

This proposed factor accounts for DRG reclassifications and recalibration and for changes in the GAF. It also incorporates the effects on the GAF of FY 2002 geographic reclassification decisions made by the MGCRB compared to FY 2001 decisions. However, it does not account for changes in payments due to changes in the DSH and IME adjustment factors or in the large urban add-on.

#### 4. Exceptions Payment Adjustment Factor

Section 412.308(c)(3) requires that the standard Federal rate for inpatient capital-related costs be reduced by an adjustment factor equal to the estimated proportion of additional payments for exceptions under § 412.348 relative to total capital payments payments under the hospital-specific rate and Federal rate. We use the model originally developed for determining the budget neutrality adjustment factor to determine the regular exceptions payment adjustment factor. We describe that model in Appendix B to this proposed rule. An adjustment for regular exceptions is necessary for determining the FY 2002 rates because we will continue to pay regular exceptions for cost reporting periods

beginning before October 1, 2001 but ending in FY 2002 in accordance with § 412.312(c)(3). In FY 2003 and later, no payments will be made under the regular exceptions provision, hence we will only compute a budget neutrality adjustment under § 412.348(d) for special exceptions. We describe the proposed methodology to determine to special exceptions adjustment in section V.D. of this proposed rule. For FY 2002, the exceptions adjustment is a combination of the adjustment that would be made under the regular exceptions provision and under the special exceptions provision under § 412.348(g).

For FY 2001, we estimated that exceptions payments would equal 2.15 percent of aggregate payments based on the Federal rate and the hospital-specific rate. Therefore, we applied an exceptions reduction factor of 0.9785 ( $1 - 0.0215$ ) in determining the Federal rate. For this proposed rule, we estimate that regular exceptions payments for FY 2002 will equal 0.63 percent of aggregate payments based on the Federal rate we estimate that special exceptions payments for FY 2002 will equal 0.12 percent of aggregate payments based on the Federal rate. Therefore, we estimate that total exceptions payments for FY 2002 will equal 0.75 percent ( $0.63 + 0.12 = 0.75$ ) of aggregate payments based on the Federal rate and we are proposing an exceptions payment reduction factor of 0.9925 ( $1 - 0.0075$ ) to the Federal rate for FY 2002. The proposed exceptions reduction factor for FY 2002 is 1.43 percent higher than the factor for FY 2001 published in the August 1, 2000 final rule. This increase is primarily due to the expiration of the regular exceptions provision and the narrowly defined nature of the special exceptions policy.

The exceptions reduction factors are not built permanently into the rates; that is, the factors are not applied cumulatively in determining the Federal rate. As explained previously, in accordance with section 547 of Public Law 106-554, the proposed FY 2002 adjustments and rates are based on the FY 2001 adjustments and rates published in the August 1, 2000 final rule (65 FR 47122). Therefore, the proposed net adjustment to the FY 2002 Federal rate is 0.9925/0.9785, or 1.0143.

#### 5. Standard Capital Federal Rate for FY 2002

For FY 2001, the capital Federal rate was \$383.06 for discharges occurring between October 1, 2000 and April 1, 2001. As a result of implementing section 301(a) of Public Law 106-554,

for discharges occurring from April to October 2001, the capital Federal rate was \$380.85. However, as explained previously, in accordance with section 547 of Public Law 106-554, the proposed FY 2002 adjustments and rates are based on the FY 2001 adjustments and rates published in the August 1, 2000 final rule (65 FR 47122). As a result of changes we are proposing to the factors used to establish the Federal rate, the proposed FY 2002 Federal rate is \$389.09. The proposed Federal rate for FY 2002 was calculated as follows:

- The proposed FY 2002 update factor is 1.0110; that is, the proposed update is 1.10 percent.
- The proposed FY 2002 budget neutrality adjustment factor that is applied to the standard Federal payment rate for changes in the DRG relative weights and in the GAF is 0.9913.
- The proposed FY 2002 outlier adjustment factor is 0.9426.
- The proposed FY 2002 (regular and special) exceptions payments adjustment factor is 0.9925.

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

We are providing a chart that shows how each of the factors and adjustments for FY 2002 affected the computation of the proposed FY 2002 Federal rate in comparison to the FY 2001 Federal rate. The proposed FY 2002 update factor has the effect of increasing the Federal rate by 1.10 percent compared to the FY 2001 rate published in the August 1, 2000 final rule, while the proposed geographic and DRG budget neutrality factor has the effect of decreasing the Federal rate by 0.87 percent. The proposed FY 2002 outlier adjustment factor has the effect of increasing the Federal rate by 0.18 percent compared to the FY 2001 rate published in the August 1, 2000 final rule. The proposed FY 2002 (regular and special) exceptions reduction factor has the effect of increasing the Federal rate by 1.43 percent compared to the exceptions reduction for FY 2001. The combined effect of all the proposed changes is to increase the proposed Federal rate by 1.85 percent compared to the Federal rate for FY 2001.

## COMPARISON OF FACTORS AND ADJUSTMENTS: FY 2001 FEDERAL RATE AND PROPOSED FY 2002 FEDERAL RATE

	FY 2001	Proposed FY 2002	Change	Percent change
Update factor <sup>1</sup> .....	1.0090	1.0110	1.0110	1.10
GAF/DRG Adjustment Factor <sup>1</sup> .....	0.9979	0.9913	0.9913	-0.87
Outlier Adjustment Factor <sup>2</sup> .....	0.9409	0.9426	1.0018	0.18
Exceptions Adjustment Factor <sup>2</sup> .....	0.9785	0.9925	1.0143	1.43
Federal Rate .....	\$382.03	\$38.09	1.018	1.85

<sup>1</sup> The update factor and the GAF/DRG budget neutrality factors are built permanently into the rates. Thus, for example, the incremental change from FY 2000 to FY 2001 resulting from the application of the 0.9913 GAF/DRG budget neutrality factor for FY 2001 is 0.9913.

<sup>2</sup> The outlier reduction factor and the exceptions reduction factor are not built permanently into the rates; that is, these factors are not applied cumulatively in determining the rates. Thus, for example, the net change resulting from the application of the FY 2001 outlier reduction factor is 0.9426/0.9409, or 1.0018.

## 6. Special Rate for Puerto Rico Hospitals

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

Because we implemented a separate GAF for Puerto Rico in FY 1998, we also apply separate budget neutrality adjustments for the national GAF and for the Puerto Rico GAF. However, we apply the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. The Puerto Rico GAF budget neutrality factor is 0.99941, while the DRG adjustment is 0.9943, for a combined cumulative adjustment of 0.9937.

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

to the Puerto Rico rate as a result of Public Law 105-33.

For FY 2001, before application of the GAF, the special rate for Puerto Rico hospitals was \$185.06. As explained previously, in accordance with section 547 of Public Law 106-554, the proposed FY 2002 adjustments and rates are based on the FY 2001 rates published in the August 1, 2000 final rule. With the changes we are proposing to the factors used to determine the rate, the proposed FY 2002 special rate for Puerto Rico is \$188.67.

### *B. Calculation of Inpatient Capital-Related Prospective Payments for FY 2002*

With the end of the capital prospective payment system transition period, all hospitals (except those defined as "new" under § 412.300(b)) will be paid based on 100 percent of the Federal rate in FY 2002. The applicable Federal rate was determined by making adjustments as follows:

- For outliers, by dividing the standard Federal rate by the outlier reduction factor for that fiscal year; and
- For the payment adjustments applicable to the hospital, by multiplying the hospital's GAF, disproportionate share adjustment factor, and IME adjustment factor, when appropriate.

For purposes of calculating payments for each discharge during FY 2002, the standard Federal rate is adjusted as follows:

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

The result is the adjusted Federal rate.

Hospitals also may 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. The proposed outlier thresholds for FY 2002 are in section II.A.4.c. of this Addendum. For FY 2002, a case qualifies as a cost outlier if the cost for the case (after standardization for the indirect teaching adjustment and disproportionate share adjustment) is greater than the prospective payment rate for the DRG plus \$20,900.

During the capital prospective payment system transition period, a hospital also may receive an additional payment under the regular an exceptions process through its cost reporting period beginning before October 1, 2001 but ending in FY 2002 if its total inpatient capital-related payments are less than a minimum percentage of its allowable Medicare inpatient capital-related costs. The minimum payment level is established by class of hospital under § 412.348(c). Under § 412.348(d), the amount of a regular exceptions payment is determined by comparing the cumulative payments made to the hospital under the capital prospective payment system to the cumulative minimum payment levels applicable to the hospital for each cost reporting period subject to that system. Any amount by which the hospital's cumulative payments exceed its cumulative minimum payment is deducted from the additional payment that would otherwise be payable for a cost reporting period.

An eligible hospital may qualify for a special exception payment under § 412.348(g) through the 10th year beyond the end of the capital transition period if meets (1) a project need requirement described at § 412.348(g)(2), which in the case of certain urban hospitals includes an excess capacity test; and (2) a project size requirement as described at § 412.348(g)(5). Eligible hospitals include sole community hospitals, urban hospitals with at least 100 beds that have a DSH percentage of at least

20.2 percent, and hospitals that have a combined Medicare and Medicaid inpatient utilization of at least 70 percent. Under § 412.348(g)(8), the amount of a special exceptions payment is determined by comparing the cumulative payments made to the hospital under the capital prospective payment system to the cumulative minimum payment level. This amount is offset by (1) any amount by which a hospital's cumulative capital payments exceed its cumulative minimum payment levels applicable under the regular exceptions process for cost reporting periods beginning during which the hospital has been subject to capital PPS; and (2) any amount by which a hospital's current year operating and capital payments (excluding 75 percent of operating DSH payments) exceed its operating and capital costs. The minimum payment level is 70 percent for all eligible hospitals under § 412.348(g).

New hospitals as defined under § 412.300 are exempted from the capital prospective payment system for their first 2 years of operation and are paid 85 percent of their reasonable costs during that period. A new hospital's old capital costs are its allowable costs for capital assets that were put in use for patient care on or before the later of December 31, 1990, or the last day of the hospital's base year cost reporting period, and are subject to the rules pertaining to old capital and obligated capital as of the applicable date. Effective with the third year of operation, we will pay the hospital under either the fully prospective methodology, using the appropriate transition blend in that Federal fiscal year, or the hold-harmless methodology. If the hold-harmless methodology is applicable, the hold-harmless payment for assets in use during the base period would extend for 8 years, even if the hold-harmless payments extend beyond the normal transition period.

### C. Capital Input Price Index

#### 1. Background

Like the operating input price index, the capital input price index (CIPI) is a fixed-weight price index that measures the price changes associated with costs during a given year. The CIPI differs from the operating input price index in one important aspect—the CIPI reflects the vintage nature of capital, which is the acquisition and use of capital over time. Capital expenses in any given year are determined by the stock of capital in that year (that is, capital that remains on hand from all current and prior capital acquisitions). An index measuring

capital price changes needs to reflect this vintage nature of capital. Therefore, the CIPI was developed to capture the vintage nature of capital by using a weighted-average of past capital purchase prices up to and including the current year.

Using Medicare cost reports, American Hospital Association (AHA) data, and Securities Data Company data, a vintage-weighted price index was developed to measure price increases associated with capital expenses. We periodically update the base year for the operating and capital input prices to reflect the changing composition of inputs for operating and capital expenses. Currently, the CIPI is based to FY 1992 and was last rebased in 1997. The most recent discussion of the cost category weights in the CIPI was in the final rule with comment period for FY 1998 published on August 29, 1997 (62 FR 46050).

#### 2. Forecast of the CIPI for Federal Fiscal Year 2001

We are forecasting the CIPI to increase 0.9 percent for FY 2002. This reflects a projected 1.5 percent increase in vintage-weighted depreciation prices (building and fixed equipment, and movable equipment) and a 3.5 percent increase in other capital expense prices in FY 2002, partially offset by a 1.3 percent decline in vintage-weighted interest rates in FY 2002. The weighted average of these three factors produces the 0.9 percent increase for the CIPI as a whole.

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

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

hospitals and units in the same class (psychiatric, rehabilitation, and long-term care) for cost reporting periods ending during FY 1996. The target amount is multiplied by the number of Medicare discharges in a hospital's cost reporting period, yielding the ceiling on aggregate Medicare inpatient operating costs for the cost reporting period.

Each hospital-specific target amount is adjusted annually, at the beginning of each hospital's cost reporting period, by an applicable update factor.

Section 1886(b)(3)(B) of the Act, which is implemented in regulations at § 413.40(c)(3)(vii), provides that for cost reporting periods beginning on or after October 1, 1998 and before October 1, 2002, the update factor for a hospital or unit depends on the hospital's or hospital unit's costs in relation to the ceiling for the most recent cost reporting period for which information is available. For hospitals with costs exceeding the ceiling by 10 percent or more, the update factor is the market basket increase. For hospitals with costs exceeding the ceiling by less than 10 percent, the update factor is the market basket minus .25 percent for each percentage point by which costs are less than 10 percent over the ceiling. For hospitals with costs equal to or less than the ceiling but greater than 66.7 percent of the ceiling, the update factor is the greater of 0 percent or the market basket minus 2.5 percent. For hospitals with costs that do not exceed 66.7 percent of the ceiling, the update factor is 0.

The most recent forecast of the market basket increase for FY 2002 for hospitals and hospital units excluded from the prospective payment system is 3.0 percent. Therefore, the update to a hospital's target amount for its cost reporting period beginning in FY 2002 would be between 0.5 and 3.0 percent, or 0 percent, depending on the hospital's or unit's costs in relation to its rate-of-increase limit.

In addition, § 413.40(c)(4)(iii) requires that for cost reporting periods beginning on or after October 1, 1998 and before October 1, 2002, the target amount for each psychiatric hospital or hospital unit, rehabilitation hospital or hospital unit, and long-term care hospital cannot exceed a cap on the target amounts for hospitals in the same class.

Section 1886(b)(3)(H) of the Act, as amended by section 121 of Public Law 106-113, provides 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. On August

1, 2000, we published an interim final rule with comment period that implemented this provision for cost reporting periods beginning on or after October 1, 1999 and before October 1, 2000 (65 FR 47026) and a final rule that implemented the provision for cost reporting periods beginning on or after October 1, 2000 and before October 1, 2001 (65 FR 47054). This proposed rule addresses the wage adjustment to the caps for cost reporting periods beginning on or after October 1, 2001.

As discussed in section VI. of the preamble of this proposed rule, the cap on the target amount per discharge is determined by adding the hospital's nonlabor-related portion of the national 75th percentile cap to its wage-adjusted, labor-related portion of the national 75th percentile cap (the labor-related portion of costs equals 0.71553 and the nonlabor-related portion of costs equals 0.28447). A hospital's wage-adjusted, labor-related portion of the target amount is calculated by multiplying the labor-related portion of the national 75th percentile cap for the hospital's class by the wage index under the hospital inpatient prospective payment system (see § 412.63), without taking into account reclassifications under sections 1886(d)(8)(B) and (d)(10) of the Act.

As discussed in section VI. of the preamble of this proposed rule, we are proposing to make an adjustment to the caps on target amounts for new and existing excluded hospitals and units. In calculating the wage-adjusted caps on target amounts for new and existing excluded and units for FY 2001, we inadvertently made an error. In wage neutralizing FY 1996 target amounts, we used the FY 2000 hospital inpatient prospective payment system wage index published in Tables 4A and 4B of the July 30, 1999 final rule (64 FR 41585 through 41593), which is based on wage data after taking into account geographic reclassifications under section 1886(d)(8) of the Act. We are proposing to use pre-reclassified wage data in our recalculation of the caps for FY 2002. We propose to recalculate the limits for new excluded hospitals and units, as well as calculate the cap for existing excluded hospitals and units using the same wage index used under the prospective payment system for skilled nursing facilities (SNF) as shown in Table 7 of the July 30, 1999 SNF final rule (64 FR 41690). We do not anticipate a significant impact on overall payments to these hospitals and units.

Section 307(a) of Public Law 106-554 amended section 1886(b)(3) of the Act to provide for a 2-percent increase to the wage-adjusted 75th percentile cap on

the target amount for long-term care hospitals, effective for cost reporting periods beginning during FY 2001. This provision is applicable to long-term care hospitals that were subject to the cap for existing excluded hospitals and units, as specified in § 413.40(c).

In addition to the increase to the cap on target amounts for long-term care hospitals, section 307(a) of Public Law 106-554 amended section 1886(b)(3)(A) of the Act to make the section applicable to all long-term care hospitals, effective for cost reporting periods beginning during FY 2001. This provision requires a revision to the determination of each long-term care hospital's FY 2001 target amount as specified in § 413.40(c)(4). For cost reporting periods beginning during FY 2001, the hospital-specific target amount otherwise determined for a long-term care hospital as specified under § 413.40(c)(4)(ii) is multiplied by 1.25 (that is, increased by 25 percent). However, the revised FY 2001 target amount for a long-term care hospital cannot exceed its wage-adjusted national cap as required by section 1886(b)(3) of the Act, as amended by section 307(a) of Public Law 106-554.

For cost reporting periods beginning in FY 2002, the proposed caps are as follows:

Class of excluded hospital or unit	Labor-related share	Nonlabor-related share
Psychiatric .....	\$8,404	\$3,341
Rehabilitation ....	15,689	6,237
Long-Term Care	31,399	12,483

Regulations at § 413.40(d) specify the formulas for determining bonus and relief payments for excluded hospitals and specify established criteria for an additional bonus payment for continuous improvement. Regulations at § 413.40(f)(2)(ii) specify the payment methodology for new hospitals and hospital units (psychiatric, rehabilitation, and long-term care) effective October 1, 1997.

#### V. Tables

This section contains the tables referred to throughout the preamble to this proposed rule and in this Addendum. For purposes of this proposed rule, and to avoid confusion, we have retained the designations of Tables 1 through 5 that were first used in the September 1, 1983 initial prospective payment final rule (48 FR 39844). Tables 1A, 1C, 1D, 2, 3A, 3B, 4A, 4B, 4C, 4F, 4G, 4H, 5, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H, 7A, 7B, 8A, and 8B are presented below. The tables presented below are as follows:

Table 1A—National Adjusted Operating Standardized Amounts, Labor/Nonlabor

Table 1C—Adjusted Operating Standardized Amounts for Puerto Rico, Labor/Nonlabor

Table 1D—Capital Standard Federal Payment Rate

Table 2—Hospital Average Hourly Wage for Federal Fiscal Years 2000 (1996 Wage Data), 2001 (1997 Wage Data) and 2002 (1998 Wage Data) Wage Indexes and 3-Year Average of Hospital Average Hourly Wages

Table 3A—3-Year Average Hourly Wage for Urban Areas

Table 3B—3-Year Average Hourly Wage for Rural Areas

Table 4A—Wage Index and Capital Geographic Adjustment Factor (GAF) for Urban Areas

Table 4B—Wage Index and Capital Geographic Adjustment Factor (GAF) for Rural Areas

Table 4C—Wage Index and Capital Geographic Adjustment Factor (GAF) for Hospitals That Are Reclassified

Table 4F—Puerto Rico Wage Index and Capital Geographic –Adjustment Factor (GAF)

Table 4G—Pre-Reclassified Wage Index for Urban Areas

Table 4H—Pre-Reclassified Wage Index for Rural Areas

Table 5—List of Diagnosis Related Groups (DRGs), Relative Weighting Factors, Geometric and Arithmetic Mean Length of Stay

Table 6A—New Diagnosis Codes

Table 6B—New Procedure Codes

Table 6C—Invalid Diagnosis Codes

Table 6D—Invalid Procedure Codes

Table 6E—Revised Diagnosis Code Titles

Table 6F—Revised Procedure Code Titles

Table 6G—Additions to the CC Exclusions List

Table 6H—Deletions to the CC Exclusions List

Table 7A—Medicare Prospective Payment System Selected –Percentile Lengths of Stay FY 2000 MedPAR Update 12/00 –GROUPE V18.0

Table 7B—Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 2000 MedPAR Update 12/00 GROUPE V20.0

Table 8A—Statewide Average Operating Cost-to-Charge Ratios for Urban and Rural Hospitals (Case Weighted) March 2001

Table 8B—Statewide Average Capital Cost-to-Charge Ratios (Case Weighted) March 2001

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

Large urban areas		Other areas	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
\$2,940.89	\$1,195.38	\$2,894.33	\$1,176.46

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

	Large urban areas		Other areas	
	Labor	Nonlabor	Labor	Nonlabor
National .....	\$2,915.45	\$1,185.04	\$2,915.45	\$1,185.04
Puerto Rico .....	1,414.18	569.25	1,391.79	560.23

TABLE 1D.—CAPITAL STANDARD FEDERAL PAYMENT RATE

	Rate
National .....	\$389.09
Puerto Rico .....	188.67

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES

Provider No.	Average hourly wage FFY 2000	Average hourly wage FFY 2001	Average** hourly wage FFY 2002	Average*** hourly wage (3 years)
010001 .....	15.8484	16.4088	17.1352	16.4665
010004 .....	15.0194	17.9732	19.0010	17.1863
010005 .....	16.2615	17.5985	18.6554	17.4986
010006 .....	17.3081	16.7480	17.3537	17.1306
010007 .....	14.8048	15.4798	15.6788	15.3288
010008 .....	17.6549	14.7443	17.4728	16.6080
010009 .....	17.5328	18.7731	18.4390	18.2439
010010 .....	15.9090	16.4468	16.4664	16.2848
010011 .....	20.6261	20.7972	21.9311	21.1001
010012 .....	19.2992	17.7171	15.8686	17.5430
010015 .....	18.3461	15.4510	18.7062	17.3913
010016 .....	16.1311	17.2473	18.6772	17.4112
010018 .....	18.9617	17.6449	18.9388	18.5180
010019 .....	15.4910	16.3493	17.0672	16.3245
010021 .....	14.6297	16.2919	15.1241	15.3000
010022 .....	20.5050	18.5879	17.6435	18.8422
010023 .....	16.2581	16.1025	16.3209	16.2283
010024 .....	16.0263	16.2900	16.2974	16.2091
010025 .....	14.5311	15.1356	15.1548	14.9441
010027 .....	14.9278	11.7900	16.8595	14.1053
010029 .....	16.4103	17.6461	18.3605	17.4403
010031 .....	18.0194	18.7835	18.5180	18.4445
010032 .....	12.6540	12.5995	15.3590	13.6017
010033 .....	19.6797	20.3923	21.1818	20.4188
010034 .....	14.7342	15.0959	15.3639	15.0606
010035 .....	17.4788	20.1853	16.0377	17.7343
010036 .....	17.2880	17.8140	17.0366	17.3872
010038 .....	18.3309	18.2671	19.6098	18.7632
010039 .....	18.8080	20.1045	20.3406	19.7778
010040 .....	19.1030	18.9376	19.9152	19.2851
010043 .....	16.2022	30.7489	18.6640	19.9982
010044 .....	17.0229	22.0091	24.0265	20.8906
010045 .....	15.0065	15.2200	17.0417	15.7248
010046 .....	17.1822	17.3970	18.9737	17.8750
010047 .....	16.3803	13.3521	15.4332	15.2044
010049 .....	14.4823	14.7590	15.5246	14.9487
010050 .....	15.4159	18.5163	17.3895	17.0820

\* Wage data not available for the provider that year.

\*\* For Federal Fiscal Year 2002 only, the average hourly wage is based upon data on file as of February 15, 2001. It does not reflect changes processed after that date.

\*\*\* The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FFY 2000	Average hourly wage FFY 2001	Average** hourly wage FFY 2002	Average*** hourly wage (3 years)
010051	9.9390	11.9275	11.8108	11.1940
010052	13.8649	16.5486	18.0653	16.1248
010053	13.1778	14.6267	15.5649	14.5406
010054	17.1246	18.5103	19.5148	18.4901
010055	18.1930	18.9526	18.8590	18.6711
010058	12.7809	16.1702	16.9715	15.1274
010059	18.1886	19.1286	18.8020	18.7124
010061	15.9215	14.9547	14.5003	15.1112
010062	13.5690	14.7732	12.3259	13.5151
010064	20.8966	20.4139	19.5256	20.2712
010065	15.6357	16.4049	16.8752	16.3279
010066	12.0681	15.4317	13.1559	13.4757
010068	18.7367	12.0525	12.9616	14.2644
010069	13.5684	13.8636	14.7211	14.0429
010072	14.3481	14.9526	16.2339	15.1957
010073	12.8328	13.8601	14.1273	13.6015
010078	17.7110	17.9202	18.1028	17.9134
010079	16.8701	16.4421	14.5611	15.8427
010080	13.8473	*	*	13.8473
010081	16.9823	18.9474	17.2996	17.7081
010083	16.2146	16.8933	18.0312	17.0916
010084	18.7794	18.4965	18.7769	18.6812
010085	18.8696	18.4744	19.6888	19.0044
010086	14.9255	16.6694	16.5711	16.0968
010087	18.3889	19.0033	17.3321	18.3237
010089	16.6090	16.8042	17.7800	17.0521
010090	18.1121	18.3866	18.9445	18.4882
010091	16.3620	13.9405	17.0799	15.6820
010092	16.4980	16.9900	17.8144	17.1322
010094	18.5603	*	*	18.5603
010095	11.8993	12.4525	12.2597	12.2090
010097	12.8955	13.0413	12.7286	12.8889
010098	14.2787	15.9165	14.0300	14.6833
010099	15.9309	15.9874	15.5619	15.8073
010100	15.4826	17.2011	17.7237	16.8503
010101	15.4173	15.3859	14.4460	15.0721
010102	12.7251	13.7933	13.8136	13.4259
010103	19.3115	17.9358	16.6514	17.9628
010104	18.0997	17.7126	15.9964	17.2534
010108	20.7914	17.9017	19.4617	19.3047
010109	14.0870	15.3107	14.6834	14.6934
010110	15.9066	15.6317	15.8283	15.7917
010112	15.1056	15.1401	16.8271	15.6716
010113	17.2440	16.9683	13.9413	15.9844
010114	17.2612	15.2454	17.0136	16.4485
010115	13.7524	14.6268	14.9632	14.4787
010118	16.6889	18.8477	17.0834	17.5145
010119	18.1707	18.8024	20.7741	19.7059
010120	17.0332	17.2336	18.2567	17.5146
010121	15.1806	14.6444	14.5262	14.8160
010123	18.1604	16.7344	19.2140	17.9949
010124	16.2666	16.2846	16.7465	16.4273
010125	14.4153	15.5304	16.0136	15.3557
010126	17.6405	19.5710	19.1065	18.7347
010127	19.6095	19.5190	18.2786	19.1726
010128	12.5747	14.5056	14.4322	13.6385
010129	14.4267	14.7286	16.1733	15.1385
010130	16.3465	16.6809	18.1314	16.9797
010131	17.9076	17.8260	20.1883	18.6602
010134	10.7817	18.8835	19.9856	15.8677
010137	15.9348	12.1217	20.4561	15.8609
010138	12.1295	12.8675	14.5254	13.1763
010139	19.9487	19.0001	20.6815	19.8355

\* Wage data not available for the provider that year.

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\*\*\* The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FFY 2000	Average hourly wage FFY 2001	Average** hourly wage FFY 2002	Average*** hourly wage (3 years)
010143	15.7144	16.7911	17.6212	16.7651
010144	17.1211	17.1320	17.7580	17.3377
010145	20.7460	20.8434	20.5895	20.7209
010146	18.8561	18.5198	19.1415	18.8309
010148	14.6443	12.2214	15.8349	13.9784
010149	17.0836	18.6333	18.0156	17.9216
010150	16.9749	17.8951	18.8977	17.9203
010152	17.3835	17.8306	18.2173	17.8172
010155	16.7028	9.0300	15.0689	12.5183
010158	*	17.3227	18.3957	17.8637
020001	27.9690	28.1747	27.4110	27.8426
020002	26.9145	24.5815	25.1987	25.5092
020004	26.3979	30.5667	25.4679	27.5927
020005	29.0068	30.2920	29.2378	29.5337
020006	26.7706	31.2404	28.1417	28.8630
020007	24.9555	27.8319	32.3852	28.0097
020008	30.4712	29.4146	30.8691	30.2487
020009	23.1801	20.1930	18.4660	20.3801
020010	18.6417	23.6727	22.7559	21.4818
020011	29.4697	30.4727	28.0658	29.3006
020012	23.9259	24.8543	25.5320	24.7635
020013	26.8172	23.8847	28.1557	26.0576
020014	24.0932	27.3823	24.9201	25.4246
020017	24.9714	26.8319	27.6501	26.5037
020024	22.7263	24.0872	25.3205	24.0621
020025	27.1529	21.7557	20.2583	22.6334
030001	19.8695	20.3673	21.7869	20.6506
030002	21.6263	21.5977	21.8375	21.6886
030003	23.6722	23.4833	22.6804	23.3063
030004	17.7333	14.0711	15.5478	15.4308
030006	17.6409	18.2668	19.7289	18.5307
030007	18.5602	19.6708	21.5169	19.9379
030008	*	22.2758	22.2190	22.2524
030009	17.9343	18.1794	18.7557	18.2786
030010	18.7997	19.0907	19.5123	19.1422
030011	20.0784	19.2973	19.4310	19.5785
030012	19.4245	18.9918	20.6585	19.6997
030013	21.0182	20.7458	19.6369	20.4298
030014	19.4697	19.9315	19.7966	19.7342
030016	20.5606	19.3967	19.4785	19.8559
030017	20.4185	22.8765	21.7938	21.6805
030018	18.9115	20.2032	20.8980	20.0193
030019	19.9211	21.7005	21.2540	20.9846
030022	15.7886	19.2966	17.3485	17.0947
030023	22.4365	23.6697	24.1678	23.4686
030024	21.6692	22.2541	22.6199	22.1974
030025	17.6759	12.7254	11.9894	13.7385
030027	17.5796	15.7554	17.6555	16.9563
030030	21.6249	20.8303	21.6932	21.3795
030033	16.8396	20.0044	20.2820	18.9069
030034	19.0868	16.8241	20.8689	18.8279
030035	19.7153	19.2781	20.0226	19.6580
030036	18.9449	20.7567	21.6371	20.4743
030037	21.4376	22.8266	23.7615	22.6712
030038	22.0777	22.6776	22.9822	22.5885
030040	17.9722	18.5456	19.7636	18.7537
030041	17.4389	15.8921	18.8717	17.2718
030043	20.7721	20.9341	20.5598	20.7468
030044	16.4654	16.8649	17.6575	17.0214
030047	19.6916	22.6401	21.4412	21.2271
030049	19.0896	19.0881	19.3580	19.1639
030054	14.4861	15.3338	15.0657	14.9801
030055	18.2751	16.3613	20.2991	18.2684

\* Wage data not available for the provider that year.

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\*\*\* The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FFY 2000	Average hourly wage FFY 2001	Average** hourly wage FFY 2002	Average*** hourly wage (3 years)
030059	21.7100	24.0465	22.6279	22.7570
030060	16.7661	19.2461	18.6313	18.2043
030061	17.3470	18.9063	19.9047	18.7238
030062	17.4825	17.6738	18.0603	17.7568
030064	18.5391	19.5673	19.9437	19.3687
030065	19.9277	20.5130	20.7838	20.4254
030067	15.6207	14.4446	17.2778	15.7364
030068	17.3482	17.3614	17.7208	17.4823
030069	19.0013	19.0961	21.0936	19.7255
030080	19.9865	20.5144	20.6581	20.3684
030083	23.6433	23.3355	23.5229	23.4991
030085	17.8402	21.0954	20.8611	19.9420
030086	18.5030	19.5436	*	19.0352
030087	20.0469	21.4084	21.9465	21.1838
030088	19.5772	19.8682	20.4978	20.0029
030089	19.9018	20.4019	20.9516	20.4404
030092	21.5628	20.6986	21.8308	21.3646
030093	19.4688	19.7262	20.4314	19.9052
030094	19.4773	21.6218	22.8123	21.4086
030095	14.2499	13.7293	13.7664	13.9087
030099	18.0747	16.1541	18.2263	17.4781
030100	*	*	23.7609	23.7609
030101	*	*	19.2547	19.2547
030102	*	*	18.2413	18.2413
040001	15.5735	15.1624	16.9178	15.8741
040002	14.0865	13.0592	15.1107	14.0333
040003	14.0027	14.2089	15.5740	14.5731
040004	17.2926	17.8476	17.9034	17.6718
040005	12.8825	13.2597	11.1318	12.3937
040007	19.5299	21.9583	18.6998	19.9568
040008	12.6974	15.3040	14.7985	14.3087
040010	17.6231	18.6023	19.4913	18.6031
040011	12.2654	14.5319	16.0995	14.1756
040014	15.3853	17.6340	18.1434	17.0051
040015	14.6045	16.5891	15.5207	15.5649
040016	17.5431	19.0295	20.2321	18.9152
040017	14.9533	13.5098	15.4686	14.6576
040018	17.5602	17.6027	18.7463	17.9749
040019	25.7080	22.6769	23.4163	23.8479
040020	14.8059	16.4827	18.9844	16.6335
040021	16.4628	17.6398	19.6835	17.8176
040022	16.0006	17.0397	14.8398	15.8797
040024	15.7282	14.4541	17.6523	15.9585
040025	10.9496	11.5079	13.4705	11.8847
040026	18.2398	19.5563	19.7924	19.1863
040027	14.5406	16.0975	17.4431	16.0716
040028	12.8409	14.6584	13.9946	13.7921
040029	17.7777	17.8787	21.1370	18.9480
040030	14.1541	13.5428	11.2402	12.7784
040032	13.3280	13.7030	13.2872	13.4471
040035	11.2123	12.8300	10.9569	11.6408
040036	17.9080	18.9757	20.0835	18.9954
040037	13.4815	14.6559	14.0941	14.0704
040039	13.8386	14.3576	14.7177	14.3115
040040	17.4283	18.0895	19.1984	18.2668
040041	13.3613	15.9896	16.4624	15.2103
040042	14.6641	15.2142	15.2057	15.0333
040044	11.4422	12.6275	13.3501	12.5381
040045	18.7724	14.9429	16.2469	16.4870
040047	16.3948	16.8654	17.5336	16.9538
040048	15.8203	*	*	15.8203
040050	11.7934	13.3818	14.0036	13.0341
040051	16.2803	15.8627	16.6039	16.2390

\* Wage data not available for the provider that year.

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\*\*\* The 3-year average hourly wage is weighted by salaries and hours.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FFY 2000	Average hourly wage FFY 2001	Average** hourly wage FFY 2002	Average*** hourly wage (3 years)
040053	15.8193	16.3610	15.0219	15.7502
040054	15.0412	15.3219	14.2577	14.8844
040055	16.1029	17.1269	17.7214	16.9813
040058	15.6706	17.6766	16.4278	16.6344
040060	11.4686	12.8148	17.9805	13.6105
040062	17.2757	18.2048	17.8902	17.8204
040064	12.4007	10.7255	11.5029	11.4801
040066	17.6429	18.3377	17.8338	17.9377
040067	13.4930	14.6014	14.4741	14.1956
040069	16.1147	17.5052	17.0026	16.8681
040070	15.4757	16.9027	16.9700	16.4358
040071	16.3022	16.9610	17.2834	16.8497
040072	15.8425	16.0895	17.4822	16.4893
040074	17.3819	18.3224	18.7542	18.1968
040075	12.7496	13.3623	14.0975	13.3977
040076	18.5512	19.0732	20.5840	19.3801
040077	12.4625	12.9211	13.9114	13.0965
040078	17.8573	18.7600	18.5821	18.4100
040080	15.7397	19.2461	19.3707	18.0636
040081	10.6791	11.3169	11.1332	11.0311
040082	16.5127	16.2152	15.1331	15.9302
040084	17.2469	17.2613	17.7295	17.4070
040085	15.7765	16.8957	16.5216	16.3838
040088	15.6710	17.9636	17.1624	16.9372
040090	17.5503	17.8282	19.0824	18.0989
040091	17.0444	19.8700	20.1378	18.8893
040093	12.9010	12.3537	13.9741	13.0114
040100	14.9688	14.7587	15.6833	15.1704
040105	14.2409	15.3319	14.3896	14.6616
040106	15.4000	15.6545	18.1341	16.4515
040107	19.6184	18.8120	17.8628	18.6841
040109	13.9807	14.6266	16.6278	15.0815
040114	18.3133	18.8743	21.1110	19.3778
040116	19.5695	20.2716	*	19.9151
040118	17.4300	19.3720	18.2123	18.3407
040119	15.3847	15.5338	16.7730	15.9002
040124	17.2547	19.1349	19.2889	18.5723
040126	11.6845	12.5368	11.6517	11.9404
040132	13.1760	17.5179	10.3875	13.4483
040134	*	18.0787	19.0185	18.5701
040135	*	22.6761	23.0084	22.8797
050002	27.6006	37.8295	36.9630	33.5586
050006	19.5272	19.5594	18.2061	19.0382
050007	29.5398	30.7126	30.8676	30.4910
050008	25.8570	26.2458	26.3682	26.1654
050009	26.2506	26.8159	28.0701	27.0878
050013	24.8541	23.2201	28.0569	25.1985
050014	24.5302	22.8478	23.6745	23.6450
050015	25.3838	26.2481	27.7731	26.4938
050016	20.1542	20.5566	21.2045	20.6377
050017	23.6639	23.9625	24.4598	24.0349
050018	14.6622	15.4721	15.2903	15.1444
050021	28.5003	25.8966	*	27.2682
050022	22.9583	24.0318	24.5254	23.8802
050024	20.3427	21.3989	22.4274	21.4070
050025	21.9952	23.3896	23.9879	23.0936
050026	28.6850	27.8736	27.0130	27.8531
050028	16.4531	16.4671	17.6138	16.8496
050029	23.2911	25.1259	24.6839	24.3441
050030	21.0096	20.9812	21.5621	21.1955
050032	22.5868	25.2010	24.3598	24.0616
050033	24.5609	24.9328	31.7747	27.1293
050036	20.4703	21.2420	20.1678	20.6131

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TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2000 (1996 WAGE DATA), 2001 (1997 WAGE DATA) AND 2002 (1998 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FFY 2000	Average hourly wage FFY 2001	Average** hourly wage FFY 2002	Average*** hourly wage (3 years)
050038	27.8274	28.6528	29.9698	28.8293
050039	22.2524	22.7117	22.5974	22.5195
050040	30.6664	32.1287	30.4110	31.0613
050042	22.2343	24.8067	24.5260	23.8317
050043	33.2286	32.9958	33.8255	33.3456
050045	20.7307	19.8831	21.1474	20.5973
050046	31.3831	25.3185	25.2005	27.4555
050047	29.4412	29.9255	29.9580	29.7840
050051	17.8401	17.8945	18.7809	18.1179
050054	19.3686	20.7212	22.0982	20.7075
050055	29.0872	29.3984	29.2730	29.2593
050056	23.8507	27.4321	23.8058	24.9609
050057	21.7581	21.1554	20.7050	21.1842
050058	25.7261	23.1641	23.3009	23.9601
050060	20.9219	20.7747	20.5450	20.7207
050061	23.7443	23.5454	24.5488	23.9503
050063	23.0724	24.8851	25.7593	24.5061
050065	21.1848	24.0420	24.3835	23.0762
050066	21.4187	16.5725	16.1649	17.6784
050067	21.3029	23.1966	25.8857	23.3989
050068	28.4804	20.6851	19.3615	22.4409
050069	29.2980	25.9420	24.6153	26.4351
050070	32.5964	32.5166	33.0195	32.7172
050071	33.1379	33.1850	33.3740	33.2367
050072	32.9660	33.2858	38.5136	34.8941
050073	34.6111	33.3922	31.4874	33.0669
050075	33.5246	33.9095	32.6142	33.3899
050076	33.8835	27.7797	32.7847	31.3195
050077	23.2986	24.1019	24.2083	23.8775
050078	22.8023	23.0736	24.3150	23.3638
050079	34.4253	33.2432	30.0167	32.3461
050082	21.7004	22.1009	23.7617	22.5498
050084	23.0966	23.5866	25.4517	24.0054
050088	24.0634	20.8406	24.9641	23.1779
050089	20.0194	20.9117	21.9331	20.9434
050090	23.8969	23.4097	23.9183	23.7390
050091	22.2220	25.2792	23.7713	23.6457
050092	15.3841	16.7969	17.1211	16.4241
050093	24.0837	25.2130	25.6647	24.9860
050095	33.3761	33.6718	32.5552	33.2492
050096	21.6752	20.0487	22.7394	21.3870
050097	22.6147	16.7054	22.5991	20.1968
050099	24.2921	24.8091	23.5693	24.1958
050100	30.0552	29.8758	25.0335	28.0584
050101	30.0132	31.0264	31.8957	30.9871
050102	21.2947	22.2937	24.0014	22.4745
050103	25.3384	24.7932	25.4133	25.1832
050104	25.4407	25.5797	26.8367	25.9399
050107	21.7649	21.2690	22.2019	21.7497
050108	25.2116	23.5564	25.1307	24.5504
050109	26.4768	*	*	26.4768
050110	20.1769	20.1870	19.9589	20.1175
050111	21.7397	21.5487	20.7897	21.3840
050112	26.2922	25.3015	26.8182	26.1335
050113	27.7805	28.8420	28.5224	28.4025
050114	25.9073	24.7286	26.6757	25.7599
050115	21.0499	21.3291	23.0182	21.8124
050116	25.5919	25.2130	24.9196	25.2412
050117	20.4379	23.3612	22.2123	21.9903
050118	23.9976	23.7698	23.7129	23.8243
050121	18.8818	19.5252	18.4827	18.9563
050122	*	26.3172	26.9546	26.6358
050124	23.0193	22.7736	24.5069	23.3667

\* Wage data not available for the provider that year.

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Provider No.	Average hourly wage FFY 2000	Average hourly wage FFY 2001	Average** hourly wage FFY 2002	Average*** hourly wage (3 years)
050125	24.0434	29.6147	32.0230	28.3742
050126	23.8424	23.9247	24.6752	24.1448
050127	19.7654	22.1937	20.9157	20.9577
050128	24.1801	25.7240	26.6132	25.5185
050129	27.1586	26.5030	23.0719	25.3795
050131	29.0570	31.0732	32.5462	30.8106
050132	22.9139	24.0834	24.0173	23.6527
050133	24.4011	24.9746	23.2093	24.1354
050135	27.0341	23.2361	24.7157	24.9796
050136	24.4336	24.7921	24.4162	24.5396
050137	30.0725	32.6507	31.5620	31.4326
050138	37.4088	37.3286	40.3920	38.3945
050139	31.3785	32.9351	30.3774	31.5037
050140	33.6644	34.1499	31.6524	33.0748
050144	25.7483	27.8751	27.4069	26.9409
050145	33.0620	32.3857	34.5185	33.3152
050148	21.0584	21.9211	20.0971	20.9748
050149	23.3754	24.6078	26.8674	24.8666
050150	23.4777	24.9073	24.6596	24.3771
050152	27.7504	34.0766	33.3305	31.5833
050153	29.5915	30.5714	32.3389	30.8441
050155	22.9420	21.0257	25.3354	22.9852
050158	27.9789	27.5623	28.6071	28.0313
050159	25.2105	23.2912	22.5313	23.6099
050167	21.6778	21.9128	21.8796	21.8226
050168	25.2504	23.3511	25.1937	24.5830
050169	24.6361	22.3888	24.8407	23.8796
050170	22.1989	23.9574	24.3654	23.4164
050172	17.6976	20.1841	19.6120	19.1630
050173	23.3255	24.5545	24.8694	24.1923
050174	31.2136	30.2140	30.1320	30.4943
050175	27.7875	27.2806	24.7548	26.2477
050177	20.2485	21.7943	21.1396	21.0728
050179	19.2861	21.7175	23.8868	21.4573
050180	32.1883	31.8947	33.3257	32.5107
050183	19.9765	20.3638	*	20.1665
050186	21.9062	22.4155	23.6288	22.6119
050188	27.4364	28.0918	28.2364	27.9460
050189	23.2415	22.8687	27.4071	24.6245
050191	26.7297	20.8321	25.2399	24.1511
050192	17.8095	18.6701	14.0828	16.5416
050193	23.7260	22.6316	24.9444	23.7567
050194	28.2701	29.7371	29.3310	29.0932
050195	34.7789	35.5621	36.9068	35.7823
050196	16.6866	18.5180	18.2411	17.8430
050197	31.4513	35.7449	32.0779	32.9661
050204	24.3944	23.6105	22.7099	23.5849
050205	21.1545	23.6831	24.1691	23.0778
050207	20.8576	21.6214	22.9941	21.8243
050211	31.2175	31.6084	31.7280	31.5153
050213	20.7338	21.4806	21.4438	21.1694
050214	20.8704	21.7335	24.0276	22.1888
050215	28.4058	29.8563	32.4402	30.1364
050217	19.8913	19.6010	20.2042	19.9076
050219	25.4730	21.7444	21.2458	22.6404
050222	27.0713	27.4809	26.9958	27.1794
050224	23.7942	23.5316	23.5101	23.6043
050225	20.7978	23.3480	21.6206	21.8948
050226	26.9297	27.7315	24.4443	26.2380
050228	30.3772	34.0711	34.2596	32.7722
050230	25.3640	27.7357	26.6291	26.5638
050231	25.5798	26.1508	26.7319	26.1758
050232	23.3849	24.3072	24.5245	24.0793

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