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Health Care Financing Administration

42 CFR Parts 412, 413, 483, and 485

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 412, 413, 483, and 485

[HCFA–1053–F]

RIN 0938–AJ50

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

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

ACTION: Final rule.

SUMMARY: We are revising the Medicare hospital inpatient prospective payment systems for operating costs and capital-related costs to implement changes arising from our continuing experience with the systems. In addition, in the addendum to this final rule, we describe changes in the amounts and factors necessary to determine rates for Medicare hospital inpatient services for operating costs and capital-related costs. These changes are applicable to discharges occurring on or after October 1, 1999. We also set forth rate-of-increase limits as well as policy changes for hospitals and hospital units excluded from the prospective payment systems. Finally, we are revising certain policies governing payment to hospitals for the direct costs of graduate medical education.

DATES: The provisions of this final rule are effective October 1, 1999. This rule is a major rule as defined in Title 5, United States Code, section 804(2). Pursuant to 5 U.S.C. section 801(a)(1)(A), we are submitting a report to Congress on this rule on July 30, 1999.

FOR FURTHER INFORMATION CONTACT:
Steve Phillips, (410) 786–4531, Operating Prospective Payment, Diagnosis-Related Group (DRG), and Wage Index Issues.
Tzvi Hefter, (410) 786–4487, Capital Prospective Payment, Excluded Hospitals, and Graduate Medical Education Issues.

SUPPLEMENTARY INFORMATION:

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I. Background

A. Summary

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

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

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

The regulations governing the hospital inpatient prospective payment systems are located in 42 CFR part 412. The regulations governing excluded hospitals and hospital units are located in parts 412 and 413, and the GME regulations are located in part 413.

B. Summary of the Provisions of the May 7, 1999 Proposed Rule

On May 7, 1999, we published a proposed rule in the **Federal Register** (64 FR 24716) that set forth proposed changes to the Medicare hospital inpatient prospective payment systems for both operating costs and capital-related costs that would be effective for discharges occurring on or after October 1, 1999. We also proposed changes concerning GME costs and excluded hospitals and units, as well as critical access hospitals (CAHs). On June 15, 1999, we issued a correction notice (64 FR 31995) for the May 7, 1999 proposed rule. That notice corrected Table 3C of the Addendum (which lists each hospital's case-mix index and adjusted average hourly wage based on data on file at HCFA as of February 22, 1999) and made several other technical corrections.

In the proposed rule, we noted that the efforts that we were undertaking to make the Medicare computer systems compliant on January 1, 2000, would not delay our ability to make timely and updated payments to hospitals under the FY 2000 prospective payment systems final rule. This statement still applies and the changes and updated rates set forth in this final rule will be implemented on October 1, 1999.

The following is a summary of the contents of the proposed rule:

- In order to avoid compromising our ability to process and pay hospital claims during the period leading up to and immediately following January 1, 2000, we did not propose to implement any revisions to the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD–9–CM) coding system. We did propose to make some limited changes to certain DRG classifications for FY 2000 and described other proposed decisions

concerning DRGs. We also recalibrated the DRG relative weights based on the proposed DRG changes and updated Medicare claims data.

• We proposed an FY 2000 hospital wage index update, using FY 1996 wage data, and revisions to the wage index based on hospital redesignations. In addition, we proposed to begin excluding from the wage index Part A physician wage costs that are teaching-related, as well as resident and Part A certified registered nurse anesthetist (CRNA) costs.

• We proposed several policy changes in the regulations in 42 CFR parts 412 and 413 and proposed to continue existing policy concerning classifications of sole community hospitals; the indirect medical education adjustment; and Medicare Geographic Classification Review Board (MGCRB) decisions. In addition, we updated the qualifying criteria for rural referral centers and proposed several changes to the regulations governing payments for the direct costs of GME programs.

• We discussed the special exceptions process for certain eligible hospitals to receive additional payments for major construction or renovation projects that began soon after the start of the capital prospective payment system and proposals that we had received to change the eligibility criteria for these payments.

• We discussed a number of proposals concerning Medicare payments to excluded hospitals and hospital units and CAHs. These proposed changes related to limits on and adjustments to the proposed target amounts for FY 2000; changes in bed size or status of excluded hospitals or hospital units; payment for Medicare services furnished at satellite hospital locations; responsibility for care of patients in hospitals-within-hospitals; the allowable emergency response time for CAHs located in frontier or other specifically defined remote areas; and compliance with minimum data set requirements by CAHs with swing bed approval.

• In the addendum to the proposed rule, we set forth proposed changes to the amounts and factors for determining the FY 2000 prospective payment rates for operating costs and capital-related costs. We also addressed update factors for determining the rate-of-increase limits for cost reporting periods beginning in FY 2000 for hospitals and hospital units excluded from the prospective payment system.

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

• In Appendix B of the proposed rule, we set forth the technical appendix on the proposed FY 2000 capital cost model.

• In Appendix C of the proposed rule, as required by section 1886(e)(3)(B) of the Act, we set forth our report to Congress on our initial estimate of a recommended update factor for FY 2000 for both hospitals included in and hospitals excluded from the prospective payment systems.

• In Appendix D of the proposed rule, as required by sections 1886(e)(4) and (e)(5) of the Act, we included our recommendation of the appropriate percentage change for FY 2000 for—

—Large urban area and other area average standardized amounts (and hospital-specific rates applicable to sole community hospitals and Medicare-dependent, small rural hospitals) for hospital inpatient services paid for under the prospective payment system for operating costs; and

—Target rate-of-increase limits to the allowable operating costs of hospital inpatient services furnished by hospitals and hospital units excluded from the prospective payment system.

• In the proposed rule, we discussed the recommendations concerning hospital inpatient payment policies made by the Medicare Payment Advisory Commission (MedPAC) and presented our responses to those recommendations. Under section 1805(b) of the Act, MedPAC is required to submit a report to Congress, not later than March 1 of each year, that reviews and makes recommendations on Medicare payment policies.

C. Public Comments Received in Response to the Proposed Rule

We received a total of 82 timely items of correspondence containing multiple comments on the proposed rule. The main areas of concern addressed by the commenters were removal of teaching-related and CRNA costs from the wage index, payments for services furnished at satellite hospital locations, and limits on the transfer of patients in hospitals-within-hospitals. We also received a number of comments relating to the eligibility criteria for hospitals to qualify for capital exceptions payments.

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

II. Changes to DRG Reclassifications and Recalibrations of Relative Weights

A. Background

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

Congress recognized that it would be necessary to recalculate the DRG relative weights periodically to account for changes in resource consumption. Accordingly, section 1886(d)(4)(C) of the Act requires that the Secretary adjust the DRG classifications and relative weights at least annually. These adjustments are made to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources.

As discussed in more detail in section II.B.8 of this preamble, we are not implementing any revisions to the ICD–9–CM codes. We have undertaken, and continue to undertake, major efforts to ensure that all of the Medicare computer systems are ready to function on January 1, 2000. If we were to implement changes to the ICD–9–CM codes on October 1, 1999, we would endanger the functioning of the Medicare computer systems, and, specifically, we might compromise our ability to process hospital bills. We can, however, reclassify existing codes into different DRGs, if appropriate.

The changes to the DRG classification system, and the recalibration of the DRG weights for discharges occurring on or after October 1, 1999, are discussed below.

B. DRG Reclassification

1. General

Cases are classified into DRGs for payment under the prospective payment system based on the principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay, as well as age, sex, and discharge status of the patient. The diagnosis and procedure information is reported by the hospital using ICD–9–CM codes. The Medicare fiscal intermediary enters the information into its claims processing system and subjects it to a series of automated screens called the

Medicare Code Editor (MCE). These screens are designed to identify cases that require further review before classification into a DRG can be accomplished.

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

Currently, cases are assigned to one of 499 DRGs in 25 major diagnostic categories (MDCs). Most MDCs are based on a particular organ system of the body (for example, MDC 6, Diseases and Disorders of the Digestive System); however, some MDCs are not constructed on this basis since they involve multiple organ systems (for example, MDC 22, Burns).

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

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

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

We proposed several changes to the DRG classification system for FY 2000 and other decisions concerning DRGs. The proposed changes, the comments we received concerning them, and the final DRG changes are set forth below. Unless otherwise noted, our DRG analysis is based on the full (100 percent) FY 1998 MedPAR file, which contains data from bills received through March 31, 1999.

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

In the May 7, 1999 proposed rule, we noted that the following codes in the newborn observation series are included in the allowable secondary diagnoses under DRG 391 (Normal Newborn):

V29.0, Observation for suspected infectious disease
V29.1, Observation for suspected neurological condition
V29.8, Observation for other specified suspected condition
V29.9, Observation for unspecified suspected condition

There are two related codes, however, that currently are not included as allowable secondary diagnoses under DRG 391: V29.2 (Observation for suspected respiratory condition) and V29.3 (Observation for suspected genetic or metabolic condition). (In the proposed rule, we incorrectly stated that V29.3 was titled ''Observation for other genetic problem.'') Diagnosis codes V29.2 and V29.3 (as well as the other V29.x codes noted above) are used to indicate that the newborn was suspected of having an abnormal condition resulting from exposure from the mother or the birth process, but is without signs or symptoms and, after examination and observation, no abnormal condition is found to exist. Currently, when either V29.2 or V29.3 is the only secondary diagnosis for an otherwise healthy newborn, the case is assigned to DRG 390 (Neonate with Other Significant Problems). Based on a belief that the presence of diagnosis code V29.2 or V29.3 should not exclude a newborn from being classified as normal, we proposed to include diagnosis codes V29.2 and V29.3 in the list of allowable secondary diagnoses under DRG 391 (Normal Newborn).

We received one comment on this proposal.

Comment: The commenter questioned whether any of the codes in the V29 series should be assigned to DRG 391. The commenter believes that the infants assigned to diagnosis code in the V29 series do not belong in the same clinical group as ''normal newborn.'' The commenter recommended that, before moving codes V29.2 and V29.3 to DRG 391, we should examine data such as the average length of stay for DRGs 390 and 391 and those cases coded with V29.x. Citing one hospital's experience, the commenter noted that 2.7 percent of the cases in DRG 391 were assigned a secondary diagnosis of V29.0 (Observation for suspected infectious disease). In addition, cases with secondary diagnosis codes V29.1, V29.8, and V29.9 represented less than 1 percent each of all cases in DRG 391. The commenter also reported that, for DRG 390, less than 1 percent of cases were assigned a secondary diagnosis code of V29.2 or V29.3. The commenter believes that the length of stay and resource consumption for these cases should be compared to other cases assigned to DRG 390 and DRG 391 to determine whether a separate DRG should be created to adequately categorize these infants.

Response: The experience of the hospital reported by the commenter indicates that newborn cases with a secondary diagnosis of V29.2 or V29.3 represent a small percentage of newborn cases. Medicare data do not contain enough data on newborns to verify this.

In the FY 1998 MedPAR file, there are only nine cases assigned to DRG 390 and none to DRG 391. In fact, in FY 1998, there were only 18 cases assigned to all of MDC 15. Because of the lack of data on newborns in the Medicare claims file, the relative weights and lengths of stay for the DRGs in MDC 15 are based on non-Medicare data collected from 19 States. (See the September 1, 1995 final rule (60 FR 45781) for a detailed discussion of this policy.) Therefore, we rely closely on experts outside of HCFA when we make any changes in MDC 15. We had received information before publication of the proposed rule suggesting that V29.2 and V29.3 should be included with the other V29.x codes in DRG 391. After verifying with our medical consultants that this information was clinically accurate, we proposed to make this DRG classification change. We do note that the average lengths of stay for DRG 390 and 391 do not differ dramatically (3.4 and 3.1 days, respectively). However, the relative weight for DRG 390 is significantly higher than that for DRG 391 (1.5908 and 0.1516, respectively). Thus, we believe the amount of resource use devoted to newborns in DRG 390 is not

connected to the amount of time spent in the hospital.

The commenter did not provide any length of stay or resource use data nor did the commenter provide any reason that codes V29.2 or V29.3 should be treated differently than the other codes in category V29.x. We believe that DRG 390, as its title indicates, should be used to classify newborns with significant problems. Newborns who exhibit no signs or symptoms and are merely evaluated or observed for a suspected condition that is ruled out should not be classified with newborns who have significant problems that require treatment.

We note that DRG 391 includes newborns who have minor problems or conditions that require treatment. For example, some newborns with jaundice, newborns with scalp injuries or mild birth asphyxia, and newborns with minor skin infections are all classified to DRG 391. Thus, that DRG does contain newborn cases for which some medical treatment must be provided. We believe that including newborns observed for suspected respiratory, genetic, or metabolic conditions in DRG 391 is clinically appropriate. Therefore, as proposed, we will include V29.2 and V29.3 as allowable secondary diagnoses under DRG 391, as are the rest of the codes in that category.

3. MDC 19 (Mental Diseases and Disorders)

We proposed to revise the title of DRG 425, ''Acute Adjustment Reaction and Disturbances of Psychosocial Dysfunction'' under MDC 19 to read ''Acute Adjustment Reaction and Psychosocial Dysfunction.'' Correspondents had stated that the terms ''disturbances'' and ''dysfunction'' were redundant since the terms have similar meanings.

We received one comment in support of this revision. Therefore, we are adopting this proposed revision as final.

4. MDC 22 (Burns)

In the July 31, 1998 final rule (63 FR 40957), we implemented an extensive redesign of the DRGs for burns to more appropriately capture the variation in resource use associated with different classes of burn patients. After these DRGs went into effect on October 1, 1998, we were contacted by several hospitals about our inclusion of the fifth digit ''0'' on codes 948.10 through 948.90 to capture cases of full-thickness burns. These hospitals stated that codes in category 948 with a fifth digit of ''0'' should not be assigned to DRGs 506 through 509 as full-thickness burns since not all of these cases will have a full-thickness (third degree) burn. The fifth digit ''0'' can capture cases in which there actually is no third degree burn. The hospitals requested that we consider removing from the full-thickness burn DRGs 506 through 509 all codes in the 948 category with a fifth digit of ''0'' as follows:

948.00 Body burn involving less than 10 percent of body surface, third degree less than 10 percent or unspecified

948.10 Body burn involving 10 to 19 percent of body surface, third degree less than 10 percent or unspecified

948.20 Body burn involving 20 to 29 percent of body surface, third degree less than 10 percent or unspecified

948.30 Body burn involving 30 to 39 percent of body surface, third degree less than 10 percent or unspecified

948.40 Body burn involving 40 to 49 percent of body surface, third degree less than 10 percent or unspecified

948.50 Body burn involving 50 to 59 percent of body surface, third degree less than 10 percent or unspecified

948.60 Body burn involving 60 to 69 percent of body surface, third degree less than 10 percent or unspecified

948.70 Body burn involving 70 to 79 percent of body surface, third degree less than 10 percent or unspecified

948.80 Body burn involving 80 to 89 percent of body surface, third degree less than 10 percent or unspecified

948.90 Body burn involving 90 percent or more of body surface, third degree less than 10 percent or unspecified.

We agreed with the hospitals and proposed that the codes listed above be removed from DRGs 506 through 509 and added to DRG 510 (Nonextensive Burns with CC or Significant Trauma) and DRG 511 (Nonextensive Burns without CC or Significant Trauma). Hospitals have been instructed in *Coding Clinic for ICD–9–CM*, Fourth Quarter, 1994 (pages 22 through 28) to code the site of the burn first (codes 940 through 947), when known. Codes from category 948 may be used as a principal diagnosis only when the site of the burn is not specified. Category 948 is used as an additional code to provide information on the percentage of total body that is burned or to show the percentage of burn that was third degree. When hospitals report codes properly, full-thickness burns would be assigned to a code for burn of the specific site (940 through 947). This site code also shows the degree of the burn. Furthermore, for those rare cases in which the site is not provided, but it is known that 10 percent or more of the body has a third degree burn, hospitals may report this information through the use of category 948 with a fifth digit of ''1'' through ''9.'' All of these cases would continue to be classified as full-thickness burns in DRGs 506 through 509. Therefore, the proposed removal of codes 948.1 through 948.9 with a fifth digit of ''0'' would not prevent cases from being assigned to one of the full-thickness DRGs when there is a third degree burn and the case is correctly coded.

Comment: One commenter stated that while it is true that codes in category 948 with a fifth digit of ''0'' may be assigned when there is no third degree burn, fifth digit ''0'' is also used to report cases that have a body surface of 1 to 9 percent involved in third degree burns. The commenter suggested that consideration be given to these cases as the presence of a third degree burn represents additional risk to the patient.

Response: We agree with the commenter that the presence of third degree burns represents additional risk to the patient and may result in a higher resource use. More accurately capturing this fact was one of the primary purposes in revising the burn DRGs in FY 1999. However, as the commenter noted, in category 948, the fifth digit of ''0'' includes cases with no third degree burns as well as third degree burns involving 1 to 9 percent of the body surface. It is precisely because many of the cases coded in 948 with a ''0'' fifth digit have no third degree burns that we believe it is not appropriate to include these codes in DRGs 506 through 509. As stated above, hospitals have been instructed to code the site of the burn first (codes 940 through 947), when known. These codes capture information on the site of the burn as well as whether the burn is a third degree burn. Therefore, by using the more precise codes in the 940 through 947 series, hospitals will be appropriately assigning cases with minor third degree burns to DRGs 506 through 509.

We are adopting as final our proposal to remove codes in the 948 category with a fifth digit of ''0'' from the list of full-thickness burns.

5. Surgical Hierarchies

Some inpatient stays entail multiple surgical procedures, each one of which, occurring by itself, could result in

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

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

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

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

We note that, notwithstanding the foregoing discussion, there are a few instances when a surgical class with a lower average relative weight is ordered above a surgical class with a higher average relative weight. For example, the ''other OR procedures'' surgical class is uniformly ordered last in the surgical hierarchy of each MDC in which it occurs, regardless of the fact that the relative weight for the DRG or DRGs in that surgical class may be higher than that for other surgical classes in the MDC. The ''other OR procedures'' class is a group of procedures that are least likely to be related to the diagnoses in the MDC but are occasionally performed on patients with these diagnoses. Therefore, these procedures should be considered only if no other procedure more closely related to the diagnoses in the MDC has been performed.

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

Based on the preliminary recalibration of the DRGs, we proposed to modify the surgical hierarchy as set forth below. However, in developing the proposed rule, we were unable to test the effects of proposed revisions to the surgical hierarchy and to reflect these changes in the proposed relative weights due to the unavailability of revised GROUPER software at the time the proposed rule was prepared. Rather, we simulated most major classification changes to approximate the placement of cases under the proposed reclassification and then determined the average charge for each DRG. These average charges then serve as our best estimate of relative resource use for each surgical class. We tested the proposed surgical hierarchy changes after the revised GROUPER was received. The final changes in the DRG relative weights are reflected in this final rule.

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

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

We received two comments in support of the two surgical hierarchy proposals. In addition, based on a test of the proposed revisions using the most recent MedPAR file and the revised GROUPER software, we have found that the revisions are still supported by the data and no additional changes are indicated. Therefore, we are incorporating the proposed revisions and reorders in this final rule.

6. Refinement of Complications and Comorbidities (CC) List

There is a standard list of diagnoses that are considered CCs. We developed this list using physician panels to include those diagnoses that, when present as a secondary condition, would be considered a substantial complication or comorbidity. In previous years, we have made changes to the standard list of CCs, either by adding new CCs or by deleting CCs already on the list. In the May 7, 1999 proposed rule, we did not propose to delete any of the diagnosis codes on the CC list.

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

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

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

• The same condition in anatomically proximal sites should not be considered CCs for one another.

• Closely related conditions should not be considered CCs for one another.

The creation of the CC Exclusions List was a major project involving hundreds of codes. The FY 1988 revisions were intended to be only a first step toward refinement of the CC list in that the criteria used for eliminating certain diagnoses from consideration as CCs were intended to identify only the most obvious diagnoses that should not be considered complications or comorbidities of another diagnosis. For that reason, and in light of comments and questions on the CC list, we have continued to review the remaining CCs to identify additional exclusions and to remove diagnoses from the master list that have been shown not to meet the definition of a CC. (See the September 30, 1988 final rule for the revision made for the discharges occurring in FY 1989 (53 FR 38485); the September 1, 1989 final rule for the FY 1990 revision (54 FR 36552); the September 4, 1990 final rule for the FY 1991 revision (55 FR 36126); the August 30, 1991 final rule for the FY 1992 revision (56 FR 43209); the September 1, 1992 final rule for the FY 1993 revision (57 FR 39753); the September 1, 1993 final rule for the FY 1994 revisions (58 FR 46278); the September 1, 1994 final rule for the FY 1995 revisions (59 FR 45334); the September 1, 1995 final rule for the FY 1996 revisions (60 FR 45782); the August 30, 1996 final rule for the FY 1997 revisions (61 FR 46171); the August 29, 1997 final rule for the FY 1998 revisions (62 FR 45966); and the July 31, 1998 final rule for the FY 1999 revisions (63 FR 40954).) In the May 7, 1999 proposed rule, we did not propose to add or delete any codes from the CC list.

In addition, because we are not making changes to the ICD–9–CM codes for FY 2000, we are not modifying the current list for new or deleted codes. Therefore, there are no revisions to the CC Exclusions List for FY 2000.

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

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

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

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

All remaining OR procedures are assigned to DRGs 468 and 477, with DRG 477 assigned to those discharges in which the only procedures performed are nonextensive procedures that are unrelated to the principal diagnosis. The original list of the ICD–9–CM procedure codes for the procedures we consider nonextensive procedures, if performed with an unrelated principal diagnosis, was published in Table 6C in section IV of the Addendum to the September 30, 1988 final rule (53 FR 38591). As part of the final rules published on September 4, 1990, August 30, 1991, September 1, 1992, September 1, 1993, September 1, 1994, September 1, 1995, August 30, 1996, and August 29, 1997, we moved several other procedures from DRG 468 to 477, and some procedures from DRG 477 to 468. (See 55 FR 36135, 56 FR 43212, 57 FR 23625, 58 FR 46279, 59 FR 45336, 60 FR 45783, 61 FR 46173, and 62 FR 45981, respectively.) No procedures were moved in FY 1999, as noted in the July 31, 1998 final rule (63 FR 40962).

a. Adding Procedure Codes to MDCs

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

First, we proposed to move three codes from DRG 468 to MDC 1 (Diseases and Disorders of the Nervous System), all of which would be assigned to DRGs 7 and 8 (Peripheral and Cranial Nerve and Other Nervous System Procedure).[1] Procedure code 38.7 (Interruption of the vena cava) is sometimes performed in conjunction with treatment for the principal diagnosis 434.11 (Cerebral embolism with infarction), which is assigned to MDC 1. Our medical advisors believe that procedure code 38.7 is appropriately performed for some neurological conditions such as a cerebral embolism with infarction. Because the current DRG configuration does not allow this assignment, we proposed to add procedure code 38.7 to DRGs 7 and 8.

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

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

Fourth, insertion of totally implantable infusion pump (procedure code 86.06) is not assigned to MDC 5 (Diseases and Disorders of the Circulatory System) in the current DRG configuration. Infusion pumps should

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

be assigned to all MDCs in which subcutaneous insertion of the pump is appropriate. Procedure code 86.06 may be performed on patients with a principal diagnosis in MDC 5 such as 451.83 (Phlebitis and thrombophlebitis of the deep veins of other extremities). Therefore, we proposed to add procedure code 86.06 to DRG 120 (Other Circulatory System OR Procedures) in MDC 5.

We received two comments on these MDC and DRG assignments, both of which concurred with our proposed changes. Therefore, we are adopting them as final.

b. Reassignment of Procedures Among DRGs 468, 476, and 477

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

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

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

The NCHS has lead responsibility for the ICD–9–CM diagnosis codes included in the *Tabular List* and *Alphabetic Index for Diseases,* while HCFA has lead responsibility for the ICD–9–CM procedure codes included in the *Tabular List* and *Alphabetic Index for Procedures.*

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

The Committee presented proposals for coding changes for FY 2000 at public meetings held on June 4 and November 2, 1998. Even though the Committee conducted public meetings and considered approval of coding changes for FY 2000 implementation, we are not implementing any changes to ICD–9–CM codes for FE 2000. We have undertaken, and continue to undertake, major efforts to ensure that all of the Medicare computer systems are ready to function on January 1, 2000. If we were to make system changes to capture additions, deletions, and modifications to ICD–9–CM codes for FY 2000, we would endanger the functioning of the Medicare computer systems, and, specifically, we might compromise our ability to process hospital bills. Therefore, the code proposals presented at the public meetings held on June 4 and November 2, 1998, that (if approved) ordinarily would have been included as new codes for October 1, 1999, are not included in this final rule. These code changes to ICD–9–CM will be considered for inclusion in the annual update for FY 2001. The initial meeting for consideration of coding changes for implementation in FY 2001 was held on May 13, 1999.

Copies of the minutes of the 1998 meetings and the May 13, 1999 meeting can be obtained from the HCFA Home Page at http://www.hcfa.gov/medicare/icd9cm.htm or from http://www.hcfa.gov/events, click on ''meetings and workshops'' link, and then click on ''reports of the ICD–9–CM coordination and maintenance committee'' link. Paper copies of these minutes are no longer available and the mailing list has been discontinued. We encourage commenters to address suggestions on coding issues involving diagnosis codes to: Donna Pickett, Co-Chairperson; ICD–9–CM Coordination and Maintenance Committee; NCHS; Room 1100; 6525 Belcrest Road; Hyattsville, Maryland 20782. Comments may be sent by E-mail to dfp4@cdc.gov.

Questions and comments concerning the procedure codes should be addressed to: Patricia E. Brooks, Co-Chairperson; ICD–9–CM Coordination and Maintenance Committee; HCFA, Center for Health Plans and Providers, Plan and Provider Purchasing Policy Group, Division of Acute Care; C4–07–07; 7500 Security Boulevard; Baltimore, Maryland 21244–1850. Comments may be sent by E-mail to pbrooks@hcfa.gov.

We received one comment in support of our decision not to update ICD–9–CM codes given the magnitude of system changes needed during the period leading up to the year 2000.

9. Other Issues

a. Implantation of Muscle Stimulator

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

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

As discussed in section II.B.7.a of this preamble, in the May 7, 1999 proposed rule, we proposed to assign code 83.92 to DRGs 7 and 8 in MDC 1. Therefore, if a case involves either procedure code 82.56 or 83.92, or both procedure codes, the case would be assigned to DRGs 7 and 8.

A presentation on one type of muscle stimulator was made by a device manufacturer before the ICD–9–CM Coordination and Maintenance Committee on November 2, 1998. The manufacturer strongly suggested that a

new code assignment be made for the procedure for insertion of this stimulator and that it be placed in category 04.9 (Other operations on cranial and peripheral nerves). However, based on comments received by the Committee, there was an overwhelming response from the coding community that a new code should not be created. The commenters believe that these codes (82.56 and 83.92) adequately described the procedures since the patient receives a tendon transfer in addition to the skeletal muscle stimulator insertion. This is done so that the quadriplegic patient can achieve some hand grasping ability where there was none before. Some quadriplegic patients receive the tendon transfer on one admission and the stimulator insertion on a subsequent admission. Others have both procedures performed on the same admission. Since the tendon transfer and stimulator insertion are being performed on quadriplegic patients, a condition found in MDC 1, we proposed to add procedure codes 82.56 and 83.92 to DRGs 7 and 8. We did not receive any comments on this proposal. Therefore, we are adopting it as final.

b. Pancreas Transplant

Through a Medicare Coverage Issues Manual revision (Transmittal No. 115, April 1999), HCFA announced that, effective July 1, 1999, Medicare covers whole organ pancreas transplantation (procedure codes 52.80 or 52.83) if it is performed simultaneous with or after a kidney transplant.

Pancreas transplantation is generally limited to those patients with severe secondary complications of diabetes, including kidney failure. However, pancreas transplantation is sometimes performed on patients with labile diabetes and hypoglycemic unawareness.

Pancreas transplantation for diabetic patients who have not experienced end-stage renal failure secondary to diabetes continue to be excluded from coverage. Medicare also excludes coverage of transplantation of partial pancreatic tissue or islet cells. Claims processing instructions to intermediaries were contained in Program Memorandum Transmittal No. A–99–16 (April 1999).

We received one comment regarding the coverage and claims processing instructions for pancreas transplants.

Comment: The commenter requested clarification on the date of coverage for services related to pancreas transplantation services furnished on or after July 1, 1999. Specifically, the commenter asked whether coverage is effective for admissions, discharges, or actual transplant surgery on or after that date. In addition, the commenter believes that if the resource use for a pancreas-kidney transplant is significantly greater than for a kidney transplant alone, then a new DRG should be created for the dual transplant. Finally, the commenter was unsure how hospitals should report the organ acquisition costs attributable to pancreas. Specifically, the commenter wanted to know if the costs should be included, on the hospital cost report with the kidney costs or whether a separate organ acquisition cost center will be established for pancreas acquisition costs.

Response: As stated in Transmittal No. 115, coverage is effective for dates of service on or after July 1, 1999. Therefore, any pancreas transplant performed on or after July 1, 1999 is covered by Medicare if all other qualifying criteria are met.

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

If a kidney and pancreas transplant are performed simultaneously or if a pancreas transplant is performed following a kidney transplant, on a patient with chronic renal failure secondary to diabetes with ketoacidosis (diagnosis codes 250.10 through 250.13), diabetes with hyperosmolarity (diagnosis codes 250.20 through 250.23), diabetes with other coma (diagnosis codes 250.30 through 250.33), diabetes with other specified manifestations (diagnosis codes 250.80 through 250.83), or diabetes with unspecified complication (diagnosis codes 250.90 through 250.93), the case would be assigned to DRG 292 or 293 (Other Endocrine, Nutritional and Metabolic OR Procedures) in MDC 10 (Endocrine, Nutritional, and Metabolic Diseases and Disorders). As the commenter notes, it is possible that the resource use for a pancreas-kidney transplant or a pancreas-only transplant might be significantly different from a kidney-only transplant. We intend to review the Medicare data in our FY 1999 MedPAR file in order to analyze whether we should either reassign these transplants to a different DRG or create a new DRG. We will announce any proposals on that issue in the FY 2001 proposed rule, which will be published in the Spring of 2000.

A separate organ acquisition cost center has been established for pancreas transplantation. The Medicare cost report will include a separate line to account for pancreas transplantation costs. In addition, in this final rule, we are making a conforming change to ' 412.2(e)(4) to include pancreas in the list of organ acquisition costs that are paid on a reasonable cost basis.

c. Immunotherapy

Effective October 1, 1994, procedure code 99.28 (Injection or infusion of biological response modifier [BRM] as an antineoplastic agent) was created. This procedure is also known as BRM therapy or immunotherapy. At that time, we designated the code as a Anon-OR@ code that does not affect DRG assignment.

Comment: One commenter, a manufacturer of a biologic response modifier, requested that we create a new DRG for BRM therapy or assign cases in which BRM therapy is performed to an existing DRG with a high relative weight. The commenter suggested that DRG 403 (Lymphoma and Non-Acute Leukemia with CC) would be an appropriate DRG. The manufacturer=s particular drug is used in the treatment of metastatic renal cell carcinoma and metastatic melanoma.

Response: Using the 100 percent FY 1998 MedPAR file that contains bills through December 31, 1998, we performed an analysis of the cases for which procedure code 99.28 was reported. Based on the commenter's request, for purposes of this analysis we examined cases only for hospitals that use the particular drug manufactured by the commenter. We identified 121 cases in 19 DRGs in 9 MDCs. No more than 31 cases were assigned to any one particular DRG. Of the 121 cases identified, 31 cases were assigned to DRG 318 (Kidney and Urinary Tract Neoplasms with CC) and 30 of the cases were assigned to DRG 82 (Respiratory Neoplasms). There was a wide range of charges (between approximately $1,300 and $125,000 per case) associated with this therapy. The average length of stay was approximately 5 days. Due to the limited number of cases that were

distributed throughout 19 DRGs and the variation of charges, we concluded that it would be inappropriate to classify these cases into a single DRG. Because of the numerous principal diagnoses reported with BRM therapy, a single DRG for procedure code 99.28 would need to be placed in the pre-MDC DRG category. Similarly, it would be impossible to classify these cases into DRG 403 because only a few cases were coded with a principal diagnosis assigned to MDC 17 (Myeloproliferative Diseases and Disorders, and Poorly Differentiated Neoplasms), the MDC that includes DRG 403. Finally, the variation in charges reflected in the 121 cases do not persuade us that there is an analytic basis for combining these cases into one DRG. Using the FY 1999 MedPAR, we intend to do a full analysis of these cases, which we will discuss in the FY 2001 proposed rule.

As a final note, any DRG classification change for procedure code 99.28 must be appropriate for all cases that receive BRM therapy, not just those that use the commenter's drug. Even if we might consider such an assignment appropriate, we have no way to distinguish between different drug therapies assigned to the same procedure code. The FY 1998 MedPAR file we analyzed contained 930 cases with procedure code 99.28. These 930 cases were assigned to 18 MDCs.

d. Heart Assist Devices

Effective May 5, 1997, we revised Medicare coverage of heart assist devices to allow coverage of a ventricular assist device used for support of blood circulation postcardiotomy if certain conditions were met. In the August 29, 1997 final rule (62 FR 45973), we moved procedure code 37.66 (Implant of an implantable pulsatile heart assist device) from DRGs 110 and 111 (Major Cardiovascular Procedures) to DRG 108 (Other Cardiothoracic Procedures) to improve payment for these procedures. In the July 31, 1998 final rule (63 FR 40956), in a further effort to improve payment for these cases, we moved procedure code 37.66 to DRGs 104 and 105 (Cardiac Valve and Other Major Cardiothoracic Procedures).

We received one comment regarding the DRG classification of procedure code 37.66.

Comment: The commenter recommended that we either reclassify heart assist device cases to DRG 103 (Heart Transplant) or create a new DRG specifically for this device and technology. The commenter cited a discrepancy between the cost of the device implantation and payment for DRGs 104 and 105 as the basis for these recommendations.

Response: We refer the reader to our response to a similar comment in the August 29, 1997 final rule (62 FR 45967). We note that the FY 1998 MedPAR file has 22 cases coded with procedure code 37.66. Of these 22 cases, 8 cases were assigned to DRG 103 (Heart Transplant) and 4 cases to DRG 483 (Tracheostomy Except for Face, Mouth, and Neck Diagnoses). The remaining 10 cases would have been assigned to DRGs 104 and 105 under the current classification.

C. Recalibration of DRG Weights

We proposed to use the same basic methodology for the FY 2000 recalibration as we did for FY 1999. (See the July 31, 1998 final rule (63 FR 40965).) That is, we recalibrated the weights based on charge data for Medicare discharges. However, we used the most current charge information available, the FY 1998 MedPAR file. (For the FY 1999 recalibration, we used the FY 1997 MedPAR file.) The MedPAR file is based on fully coded diagnostic and surgical procedure data for all Medicare inpatient hospital bills.

The final recalibrated DRG relative weights are constructed from FY 1998 MedPAR data, based on bills received by HCFA through March 1999, from all hospitals subject to the prospective payment system and short-term acute care hospitals in waiver States. The FY 1998 MedPAR file includes data for approximately 11.3 million Medicare discharges.

The methodology used to calculate the DRG relative weights from the FY 1998 MedPAR file is as follows:

- All the claims were regrouped using the DRG classification revisions discussed above in section II.B of this preamble.
- Charges were standardized to remove the effects of differences in area wage levels, indirect medical education (IME) and disproportionate share hospital (DSH) payments, and, for hospitals in Alaska and Hawaii, the applicable cost-of-living adjustment.
- The average standardized charge per DRG was calculated by summing the standardized charges for all cases in the DRG and dividing that amount by the number of cases classified in the DRG.
- We then eliminated statistical outliers, using the same criteria as were used in computing the current weights—that is, all cases that are outside of 3.0 standard deviations from the mean of the log distribution of both the charges per case and the charges per day for each DRG.
- The average charge for each DRG was then recomputed (excluding the statistical outliers) and divided by the national average standardized charge per case to determine the relative weight. A transfer case is counted as a fraction of a case based on the ratio of its length of stay to the geometric mean length of stay of the cases assigned to the DRG. That is, a 5-day length of stay transfer case assigned to a DRG with a geometric mean length of stay of 10 days is counted as 0.5 of a total case.
- We established the relative weight for heart and heart-lung, liver, and lung transplants (DRGs 103, 480, and 495) in a manner consistent with the methodology for all other DRGs except that the transplant cases that were used to establish the weights were limited to those Medicare-approved heart, heart-lung, liver, and lung transplant centers that have cases in the FY 1998 MedPAR file. (Medicare coverage for heart, heart-lung, liver, and lung transplants is limited to those facilities that have received approval from HCFA as transplant centers.)
- Acquisition costs for kidney, heart, heart-lung, liver, and lung transplants continue to be paid on a reasonable cost basis. Unlike other excluded costs, the acquisition costs are concentrated in specific DRGs (DRG 302 (Kidney Transplant); DRG 103 (Heart Transplant for Heart and Heart-Lung Transplants); DRG 480 (Liver Transplant); and DRG 495 (Lung Transplant)). Because these costs are paid separately from the prospective payment rate, it is necessary to make an adjustment to prevent the relative weights for these DRGs from including the effect of the acquisition costs. Therefore, we subtracted the acquisition charges from the total charges on each transplant bill that showed acquisition charges before computing the average charge for the DRG and before eliminating statistical outliers.

When we recalibrated the DRG weights for previous years, we set a threshold of 10 cases as the minimum number of cases required to compute a reasonable weight. We used that same case threshold in recalibrating the DRG weights for FY 2000. Using the FY 1998 MedPAR data set, there are 40 DRGs that contain fewer than 10 cases. We computed the weights for the 40 low-volume DRGs by adjusting the FY 1999 weights of these DRGs by the percentage change in the average weight of the cases in the other DRGs.

The weights developed according to the methodology described above, using the final DRG classification changes, result in an average case weight that is different from the average case weight

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

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

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

1. Introduction

As in past years, in the DRG reclassification and recalibration process for the FY 2000 final rule, we used the MedPAR file, which consists of data for approximately 11.3 million Medicare discharges. In the FY 1999 final rulemaking process, we used the FY 1997 MedPAR file to recalibrate DRGs and evaluate possible changes to DRG classifications; for this FY 2000 final rule, we used the FY 1998 MedPAR file. The Conference Report that accompanied the Balanced Budget Act of 1997 stated that ''in order to ensure that Medicare beneficiaries have access to innovative new drug therapies, the conferees believe that HCFA should consider, to the extent feasible, reliable, validated data other than Medicare Provider Analysis and Review (MedPAR) data in annually recalibrating and reclassifying the DRGs'' (H.R. Conf. Rep. No. 105–217 at 734 (1997)).

Consistent with that language, we considered non-MedPAR data in the rulemaking process for FY 1999 and in developing the May 7, 1999 proposed rule for FY 2000. We received non-MedPAR data from entities on behalf of the manufacturer of a specific drug, platelet inhibitors. The manufacturer was seeking to obtain a new DRG assignment for cases involving platelet inhibitors. The non-MedPAR data purported to show cases involving platelet inhibitors. As discussed in the proposed rule, we concluded it was not feasible to use the non-MedPAR data submitted to us because, among other things, we did not have information to verify that the cases actually involved the drug, nor did we have information to verify that the cases reflected a representative sample (and did not simply reflect high cost cases).

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

In the FY 1999 final rule, we stated a number of reasons for rejecting the non-MedPAR data we had received. Basically, the data were unreliable and the data's use was not feasible—the data could not be validated or verified.

After publication of the July 31, 1998 final rule, we met and corresponded on several occasions with the manufacturers, vendors, and legal representatives of the pharmaceutical company in an effort to resolve data issues. We reiterated that, among other things, we needed to know for each case the hospital that furnished the services. Before the publication of the proposed rule, we had not received information necessary to validate the data or the data's representativeness.

We remain open to considering non-MedPAR data in the DRG reclassification and recalibration process, but, consistent with the Conference Report, as well as our longstanding policies, the data must be ''reliable'' and ''validated.'' The July 31, 1998 final rule reflected the major factors that we consider in evaluating whether data are feasible, reliable, and validated; however, because we believed it might be useful, we discussed these issues in much greater detail in the May 7, 1999 proposed rule.

2. The DRG Reclassification and Recalibration Process

In order to understand whether it is feasible to use non-MedPAR data, and whether the data are reliable and validated, it is critical to understand the DRG recalibration and reclassification process. As described earlier, one of the first steps in the annual DRG recalibration is that the Medicare hospital inpatient claims (in the MedPAR file) from the preceding Federal fiscal year are classified using the DRG classification system (proposed or final) for the upcoming year. Cases are classified into DRGs based on the principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay, as well as age, sex, and discharge status of the patient. Each case is classified into one and only one DRG.

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

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

3. Feasible, Reliable, Validated Data

As indicated above, the Conference Report reflected the conferees' belief that, ''to the extent feasible,'' HCFA should consider ''reliable, validated data'' in recalibrating and reclassifying DRGs. The concepts of reliability and validation are closely related. In order for us to use non-MedPAR data, the non-MedPAR data must be independently validated. When an entity submits non-MedPAR data, we

must be able to independently review the medical records and verify that a particular procedure was performed for each of the cases that purportedly involved the procedure. This verification requires the identification of a particular Medicare beneficiary and the hospital where the beneficiary was treated, as well as the dates involved. Although it is unlikely that we would review 100 percent of thousands of cases submitted for review, at a minimum, we must be able to validate data through a random sampling methodology. We must also be able to verify the charges that are reflected in the data.

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

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

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

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

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

4. Submission of Data

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

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

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

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

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

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

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

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

We received a number of comments regarding this issue, including comments from MedPAC, pharmaceutical manufacturers (including two manufacturers of platelet inhibitor drugs), an industry manufacturers' association, and several

cardiologists. We received only one comment from a State hospital association; otherwise, hospital associations were silent on this issue.

Comment: MedPAC stated that HCFA's general criteria provide a valid basis for assessing the feasibility and appropriateness of using outside data to establish DRG assignments and relative weights for specific technologies. MedPAC believes that it would be helpful to entities that desire to submit useful data if HCFA would establish and publish explicit data standards to guide their efforts. MedPAC suggested the criteria might include the format and content of the patient care records; the minimum sample size; required documentation of sampling procedures; acceptable methods for ensuring that the sampled providers were representative of the relevant provider universe; and any other information that HCFA considered essential to establish the validity and reliability of the submitted data. MedPAC believes that the criteria would help to prevent misunderstandings and ensure HCFA's ability to assess whether the submitted data were adequate to serve as a basis for DRG assignment before actual MedPAR claims become available.

Response: We appreciate the Commission's support of our general criteria. We would prefer to gain further experience working with non-MedPAR data before we develop any specific criteria regarding sample sizes or methodologies. This will enable us to establish criteria that realistically reflect the availability of such data and the general suitability of the data for use in the DRG reclassification and recalibration process. Our intent at this time is to address some fundamental criteria that must be taken into consideration by outside parties interested in submitting non-MedPAR data.

We note that the timetable we set forth in the proposed rule is intended to provide adequate opportunity to permit outside parties to conform their data to our needs through testing and resubmission. This is the primary reason we believe it is generally necessary to have a sample of the data 8 months prior to the publication of the proposed rule. We are willing to meet with outside parties interested in submitting non-MedPAR data for consideration, and would suggest that those interested in submitting such data in the future should contact us to discuss the specific data they wish to submit and whether the data may be adequate.

Comment: One commenter, while supporting the idea that the data must be reliable and verifiable, indicated that HCFA should consider other means by which to accomplish this purpose. The commenter stated that many of the sources for data are restricted from releasing identifying elements of the data they collect. The commenter claimed, for example, that they could validate the method by which the data were assembled, thereby alleviating our concern that the cases may not represent Medicare beneficiaries or that the reported charges are inaccurate.

Response: We are open to considering any feasible method for validating non-MedPAR data, and that is why at this time we are not specifying explicit criteria for the types of data we will or will not consider. Instead, we have outlined general guidelines and fundamental objectives that must be met. One of those fundamental objectives is that we must be able to validate the data and to accurately identify cases to be reclassified during DRG recalibration.

In order to preserve the integrity of the DRG reclassification and recalibration process, we generally believe it is imperative that we are able to independently validate the data submitted. As noted previously, if we receive non-MedPAR data that purport to reflect cases involving a certain procedure and a certain level of charges, we must have some way to verify that data. In addition, it is not enough to simply decide that a particular diagnosis or procedure code should now be classified to a higher-weighted DRG. Cases in the MedPAR data used for recalibration with that diagnosis or procedure code should be reclassified accordingly. Otherwise, these cases will affect the calculation of the relative weights of other DRGs. Therefore, in order to allow us to ensure the accuracy of DRG recalibration, we must have some mechanism for ensuring that DRG weights are not inappropriately inflated.

Comment: Some commenters stated that the criteria regarding the feasibility of using the data are inconsistent with the intent of the Conference Report language. The commenters contend that there is no need to identify each case involving a new technology. Rather, the agency can extrapolate the findings from a representative sample of cases and estimate which cases must be moved from one DRG to another. Two of the commenters stated that this approach was used in reclassifying lithotripsy to an appropriate DRG, and that extrapolation is used to some degree in setting the physician fee schedule and was used in the proposed outpatient prospective payment system. One commenter wanted us to clarify that we would accept a representative, statistically valid sample of both non-HCFA and HCFA data that reflect cases for a period of less than a full year, as well as requesting that we specify the sources (for example, private payers, manufacturers of medical technologies, or suppliers) from which we are willing to accept such data.

Response: We did not rule out the use of extrapolation based on non-MedPAR data in the proposed rule. In fact, we stated that the data must reflect either a complete set of cases, or, at a minimum, a representative sample of hospitals and claims. However, as stated previously, the process of recalibrating the DRG weights requires that cases be moved consistent with the reclassification of diagnosis or procedure codes from one DRG to another. Failure to do so could lead to inflated or deflated relative weights, which, in turn, result in over or underpayments for cases in the affected DRGs.

We are attempting to accommodate the realities faced by outside parties as they attempt to collect and present non-MedPAR data for consideration. In addition, we will continue to explore our processes for ways to incorporate such data while preserving the empirical and clinical integrity of the recalibration process.

As noted by two commenters, in the September 3, 1986 final rule (51 FR 31486), we did, based on analysis by the Prospective Payment Assessment Commission (ProPAC), assign all cases involving a principal diagnosis of urinary stones treated by extracorporeal shock wave lithotripsy (ESWL) to DRG 323 (Urinary stones, age >69 and/or CC). Prior to this DRG change, ESWL cases were assigned to either DRG 323 or DRG 324, depending on the presence of a CC or based on the patients age (over 69). The Commission, an independent advisory body established by Congress (and MedPAC's predecessor organization), obtained information on ESWL procedure costs and other routine and ancillary hospital service charges from the American Heart Association (AHA), the American Urological Association, and seven hospitals that furnished ESWL. In addition, ProPAC obtained a preliminary summary of a study conducted by the Institute for Health Policy Analysis at Georgetown University Medical Center. This study included cost data from 16 hospitals that furnished lithotripsy. At the time of these studies, approximately 50 hospitals were furnishing ESWL. Because the ProPAC data were obtained directly from hospitals and were verified by the Commission at the

hospital level, we believed the data were reliable and used the data as a basis for reassigning ESWL cases to DRG 343 only. A full explanation of the study and ProPAC's analysis and recommendations can be found in the Technical Appendixes that accompanied ProPAC's April 1, 1986 Report to Congress.

We have not precluded using either external or internal data that represent less than a full year's worth of cases. For example, we could examine a partial year's worth of cases from the current Federal fiscal year rather than the preceding year's complete MedPAR. Once again, however, a feasible approach must be developed to enable the appropriate classification and recalibration of the DRG weights.

Finally, we do not believe it is necessary, or appropriate, to identify in advance the sources from which we are willing to accept data. At this time, we remain open to considering any data source that is reliable, verifiable, and feasible. We would note, however, that involving hospitals in any data collection would probably aid HCFA in any validation effort. Generally, if we receive non-MedPAR data, we will be contacting the hospitals that furnished the sources to verify some or all of the data.

Comment: Two commenters stated the timeframe for submission of the non-MedPAR data is unreasonable. They suggested that the submission of data 7 months before the updated DRGs take effect (March 1) in the case of internal HCFA data, and 8 months (February 1) in the case of external data, would more appropriately ensure beneficiary access.

Response: The length of time necessary to validate non-MedPAR data depends on the nature and quality of the data. In the proposed rule, we stated that a significant sample of the data should be submitted by August 1, approximately 8 months prior to the publication of the proposed rule, so that we can verify and test the data and make a preliminary assessment as to the feasibility of the data's use. Subsequently, a complete database should be submitted no later than December 1, approximately 4 months prior to the publication of the proposed rule.

We do not believe that this timeframe is unreasonable. If we were to adopt the commenter's suggestion, we would receive non-MedPAR data only 2 months before the proposed rule is scheduled to be published (April 1). This might not allow us sufficient time to ensure that the data are reliable or valid prior to their use in preparing the proposed rule.

We believe the timeframe we set forth is necessary to enable us to independently validate any non-MedPAR data submitted. In order to verify the data's reliability and validity, we believe we need to review a sufficient number of the medical records associated with the data. Expecting us to be able to accomplish this in a matter of weeks after receiving the data (which is all the time that would be available for data received in February due to the requirement to begin the process of reclassifying and recalibrating the proposed DRGs by the end of February in order for the proposed rule to be published by April 1) is unrealistic.

Comment: Many of the commenters, including the manufacturer of the platelet inhibitor drug, national associations representing device and drug manufacturers, and individual cardiologists, argued that our current process has inhibited the development of new medical technologies, and that the criteria for the use of non-MedPAR data are unworkable and would further slow the development of new technologies. Several commenters asserted that certain new technologies (including platelet inhibitors) are denied to Medicare beneficiaries due to insufficient payment.

Response: After 15 years of administering the prospective payment system, we do not have any independent evidence that Medicare beneficiaries are being denied access to new technologies by hospitals or physicians. Although we have always acknowledged that there is a time-lag between the time new technologies are introduced and the point at which we can begin to accurately identify their associated costs, we believe this has not hampered Medicare beneficiaries' access to these new technologies. The fact that under the prospective payment system a hospital might lose money on some cases but will gain money on other cases is well understood by hospitals. We received no comments from hospitals or beneficiary advocates complaining about access to new technologies in general or drug therapies in particular, and only a brief comment from a State hospital association that indicated that the use of non-MedPAR data should extend beyond drug therapies. Furthermore, as provided in § 489.53(a)(2), HCFA may terminate its participation agreement with any hospital if HCFA finds that the hospital places restrictions on the persons it will accept for treatment and it fails either to exempt Medicare beneficiaries from those restrictions or to apply them to Medicare beneficiaries the same as to all people seeking care.

Comment: Several commenters, including the manufacturer of a platelet inhibitor drug and individual cardiologists, specifically commented on our discussion in the proposed rule of the attempts by the manufacturer of the drug to introduce its data into the process, with the objective that cases in which platelet inhibitor therapy is administered should be reclassified from DRG 112 (Permanent Cardiovascular Procedures) to DRG 116 (Other Permanent Cardiac Pacemaker Implant or PTCA with Coronary Artery Stent Implant) for FY 2000. The commenters stated that HCFA has been unwilling to consider the data. One commenter stated that HCFA refused to accept these data when they were offered in December 1998.

Response: As discussed in great detail above, and also in the FY 1999 final rule, our review of the previous data submitted by the drug manufacturer found the data to be insufficient. Despite our consultation with the manufacturer's representatives in advance of their submission of data during the rulemaking process for FY 1999 (that is during the first half of calendar year 1998), in which we advised them that we must be able to identify individual hospitals and patients in order to utilize the data, this information was not included on over 90 percent of the cases submitted in May 1998. As noted in the May 7, 1999 proposed rule, we continued to meet and correspond with the manufacturers, contractors, and legal representatives of the pharmaceutical company in an effort to resolve data issues. At no time have we refused to consider any data offered by the company or its agents.

However, our discussions with these parties led us to the conclusion that it might be helpful to identify general criteria for submission of non-MedPAR data in the proposed rule. In particular, we were concerned that outside parties wishing to submit non-MedPAR data were unfamiliar with our current process and the importance of accurately reclassifying and recalibrating the DRGs. The DRG relative weights are the principle factor in adjusting the prospective payments for each of approximately 11 million Medicare discharges each year. In addition to the potential financial implications to the Medicare Trust Fund and to hospitals themselves if these weights are inaccurate, inappropriately assigning cases to higher-weighted DRGs may create incentives that are not in the best interest of Medicare beneficiaries.

We are hopeful that, by explaining the general criteria for submitting non-

MedPAR data and receiving public comments on those criteria, we can help to ensure that in the future those interested in submitting non-MedPAR data will be better informed regarding how the process can work. In particular, we believe the timeframe we set will enable us to work effectively with those interested in submitting non-MedPAR data to help them provide data that can be used.

Comment: A manufacturer of a platelet inhibitor drug expressed concern that HCFA may assign a special DRG classification for patients who receive coronary intervention with an angioplasty and treatment with platelet inhibitor therapy, but not for acute coronary syndrome patients who receive the same drugs without coronary intervention. These latter cases are assigned to DRG 124 (Circulatory Disorders Except Acute Myocardial Infarction, with Cardiac Catheterization and Complex Diagnoses) or DRG 140 (Angina Pectoris). The commenter stated that if we were to modify payment for one use and not the other, it would potentially create a financial incentive for expensive, risky, and invasive treatment. Making payment provisions for both indications at the same time, on the other hand, will give neither use an advantage over the other. We were asked by the commenter to evaluate platelet inhibitor therapy cases assigned to DRG 124 or DRG 140.

Response: Because this is the first comment we have received regarding the noncoronary intervention use of the therapy, an extensive study of DRGs 124 and 140 before publication of this final rule was not feasible. We will evaluate this issue as part of our annual update for FY 2001, when we will have MedPAR data capturing injection or infusion of platelet inhibitor (ICD–9–CM procedure code 99.20). This commenter's concern that increasing payment for one application of platelet inhibitors but not for others could actually create an inappropriate incentive in favor of a more invasive treatment, illustrates the importance of proceeding cautiously in the process of DRG reclassification and recalibration. We have a responsibility not to inadvertently create financial incentives that adversely affect clinical decisionmaking.

Comment: During the comment period, we received a revised set of data from the manufacturer seeking to have platelet inhibitor therapy cases receiving angioplasty reclassified from DRG 112 to DRG 116. The data contain 27,673 cases from 164 hospitals in which Medicare patients underwent an angioplasty. The commenter describes the data as Athe public MedPAR file with an additional field that identifies the MedPAR case as involving an angioplasty with or without platelet inhibitor therapy. Thus, HCFA can identify the patient and the hospital from these data such that they are reliable and verifiable. It also is a representative sample of claims and, therefore, it is feasible for the agency (HCFA) to use the data set. In light of the significant number of angioplasty cases contained in the data, HCFA should be able to utilize accepted statistical methods to extrapolate the results of these data and recalibrate the DRG weights.@ The manufacturer indicated that HCFA should reclassify angioplasty cases with platelet inhibitor therapy on the basis of these data.

Included with the comment are tables summarizing the results of the commenter's analysis of the data, showing that angioplasty cases receiving platelet inhibitor therapy are more expensive than those not receiving platelet inhibitors. According to the commenter, the approximate average standardized charges for the different classes of patients are as follows:

- No drug, no stent: $19,877.
- No drug, with stent: $22,968.
- Drug, no stent: $26,389.
- Drug, stent: $30,139.

Response: The submission of these data illustrates the problems of attempting to ensure that non-MedPAR data are reliable, validated, and feasible to use. Our greatest concern with respect to the data submitted by the commenter is that we must validate the data to assess whether they are reliable, and (as explained further below) this validation process would take significant time and resources because the data are not readily verifiable.

The data file submitted by the commenter is a MedPAR file with an additional field. The commenter has ''marked'' certain cases in the MedPAR file. The file contains variables named REO–FLAG and STENT–FLAG, which purportedly indicate the case received the platelet inhibitor or a coronary stent, respectively. However, the variables were placed in the file by the commenter, based on information that was not made available to HCFA; we did not receive any information to verify that the cases flagged by the commenter involved platelet inhibitors. Although we can use the FY 1998 MedPAR data to validate whether a case received a coronary stent (because the FY 1998 MedPAR data include the corresponding procedure code (36.06)), we cannot use the FY 1998 MedPAR file by itself to validate whether a case involved platelet inhibitors because the procedure code for the use of platelet inhibitors (procedure code 99.20) was not effective until October 1, 1998. Therefore, we cannot validate the data submitted to us without further investigation.

In order to do so, we believe it is necessary to review the medical records associated with the cases. Unless the entity submitting the non-MedPAR data includes medical records (or other information that would enable us to validate the data), the only method HCFA has to review medical records is through Peer Review Organization (PRO) review. Thus, we would need to request assistance in the PRO in each of the States represented in the submitted data. The PROs would then contact the hospitals involved to request copies of the medical records. Finally, based on reviewing those records, the PROs would notify HCFA whether the data can be validated.

Conducting a PRO independent validation would require a minimum of 2 to 3 months, and possibly much longer. Thus, there is not sufficient time available to conduct a review of the data submitted by the drug manufacturer. Since we cannot validate the data, it would compromise the integrity of the DRG recalibration process to use these data in the DRG reclassification and recalibration for FY 2000.

We note that the process used by the manufacturer to collect these data is not specified. Based upon our prior discussions with the manufacturer and its contractor that prepared the data, we believe the 164 hospitals represented in the sample have a contract for data analysis and review with the consultant. Although we would not rule out the possibility that this sample is statistically sufficient, we note that in general, random sampling is necessary for generalization beyond the sample itself.

The analysis submitted by the commenter is similar to that presented in last year's final rule. As we indicated at that time, our general process of waiting until we have identifiable MedPAR data applies to changes that would enhance payment as well as those that would decrease payment. Absent alternative data meeting the criteria otherwise described in the proposed rule and in this final rule, we cannot reclassify the administration of platelet inhibitors with angioplasty (procedure code 99.20) from DRG 112 to DRG 116.

Comment: Some commenters believed that the proposed weights for DRGs 112 and 116 are dramatically lower than they should be and the result will be a disincentive to use these technologies.

Another commenter stated that by not reclassifying cases receiving platelet inhibitors with angioplasty to DRG 116, we actually promote the inaccuracy of the DRG weights, by grouping these higher-cost cases with other lower-cost cases in DRG 112.

Response: With regard to the comment concerning the weights of DRGs 112 and 116, we refer the commenters to the discussion above in section II.C of this preamble concerning the steps we take in recalibrating the weights. Every year when the relative weights are recalibrated, we use charge information from the most recent Medicare data available. That is, we use the charges reported by hospitals for the cases under each DRG to establish the relative weights. Each DRG weight represents the average resources required to care for cases in that particular DRG relative to the average resources used to treat cases in all DRGs. We have not identified any problems or anomalies related to the cases in DRGs 112 and 116 and are confident that the relative weights are accurate.

With respect to the comment about our promoting the inaccuracy of the DRG weights by failing to reclassify platelet inhibitor cases, the commenter does not appear to understand the difference between reclassification and recalibration. That is, the commenter argues that the DRG relative weights are inaccurate because high-cost cases are not reclassified to a higher-weighted DRG. However, our point regarding the accuracy of the relative weights pertains to the necessity that, in the process of recalibration, cases are grouped in the DRG to be used for payment for similar cases during the upcoming year. Thus, the relative weights are accurate in the sense that they are calculated by grouping cases according to the DRG under which they would be paid.

Comment: One of the manufacturers of platelet inhibitor therapy disagreed with our statement in the proposed rule that the prospective payment system outlier policy would address the rationing of new technology to Medicare beneficiaries. The commenter argues that cases of platelet inhibitor therapy would not receive outlier payments because the cost of the drug, while it is several thousand dollars over the DRG payment, is not in excess of the fixed loss threshold ($14,575 over the DRG payment in the proposed rule for FY 2000).

Response: 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. Our statement in the proposed rule was meant to apply to all new technologies, and not specifically to platelet inhibitor therapy. As stated previously, the prospective payment system reflects ''averaging principles,'' which means, among other things, that a hospital might lose money on some cases but will gain money on other cases; sometimes new technologies lead to lower costs and we might Aoverpay@ hospitals for those cases. If a case does not qualify for an outlier payment, then presumably the case falls within the ''typical'' range of costs for cases in the DRG. We believe that, as a whole, the prospective payment system does ensure access to new technologies, including platelet inhibitor therapy.

III. Changes to the Hospital Wage Index

A. Background

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

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

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

B. FY 2000 Wage Index Update

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

The final FY 2000 wage index includes the following categories of data associated with costs paid under the hospital inpatient prospective payment system (as well as outpatient costs), which were also included in the FY 1999 wage index:

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

Consistent with the wage index methodology for FY 1999, the final wage index for FY 2000 also continues to exclude the direct and overhead salaries and hours for services not paid through the inpatient prospective payment system, such as skilled nursing facility services, home health services, or other subprovider components that are not subject to the prospective payment system. (As discussed in section III.C of this preamble, we are refining the methodology for calculating the wage index for FY 2000.)

We calculate a separate Puerto Rico-specific wage index and apply it to the Puerto Rico standardized amount. (See 62 FR 45984 and 46041.) This wage index is based solely on Puerto Rico's data. Finally, section 4410 of the BBA provides that, for discharges on or after October 1, 1997, the area wage index

applicable to any hospital that is not located in a rural area may not be less than the area wage index applicable to hospitals located in rural areas in that State.

Comment: In a general comment on the wage index, MedPac noted that new measures are needed to implement each new prospective payment system as well as for Medicare+Choice plans and suggested that we explore alternative strategies for obtaining labor prices that could be applied to each type of provider affected. MedPAC offers to assist us in examining this issue.

Response: We agree with MedPAC that this is an area warranting further attention to determine whether it is appropriate to continue to adjust payments for these other provider types based on the relative average hourly wages of hospital employees, and whether the collection of wage data for every type of Medicare provider is feasible or necessary. Currently, the data used to calculate the hospital wage index is used broadly in payment systems for other types of Medicare providers. New prospective systems for skilled nursing facilities, hospital outpatient services, and home health agencies will continue to use the hospital wage index data for the foreseeable future. We have collected data separately for skilled nursing facilities, but, pending further development and auditing of these data, we continue to use the hospital wage data (before reclassifications by the Medicare Geographic Classification Review Board) for adjusting skilled nursing facility payments at this time.

C. FY 2000 Wage Index Methodology Changes

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

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

Comment: Commenters unanimously supported our proposal to remove teaching-related and CRNA costs from the wage index. Further, two commenters recommended that we emphasize that Medicare pays its share of teaching-related wage costs through direct graduate medical education (GME) payments and that these costs are being removed from the wage index only insofar as Medicare continues to pay the costs outside of the hospital prospective payment system. Additionally, commenters favored the proposed 5-year phase-out of these costs to reduce significant redistributive impacts.

MedPAC, however, recommended that, rather than reducing the weights for the old calculation and increasing the weights for the new calculation by the proposed 20 percent each year, we should apply smaller weights to the new wage index calculation for the first 2 years. Its rationale for this is its concern that inaccurate reporting of teaching physician data, and our methodology for removing costs for hospitals that fail to report these data, may inappropriately lower the wage index values for nonteaching hospitals in the same labor market areas.

Response: We are pleased to receive strong support for our efforts to remove from the hospital wage index, wage costs that are associated with areas of the hospital not included under the hospital prospective payment system. Therefore, beginning with the FY 2000 wage index, and over a 5-year period, we are phasing-out costs related to teaching physicians, residents, and CRNAs. As recommended, we emphasize that our rationale for removing these costs from the wage index calculation is that Medicare pays for these costs separately, and these costs will be excluded from the wage index as long as they are paid separately from the hospital prospective payment system.

With respect to MedPAC's recommendation that the weight given to the average hourly wage calculated after removing CRNAs, teaching physicians, and residents, should be less than 20 percent for FY 2000, we disagree. If we applied a percentage less than 20 percent for FY 2000 (and FY 2001), we then would have to apply a higher percentage phase-out in a later fiscal year (or years) and thus increase the redistributive impact for that year. We believe that applying 20 percent increments each year promotes the smoothest transition to total exclusion of the costs.

1. Teaching Physician Costs

As discussed in the FY 1999 final rule and the FY 2000 proposed rule, before FY 1999, we included direct physician Part A costs and excluded contract physician Part A costs from the wage index calculation. Since some States prohibit hospitals from directly employing physicians, hospitals in these States were unable to include physician Part A costs because they were incurred under contract rather than directly. Therefore, for cost reporting periods beginning in 1995, we began separately collecting physician Part A costs (both direct and contract) so we could evaluate how to best handle these costs in the wage index calculation. Based on our analysis of the 1995 wage data, we decided to include the contract physician salaries in the wage index beginning with FY 1999.

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

Because the FY 1996 cost reports did not identify teaching physician salaries and hours separately from physician Part A costs, we instructed our fiscal intermediaries to collect, through a survey, teaching physician costs and hours from the teaching hospitals they service. Specifically, we requested collection of data on the costs and hours related to teaching physicians that were

included in Line 4 (salaried), Line 10 (contracted), Line 12 (home office and related organizations), and Line 18 (wage-related costs) of the Worksheet S–3, Part II. In our instructions accompanying the survey, we indicated that these teaching-related costs are those payable under the per resident amounts (§ 413.86) and reported on Worksheet A, Line 23 of the hospital's cost report.

Survey data were received from approximately 59 percent of teaching hospitals reporting physician Part A costs on their Worksheet S–3, Part II (500 out of 845). Our fiscal intermediaries reviewed the survey data for consistency with the Supplemental Worksheet A–8–2 of the hospitals' cost reports. Supplemental Worksheet A–8–2 is used to apply the reasonable compensation equivalency limits to the costs of provider-based physicians, itemizing these costs by the corresponding line number on Worksheet A.

Hospitals were given until March 5, 1999 to request changes to the initial survey data. Fiscal intermediaries had until April 5, 1999 to submit the revised data to the Health Care Provider Cost Report Information system (HCRIS) for inclusion in the May 1999 final wage data file. Due to the extraordinary effort needed to collect these data and the importance of accurately removing teaching physician costs, we allowed hospitals to request revisions to their teaching survey data up until June 5, 1999.

The hospital industry workgroup also recommended that if the teaching data collected by the intermediaries are not accurate or reliable, HCFA should include only 20 percent of reported physician Part A costs in the calculation, based on the assumption that 80 percent of total physician Part A costs are related to teaching physicians. In developing the final FY 2000 wage index (as in the proposed), if we had complete survey data for a hospital, that amount was subtracted from the amount reported on the Worksheet S–3 for physician Part A costs. These data had been verified by the fiscal intermediary before submission to us. If we did not have survey data for a teaching hospital as of June 5, 1999, we removed 80 percent of the hospital's reported total physician Part A costs and hours for the wage index.

Although removing 80 percent from the amount reported on the Worksheet S–3 for physician Part A costs allows an estimate of teaching physician costs to be removed in the majority of cases in which survey data are not available, there are instances in which a teaching hospital did not report either survey data or any physician Part A costs on its Worksheet S–3. We identified 19 of these teaching hospitals in our final database (there were 72 of these hospitals identified in the proposed rule). For purposes of calculating the FY 2000 wage index for these 19 hospitals, we subtracted the costs reported on Line 23 of the Worksheet A, Column 1 (Resident and Other Program Costs) from Line 1 of the Worksheet S–3. These costs (from Line 23, Column 1 of Worksheet A) are included in Line 1 of the Worksheet S–3, which is the sum of Column 1, Worksheet A. They also represent costs for which the hospital is paid through the per resident amount under the direct GME payment.

We believe this approach is appropriate in situations in which hospitals have failed to otherwise identify their teaching physician costs. To determine the hours to be removed, we divided the costs reported on Line 23 of Worksheet A, Column 1 by the national average hourly wage for physician Part A costs based upon Line 4 of Worksheet S–3 (the national average hourly wage is $54.48). We indicate these 19 hospitals by an asterisk in Table 3C of this final rule.

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

Comment: Two commenters disagreed with our decision to allow changes to the teaching survey data but not to corresponding lines on Worksheet S–3 during the final wage data correction period (June 5 deadline). They believed we should be willing to accept conforming wage data corrections, even during the final correction period, to achieve the goal of using the most accurate data available.

Response: If hospitals had miscategorized their teaching physician costs on their cost report in such a way that accurately completing the teaching survey would result in their teaching physician survey costs being removed twice, we did authorize corresponding revisions to Worksheet S–3. For example, some hospitals included teaching physician costs in Line 6 of their Worksheet S–3 (which is intended for reporting interns and residents' costs). Therefore, reporting these costs on their teaching physician survey, which would be subtracted from Line 4 for the salaries of teaching physicians directly employed by the hospital, would result in them being removed twice, once when the teaching physician data are subtracted from Line 1 of Worksheet S–3, and again when Line 6 of Worksheet S–3 is subtracted from Line 1.

Comment: We received several comments regarding our proposal to use the teaching survey data for teaching hospitals that submitted surveys but to remove 80 percent of the total physician Part A costs and hours for nonresponsive teaching hospitals. Most commenters supported our reliance on the teaching survey data for the FY 2000 wage index. One commenter added that we should be assertive in insisting that teaching survey data be reported accurately by hospitals and verified by fiscal intermediaries, holding hospitals to a level of accountability that is similar to the certification of a cost report at filing. Another commenter urged us to incorporate the separate collection of teaching physician Part A data into the cost report as soon as possible to ensure that the data submitted by hospitals is consistent.

Although most commenters agreed that we should reduce reported total physician Part A costs by 80 percent for teaching hospitals that do not submit the teaching survey, some took issue with this approach. One national and one State hospital association recommended we remove 100 percent of reported total physician Part A costs from nonresponsive teaching hospitals' total costs as a penalty for not reporting their data. The commenters believe that, for hospitals whose proportion of teaching physician Part A costs relative to total physician Part A costs is greater than 80 percent, there is no incentive to complete the teaching survey. On the other hand, MedPAC recommended that, since HCFA's preliminary teaching survey data indicate that teaching physician Part A costs are 68 percent of total physician Part A costs, we should have adjusted the hospital's data by that amount rather than the higher 80

percent figure. MedPAC comments that, although using the 80 percent figure may give hospitals the incentive to submit the requested survey data if their ratio of teaching physician Part A costs to total physician Part A costs is less than 80 percent, that amount could inappropriately lower the wage index values for other hospitals located in the same MSA as the nonresponsive teaching hospital. The comments do acknowledge, however, the policy dilemma in terms of the incentives not to report that may arise by setting the percentage too low.

Response: We appreciate the commenters' general support of using the survey data, as well as the efforts of hospitals and the fiscal intermediaries in this special data collection effort. We believe that, although the response rate is less than we would have preferred, the end result is a more accurate FY 2000 wage index.

Although Worksheet S–3 is being revised to provide for the separate reporting of teaching physician Part A costs, this change will not be incorporated until cost reporting periods beginning during FY 1998. Therefore, we will have to conduct another teaching physician cost survey corresponding with the FY 1997 wage data. We agree with the commenter's suggestion that the accuracy and completeness of the survey data should be certified by the hospital in the same manner as the accuracy and completeness of the cost report data must be certified.

In our calculation of the FY 2000 wage index, we removed 80 percent of physician Part A costs and hours for teaching hospitals that failed to report their teaching physician costs. We will consider the comment to remove 100 percent of these costs for nonresponsive hospitals in the future, however. Although the 80 percent figure was taken from the industry workgroup's recommendation, we believe it may be appropriate to consider raising this percentage to address the problem of hospitals failing to comply with Medicare instructions.

We appreciate MedPAC's concern that the estimation of teaching physician costs for hospitals that did not report should not disproportionately harm other hospitals in the same labor market area. Similarly, however, these hospitals should not benefit from noncompliance. Also, as noted previously, because the teaching physician costs are being removed gradually, with 80 percent of the FY 2000 wage index based on an average hourly wage that includes all of these costs, we do not believe it is necessary to reduce the 80 percent estimate to an amount based on the percentage of teaching physician Part A costs to all physician Part A costs for hospitals completing the survey to protect other hospitals in the labor market area. Any impact should be relatively minor for this first year.

Comment: Two commenters believed that hospitals that contract with physicians for Part A services are disadvantaged because the cost report and teaching survey instructions seem to be designed only for hospitals that employ physicians.

Response: The cost report and teaching survey do account for the costs of contract physicians. The first year contract physician Part A costs were included in the wage index was FY 1999. Beginning with the FY 1995 cost report, we revised Worksheet S–3 to allow a separate line item for reporting these costs. To improve the reporting for all physician-related wage costs, we made additional changes to the FY 1996 cost report. The teaching survey was patterned after the FY 1996 Worksheet S–3.

The salaries on the Worksheet S–3 for employed physicians derive from column 1 of Worksheet A. Hospitals should report the labor costs associated with contract physicians in column 2 of that same worksheet. If hospitals report their costs properly according to the cost report instructions, hospitals using contract physicians will not be disadvantaged by the way the costs are reported. We encourage hospitals to be diligent in working with their intermediaries if they have questions about reporting costs on the cost report.

Comment: We received four comments regarding the use of Worksheet A, Line 23, Column 1 as a proxy for teaching-related wage costs when a teaching hospital did not report either survey data or any physician Part A costs. One was favorable without qualifications. One commenter recommended that, beginning with the FY 2001 wage index, we should instruct hospitals to report on Worksheet S–3 the wage costs associated with teaching physicians directly from Worksheet A, Line 23 and the corresponding hours directly from hospitals' records. A national hospital association recommended that if we use Worksheet A, Line 23 for teaching salaries and a national average hourly wage for physicians to estimate the associated hours to be removed for nonreporting hospitals, then we should apply this approach to all hospitals. If we apply this method only to hospitals that do not respond to the teaching survey, the commenter believed that we should penalize nonresponsive hospitals by increasing the hourly rate by 25 percent to ensure they are not advantaged by not reporting their costs.

Several hospitals contacted us to report that, although they were listed as one of the 72 hospitals for whom we used Line 23 of Worksheet A to remove teaching physician costs, these costs were actually included in other lines of Worksheet S–3, such as Line 5, Physician Part B services, or Line 6, Interns and Residents. Therefore, since both of these lines are subtracted from Line 1 in our calculation, subtracting Line 23 from Worksheet A would remove these costs twice.

In opposing the use of Line 23 as a proxy for teaching-related costs, one commenter cautioned that, particularly for hospitals in States that are prohibited from employing physicians, Line 23, Column 1 may not include any teaching physician costs. MedPAC also stated concern with this approach, but did not cite any specific problems associated with it.

Response: For FY 2000, we are removing the amount reported on Worksheet A, Line 23, Column 1, only in the absence of teaching survey or Worksheet S–3 data for a hospital but we will continue to explore using this approach rather than the survey for identifying GME and CRNA costs to be removed in the FY 2001 wage index. The approach we adopted has the advantage of being straightforward and easy to apply. Line 1, Column 1 of Worksheet S–3 is equal to Line 101 of Column 1 of the Worksheet A. Line 23 of Column 1, which is for the reporting of nonresidents' costs related to GME that are paid separately from the prospective payment system, is included in Line 101. Therefore, one could argue that the simplest way to remove GME costs from the wage index calculation would be to subtract the costs from Line 1 of Worksheet S–3 that are attributable to the GME cost centers on Worksheet A (Lines 22 and 23).

In carving out an estimate of hours for the final 19 hospitals for which we subtracted Line 23 of Worksheet A from total salaries on Worksheet S–3, we removed an estimated amount of associated hours based on the average hourly wage of all physician Part A salaries. We did not increase this average hourly wage by 25 percent as a penalty for hospitals that did not otherwise report teaching physician costs. We do reserve the right to remove some or all of a hospital's wage data that cannot be appropriately supported by the hospital's records. We also reserve the right to pursue further action in the case of hospitals that intentionally withhold, conceal, or otherwise attempt

to circumvent the cost reporting requirements of their participation agreements.

If we were contacted timely by a hospital that reported its costs from Line 23 of Worksheet A somewhere other than Line 4 of the Worksheet S–3, we did accommodate the hospital's request to avoid removing the teaching physician Part A costs twice. We note that the majority of these situations involved hospitals that did not follow the cost reporting instructions for these costs. Despite MedPAC's general concerns about this approach to removing costs, we did not receive any comments that would cause us to rule out this seemingly straightforward approach for removing GME and CRNA costs from the FY 2001 wage index for all teaching hospitals. The biggest difficulty seems to be related to ensuring that the cost reporting instructions are uniformly followed.

Comment: Two commenters suggested using Worksheet A–8–2 of the cost report, ''Provider-Based Physicians Adjustments,'' to determine physician Part A costs, particularly for costs associated with teaching and contract physicians. The commenters reasoned that, because Worksheet A–8–2 is used to determine allowable cost and hours to be included in the Medicare cost report, HCFA should use Worksheet A–8–2 to determine physician Part A labor costs for wage index purposes. Use of the Worksheet A–8–2 would also ensure the wage index includes only those physician costs paid under Part A. One of the commenters commended us for requesting intermediaries to compare the teaching survey and Worksheet A–8–2 data, but suggested that we should also require intermediaries to use Worksheet A–8–2 data for determining teaching physician wage costs when the survey data are unacceptable.

Response: We agree that, if properly completed, Worksheet A–8–2 should be an acceptable source for teaching physician Part A data. In February, we instructed intermediaries to review hospitals' teaching survey data for consistency with Worksheet A–8–2, and when necessary, revise the data accordingly. One minor problem with relying solely on Worksheet A–8–2 is that it may include some wage-related costs that are excluded from the wage index calculation; however, these should be insignificant. We believe that Worksheet A–8–2 is an appropriate source for physician Part A costs. However, we need to examine Worksheet A–8–2 more closely before requiring that it be used to determine physician part A costs for future wage indexes.

Comment: We received two comments recommending that we remove overhead costs associated with the teaching physician, resident, and CRNA direct costs that are excluded from the wage index. The commenter compared this action to our current policy in which we remove the overhead costs associated with excluded providers such as skilled nursing facilities or rehabilitation units from the wage data. One commenter offered technical assistance to HCFA in this effort.

Response: We agree, in principle, that overhead costs associated with teaching-related and CRNA labor costs should be removed from the wage index calculation in the same way that we remove overhead costs associated with excluded areas of the hospital. However, we believe that the methodology we apply for specific patient care cost centers excluded from the wage data may not be appropriate for removing overhead related to CRNA and GME costs. Therefore, we are grateful for the commenter's offer of technical assistance to develop an appropriate methodology for allocating overhead costs related to CRNAs and GME. We anticipate that this issue will be discussed by HCFA's wage index workgroup later this year, and in next year's proposed rule for FY 2001.

2. Resident and CRNA Part A Costs

The wage index presently includes salaries and wage-related costs for residents in approved medical education programs and for CRNAs employed by hospitals under the rural pass-through provision (§ 412.113(c)). Because Medicare pays for these costs outside the prospective payment system, removing these costs from the wage index calculation would be consistent with our general policy to exclude costs that are not paid through the prospective payment system. However, because these costs were not separately identifiable on Worksheet S–3 before the FY 1995 wage data, we could not remove them.

We began collecting the resident and CRNA wage data separately on the FY 1995 cost report. However, there were data reporting problems associated with these costs. For example, the original FY 1995 cost report instructions for reporting resident costs on Line 6 of Worksheet S–3, Part III, erroneously included teaching physician salaries and other teaching program costs. Also, the FY 1995 Worksheet S–3 did not provide for separate reporting of CRNA wage-related costs. These problems were corrected in the reporting instructions for the FY 1996 cost report, and, therefore, we proposed and are now implementing the removal of CRNA and resident costs over a 5-year period, beginning with the FY 2000 wage index.

We received no comments related to this change.

3. Transition Period

The FY 2000 wage index is based on a blend of 80 percent of hospitals' average hourly wages without removing the costs and hours associated with teaching physician Part A, residents, and CRNAs, and 20 percent of the average hourly wage after removing these costs and hours from the wage index calculation. This methodology is consistent with the recommendation of the industry workgroup for a 5-year phase-out of these costs. The transition methodology is discussed in detail in section III.E of this preamble.

Comment: One hospital believed that it has been disadvantaged by HCFA's allowance of contract teaching physician Part A costs in the FY 1999 wage index, and that HCFA should disallow teaching physician costs entirely, beginning with FY 2000. The hospital stated that it is experiencing difficulty meeting the criteria for geographic reclassification for purposes of the wage index to another MSA that includes a teaching hospital that reports a large amount of contract teaching physician Part A costs.

Response: Our reasons for including contract physician Part A costs are discussed in detail in the July 31, 1998 **Federal Register** (63 FR 40967). In general, it was our belief that if contract physician Part A costs were reliably reported by hospitals, they should be included in the wage data along with the Part A costs of directly employed physicians. In that final rule, we also discussed our position that, to the greatest degree possible, the hospital wage index should reflect the wage costs associated with the areas of the hospital included under the hospital inpatient prospective payment system. Therefore, based on data we have collected since that final rule was published, and as discussed above, we are removing teaching physician costs (as well as CRNA and resident costs) for the wage data, over a 5-year period.

As is generally true with changes in the wage index, hospitals that may have once been eligible to reclassify to another MSA for purposes of the wage index may find that they no longer qualify after changes have been implemented. However, we believe that all our changes to the wage index are designed to more accurately reflect the wage costs incurred by hospitals. In the case of the teaching physician costs, we

believe that a 5-year phase out is appropriate to reduce significant redistribution impacts. With regard to the accuracy of the teaching hospital data, the intermediary verified the data and determined it is consistent with audit findings.

D. Verification of Wage Data from Medicare Cost Reports

The data for the FY 2000 wage index were obtained from Worksheet S–3, Parts II and III of the FY 1996 Medicare cost reports. The data file used to construct the final wage index includes FY 1996 data submitted to HCRIS as of early February 1999. As in past years, we performed an intensive review of the wage data, mostly through the use of edits designed to identify aberrant data. In the proposed rule, we discussed our review and methodology for resolving questionable elements in the hospital data (64 FR 24728). The revised data are reflected in this final rule. Since the proposed rule, we deleted data for four hospitals that reported aberrant and unverifiable wage data that would have significantly distorted the wage index values, and added data for seven hospitals that were not included in the proposed wage index but rather whose data have now been corrected and verified. The final FY 2000 wage index is calculated based on FY 1996 data for 5,038 hospitals.

Comment: One hospital association expressed concern that a number of hospitals might have failed to comply with the new cost reporting instructions for wage-related costs, causing an overreporting of these costs in the FY 2000 wage index. Prior to the FY 1996 cost report, the lines on Worksheet S–3 for core and other wage-related costs reflected a hospital's total costs for those categories. However, beginning with the FY 1996 cost report, core and other wage-related costs must be reported net of costs associated with excluded areas. The commenter stated that wage-related costs for a significant number of hospitals increased at least 10 percent this year and it believed that the increase is due to hospitals incorrectly reporting excluded area wage-related costs on Line 13. The commenter recommended that we develop a method to determine if a hospital misreports its wage-related costs, and that we should require correction of the data.

Response: We believe the new cost reporting instructions for wage-related costs, Lines 13 and 14 of Worksheet S–3, Part II, are clear regarding the exclusion of costs associated with excluded areas. Intermediaries were aware of the new cost reporting instructions and instructed their auditors to closely examine the costs reported in Lines 13 and 14 of Worksheet S–3, Part II for compliance. In addition, the intermediaries' FY 1996 wage data review program included an edit for hospitals having wage-related costs that increased 10 percent or more between FY 1995 and FY 1996. Furthermore, we contacted representatives of national hospital associations who agreed to alert their members of the reporting change. We are aware of numerous instances where intermediaries adjusted hospitals' wage-related costs after review. As part of the FY 1997 wage data desk review program (for the FY 2001 wage index), we will provide more specific instructions to the intermediaries to review the data reported for core and other wage-related costs to ensure no costs associated with excluded areas are included.

Comment: One commenter disagreed with the approach we used in the proposed rule to identify teaching hospitals to ensure that all of these hospitals had reported teaching physician survey data. We based our decision to remove either 80 percent of physician Part A costs and hours or the amount on Line 23, Column 1 of Worksheet A, based on whether the hospital had a resident-to-bed ratio greater than zero on the latest Provider-Specific File. The commenter suggested it would be more appropriate to base the identification of teaching hospitals on whether the hospital reported residents on its cost report for the period corresponding with the wage data.

Response: We agree with this comment. It is more appropriate to base the identification of teaching hospitals on data from the same year as the wage data we use. Therefore, we revised our method to identify teaching hospitals based on whether they reported residents during their cost reporting period beginning during FY 1996.

Comment: One State hospital association commented that the underrepresentation of physician Part A costs for hospitals in its State is due to the intermediary's exclusion of a majority of the costs reported by hospitals. The commenter believes there are inconsistencies between the two intermediaries that service hospitals in the State in their treatment of contract physician Part A costs. The commenter recommended that HCFA monitor intermediaries and enforce uniform application of Medicare principles and standards, particularly with regard to the determination of allowable physician costs on Worksheet A–8–2.

Response: For wage index purposes, contract physician costs are to be reported according to the instructions for Worksheet S–3 Part II, Line 10. The physician Part A costs reported on Worksheet S–3 may differ slightly from those reported on worksheet A–8–2 because there are minor differences in the types of wage-related costs that are allowed for each of the worksheets. The two forms serve different purposes. The wage index worksheet (S–3) may include, to a reasonable extent, the actual costs a hospital incurs. However, Worksheet A–8–2 is used to determine allowable costs for Medicare cost report purposes and includes cost limits. The commenter did not indicate exactly what inconsistencies it had found. If there are inconsistencies, we would like to address them as soon as possible for the FY 2001 wage index.

We note that, intermediaries have informed us that hours associated with contract physicians are often difficult to verify because hospitals have not developed reporting systems that accurately account for contract physician hours. Consistent with Medicare policy, intermediaries must exclude costs and other data that are insufficiently supported by a hospital's documentation.

Comment: One commenter noted several errors in the proposed rule and final wage data public use file. The commenter stated that Table 3C of the proposed rule included some hospitals with extremely low average hourly wages, and that the average hourly wages reported for some hospitals marked with an asterisk do not seem to incorporate the Worksheet A, Line 23 data as described in the footnote. Additionally, the commenter stated that the final wage data on the Internet includes two different date formats for fiscal year begin and end dates, an eight digit format and a seven digit format. The commenter asked that HCFA make the appropriate corrections in the final wage index calculation.

Response: We were informed shortly after publication of the proposed rule that there were several errors in Table 3C, including those noted by the commenter. As a result, we issued a revised Table 3C in a correction notice published in the **Federal Register** on June 15, 1999 (64 FR 31995). Although the extremely low average hourly wages still appear in Table 3C of the correction notice just as they were reported by the hospitals, the aberrant data were either corrected or deleted in the final wage index calculation. All other errors identified in Table 3C were corrected through the June 15 notice. Also, fiscal year beginning and ending dates that appear in a 7-digit date format in the final wage data public use file were

corrected to an 8-digit date format in the final calculation.

E. Computation of the Wage Index

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

Step 1—As noted above, we based the FY 2000 wage index on wage data reported on the FY 1996 Medicare cost reports. We gathered data from each of the non-Federal, short-term, acute care hospitals for which data were reported on the Worksheet S–3, Parts II and III of the Medicare cost report for the hospital's cost reporting period beginning on or after October 1, 1995 and before October 1, 1996. In addition, we included data from a few hospitals that had cost reporting periods beginning in September 1995 and reported a cost reporting period exceeding 52 weeks. These data were included because no other data from these hospitals would be available for the cost reporting period described above, and because particular labor market areas might be affected due to the omission of these hospitals. However, we generally describe these wage data as FY 1996 data.

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

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

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

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

Step 4—For each hospital reporting both total overhead salaries and total overhead hours greater than zero, we then allocated overhead costs. First, we determined the ratio of excluded area hours (sum of Lines 8 and 8.01 of Worksheet S–3, Part II) to revised total hours (Line 1 minus Lines 3, 5, and 7 of Worksheet S–3, Part II). We then computed the amounts of overhead salaries and hours to be allocated to excluded areas by multiplying the above ratio by the total overhead salaries and hours reported on Line 13 of Worksheet S–3, Part III. Finally, we subtracted the computed overhead salaries and hours associated with excluded areas from the total salaries and hours derived in Steps 2 and 3.

Step 5—For each hospital, we adjusted the total salaries plus wage-related costs to a common period to determine total adjusted salaries plus wage-related costs. To make the wage adjustment, we estimated the percentage change in the employment cost index (ECI) for compensation for each 30-day increment from October 14, 1995 through April 15, 1997 for private industry hospital workers from the Bureau of Labor Statistics' *Compensation and Working Conditions.* We use the ECI because it reflects the price increase associated with total compensation (salaries plus fringes) rather than just the increase in salaries. In addition, the ECI includes managers as well as other hospital workers. This methodology to compute the monthly update factors uses actual quarterly ECI data and ensures that the update factors match the actual quarterly and annual percent changes. The factors used to adjust the hospital's data were based on the midpoint of the cost reporting period, as indicated below.

MIDPOINT OF COST REPORTING PERIOD

After	Before	Adjustment factor
10/14/95	11/15/95	1.023163
11/14/95	12/15/95	1.021153

MIDPOINT OF COST REPORTING PERIOD—Continued

After	Before	Adjustment factor
12/14/95	01/15/96	1.019151
01/14/96	02/15/96	1.017157
02/14/96	03/15/96	1.015246
03/14/96	04/15/96	1.013489
04/14/96	05/15/96	1.011888
05/14/96	06/15/96	1.010428
06/14/96	07/15/96	1.009099
07/14/96	08/15/96	1.007900
08/14/96	09/15/96	1.006788
09/14/96	10/15/96	1.005719
10/14/96	11/15/96	1.004695
11/14/96	12/15/96	1.003653
12/14/96	01/15/97	1.002529
01/14/97	02/15/97	1.001325
02/14/97	03/15/97	1.000000
03/14/97	04/15/97	0.998514

For example, the midpoint of a cost reporting period beginning January 1, 1996 and ending December 31, 1996 is June 30, 1996. An adjustment factor of 1.009099 would be applied to the wages of a hospital with such a cost reporting period. In addition, for the data for any cost reporting period that began in FY 1996 and covers a period of less than 360 days or more than 370 days, we annualized the data to reflect a 1-year cost report. Annualization is accomplished by dividing the costs and hours by the number of days in the cost report and then multiplying the results by 365.

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

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

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

Step 8—We added the total adjusted salaries plus wage-related costs obtained in Step 5 for all hospitals in the nation and then divided the sum by the national sum of total hours from Step 4 to arrive at a national average hourly

wage (using the same blending methodology described in Step 7). Using the data as described above, the national average hourly wage is $21.1800.

Step 9—For each urban or rural labor market area, we calculated the hospital wage index value by dividing the area average hourly wage obtained in Step 7 by the national average hourly wage computed in Step 8. We note that on July 6, 1999, OMB announced the designations of two new MSAs: Auburn-Opelika, Alabama, comprising Lee County, and Corvallis, Oregon comprising Benton County.

Step 10—Following the process set forth above, we developed a separate Puerto Rico-specific wage index for purposes of adjusting the Puerto Rico standardized amounts. (The national Puerto Rico standardized amount is adjusted by a wage index calculated for all Puerto Rico labor market areas based on the national average hourly wage as described above.) We added the total adjusted salaries plus wage-related costs (as calculated in Step 5) for all hospitals in Puerto Rico and divided the sum by the total hours for Puerto Rico (as calculated in Step 4) to arrive at an overall average hourly wage of $9.86756 for Puerto Rico. For each labor market area in Puerto Rico, we calculated the hospital wage index value by dividing the area average hourly wage (as calculated in Step 7) by the overall Puerto Rico average hourly wage.

Step 11—Section 4410 of the BBA provides that, for discharges on or after October 1, 1997, the area wage index applicable to any hospital that is not located in a rural area may not be less than the area wage index applicable to hospitals located in rural areas in that State. Furthermore, this wage index floor is to be implemented in such a manner as to ensure that aggregate prospective payment system payments are not greater or less than those that would have been made in the year if this section did not apply. For FY 2000, this change affects 226 hospitals in 36 MSAs. The MSAs affected by this provision are identified in Table 4A by a footnote.

Comment: Two commenters suggested that, given the complexity of the FY 2000 wage index calculation, we should make our detailed calculation procedures and edits publicly available. This would enable hospitals and researchers to more easily replicate the wage index values. One of the commenters recommended that the detailed calculations and methods should be included in future proposed and final rules. In addition, they requested that we release the actual computer program used to calculate the wage index.

Response: We have fully explained the steps we take to calculate each hospital's average hourly wage and the wage index. In addition, we have worked with hospitals that contacted us after attempting to replicate our calculations, by reviewing their results and identifying discrepancies. In doing so, we have been able to identify certain anomalies in some of the proposed wage index values, which have been corrected in the final wage index. Therefore, we agree that it might be useful to provide more information to make it easier for the public to replicate our calculations, and we are exploring our options. However, we do not generally provide our computer programs that are used to perform the wage index calculations, or for that matter, the programs we use for all other calculations we perform.

Comment: One commenter recommended that, for leap years HCFA should use 366 days, rather than 365 days, when annualizing cost report data (see step 5 of the wage index calculation).

Response: We agree that the commenter's recommended method of annualization, which recognizes an additional day for leap years, is theoretically more accurate than our simple, across-the-board approach. However, due to the intense effort required to incorporate all of the wage data changes processed in conjunction with hospitals' final opportunity to request revisions, we were unable to evaluate and incorporate this change into our computer program in time to be reflected in the final FY 2000 wage index. Therefore, we are not adopting this recommendation for the FY 2000 wage index calculation. We would note that, as described in step 5 above, we annualize any cost reporting period that covers a period of fewer than 360 days or more than 370 days. The majority of cost reporting periods are not annualized. In those instances where annualization is done, we would further point out that it does not affect the hospital's average hourly wage calculation, since both the costs and hours are annualized by 365. The impact, therefore, of this commenter's suggestion is limited to the calculation of the labor market area average hourly wage. Furthermore, if we were to account for the additional day of a leap year in our annualization, the impact on any particular area's average hourly wage could be either positive or negative.

F. Revisions to the Wage Index Based on Hospital Redesignation

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

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

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

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

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

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

The final revised wage index values for FY 2000 are shown in Tables 4A, 4B, 4C, and 4F in the Addendum to this final rule. Hospitals that are redesignated should use the wage index values shown in Table 4C. Areas in Table 4C may have more than one wage index value because the wage index value for a redesignated urban or rural hospital cannot be reduced below the wage index value for the rural areas of the State in which the hospital is located. When the wage index value of the area to which a hospital is redesignated is lower than the wage index value for the rural areas of the State in which the hospital is located, the redesignated hospital receives the higher wage index value, that is, the wage index value for the rural areas of the State in which it is located, rather than the wage index value otherwise applicable to the redesignated hospitals.

Tables 4D and 4E list the average hourly wage for each labor market area, before the redesignation of hospitals, based on the FY 1996 wage data. In addition, Table 3C in the Addendum to this final rule includes the adjusted average hourly wage for each hospital based on the FY 1996 data (as calculated under Steps 4 and 5 above). The MGCRB will use the average hourly wage published in the final rule to evaluate a hospital's application for reclassification for FY 2001, unless that average hourly wage is later revised in accordance with the wage data correction policy described in § 412.63(w)(2). In these cases, the MGCRB will use the most recent revised data used for purposes of the hospital wage index. We note that, in adjudicating these wage index reclassification requests during FY 2000, the MGCRB will use the average hourly wages for each hospital and labor market area that are reflected in the final FY 2000 wage index.

At the time the proposed wage index was constructed, the MGCRB had completed its review of FY 2000 reclassification requests. Therefore, the proposed FY 2000 wage index values incorporated all 441 hospitals redesignated for purposes of the wage index (hospitals redesignated under section 1886(d)(8)(B) or 1886(d)(10) of the Act) for FY 2000. In this final rule, we have incorporated changes to the wage index that occurred after the proposed wage index was calculated and that resulted from withdrawals of requests for reclassification, wage index corrections, appeals, and the Administrator's review process. The changes may affect not only the wage index value for specific geographic areas, but also the wage index value redesignated hospitals receive, that is, whether they receive the wage index value for the area to which they are redesignated, or a wage index value that includes the data for both the hospitals already in the area and the redesignated hospitals. Further, the wage index value for the area from which the hospitals are redesignated may be affected.

Under § 412.273, hospitals that have been reclassified by the MGCRB are permitted to withdraw their applications within 45 days of the publication of the proposed rule. To be effective in FY 2000, the request for withdrawal of an application for reclassification had to be received by the MGCRB by June 21. A hospital that requests to withdraw its application may not later request that the MGCRB decision be reinstated.

G. Wage Data Corrections

In the proposed rule, we stated that, to allow hospitals time to evaluate the wage data used to construct the proposed FY 2000 hospital wage index, we would make available in May 1999 a final public data file containing the FY 1996 hospital wage data.

The final wage data file was released on May 7, 1999 (amended on May 14). As noted above in section III.C of this preamble, this file included hospitals' teaching survey data as well as cost report data. As with the file made available in February 1999, we made the final wage data file released in May 1999 available to hospital associations and the public (on the Internet). However, with the exception of the teaching survey data, this file was made available only for the limited purpose of identifying any potential errors made by HCFA or the intermediary in the entry of the final wage data that the hospital could not have known about before the release of the final wage data public use file, not for the initiation of new wage data correction requests.

If, after reviewing the May 1999 final data file, a hospital believed that its wage data were incorrect due to a fiscal intermediary or HCFA error in the entry or tabulation of the final wage data, it was provided an opportunity to send a letter to both its fiscal intermediary and HCFA, outlining why the hospital believed an error exists and provide all supporting information, including dates. These requests had to be *received* by us and the intermediaries no later than June 7, 1999.

Changes to the hospital wage data were made only in those very limited situations involving an error by the intermediary or HCFA that the hospital could not have known about before its review of the final wage data file. (As noted above, however, we also allowed hospitals to request changes to their teaching survey data. These requests had to comply with all of the documentation and deadline requirements specified in the May 7, 1999 proposed rule.) Specifically, neither the intermediary nor HCFA accepted the following types of requests at this stage of the process:

- Requests for wage data corrections that were submitted too late to be included in the data transmitted to HCRIS on or before April 5, 1999.
- Requests for correction of errors that were not, but could have been, identified during the hospital's review of the February 1999 wage data file.
- Requests to revisit factual determinations or policy interpretations made by the intermediary or HCFA during the wage data correction process.

Verified corrections to the wage index received timely (that is, by June 7, 1999) are incorporated into the final wage index in this final rule, to be effective October 1, 1999.

We believe the wage data correction process provides hospitals with sufficient opportunity to bring errors in their wage data to the intermediary's attention. Moreover, because hospitals had access to the final wage data by early May 1999, they had the opportunity to detect any data entry or tabulation errors made by the intermediary or HCFA before the development and publication of the FY 2000 wage index and its

implementation on October 1, 1999. If hospitals avail themselves of this opportunity, the FY 2000 wage index implemented on October 1 should be free of these errors. Nevertheless, in the unlikely event that errors should occur after that date, we retain the right to make midyear changes to the wage index under very limited circumstances.

Specifically, in accordance with § 412.63(w)(2), we may make midyear corrections to the wage index only in those limited circumstances in which a hospital can show (1) that the intermediary or HCFA made an error in tabulating its data; and (2) that the hospital could not have known about the error, or did not have an opportunity to correct the error, before the beginning of FY 2000 (that is, by the June 7, 1999 deadline). As indicated earlier, since a hospital had the opportunity to verify its data, and the intermediary notified the hospital of any changes, we do not foresee any specific circumstances under which midyear corrections would be made. However, should a midyear correction be necessary, the wage index change for the affected area will be effective prospectively from the date the correction is made.

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

Once the final wage index values are calculated and published in the **Federal Register**, the last opportunity for a hospital to seek to have its wage data revised is under the limited circumstances described in § 412.63(w)(2). As we noted in the September 1, 1995 **Federal Register**, however, hospitals are entitled to appeal any denial of a request for a wage data revision made as a result of HCFA's wage data correction process to the Provider Reimbursement Review Board (PRRB), consistent with the rules for PRRB appeals found at 42 CFR Part 405, Subpart R (60 FR 45795). As we also stated in the September 1, 1995 **Federal Register**, and as the regulation at § 412.63(w)(5) provides, any subsequent reversal of a denial of a wage revision request that results from a hospital's appeal to the PRRB or beyond will be given effect by paying the hospital under a revised wage index that reflects the revised wage data at issue. The revised wage data will not, however, be used for purposes of revisiting past adjudications of requests for geographic reclassification.

Comment: One commenter suggested that our notices of the wage index review process should be more explicit regarding dates, titles, and addresses, and should be presented in a format similar to the request for hearing language contained in most Notices of Program Reimbursements. The commenter believes this would avoid confusion and misunderstandings throughout the process.

Response: Although we believe that our notices of wage index file availability are already quite detailed, we agree they might be improved to minimize misunderstandings. For example, we intend to continue to work with our intermediaries to ensure that, in their correspondence with hospitals regarding the resolution of revision requests submitted by the hospitals, the intermediaries state more explicitly the criteria, procedures, and deadlines for requesting our intervention when a hospital disagrees with an intermediary's policy determination. We welcome any other specific recommendations.

Comment: One commenter requested that we consider providing a mid-year correction, as in the FY 1999 wage index, for those areas that are affected by a major change in the FY 2000 wage index. The commenter stated that further opportunity to review and adjust its wage data would provide a more meaningful wage index.

Response: As we stated in the February 25, 1999 final rule implementing changes resulting from the limited window of opportunity for hospitals to request revisions to their FY 1995 data used to calculate the FY 1999 wage index, we believe our usual procedures provide ample opportunity for diligent hospitals to ensure the accuracy of their wage data (64 FR 93781). The limited opportunity to request revisions to the data used to calculate the FY 1999 wage index was based on a combination of circumstances unique to that year, and hospitals should assume in the future that all requests to change their wage data must conform to the well-established guidelines discussed above. Therefore, we do not intend to again provide such a special opportunity for further revision requests.

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

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

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

In the past, we have considered and rejected two alternatives to the MSA definitions of an urban area for SCH purposes. These alternatives were the urbanized areas as defined by the Census Bureau and the health facility planning areas (HFPAs) as used by the Health Resource Services Administration. We have concluded that the MSA definition continues to be the most appropriate geographic delimiter available at this time. Therefore, in the May 7, 1999 proposed rule, we proposed to continue to apply the MSA definition of an urban area for SCH status purposes.

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

In addition, we note that our use of MSAs to define urban areas for SCH status purposes has direct statutory support. Section 1886(d)(2)(D) of the

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

We received one comment on our proposed retention of this definition.

Comment: One commenter, which had been communicating with us before the issuance of the proposed rule, continued to express concern about our policy of defining urban areas for SCH purposes based on MSAs. The commenter raised several points. First, the commenter stated that our discussion in the proposed rule is ''misleading'' because it did not mention recent litigation on this issue. Second, the commenter argued that our proposal is flawed because it results in inequitable treatment of hospitals; that is, it renders a hospital's ability to qualify as an SCH dependent on OMB's reconfiguration of MSA boundaries, and patients' ability to access inpatient hospital services is not affected by those boundaries. Third, the commenter questioned two aspects of our rationale for retaining an MSA-based definition of the urban areas in the SCH context—that OMB considers commuting patterns when defining MSAs and that use of MSAs is consistent with the methodology we use for computing the standardized amounts. Finally, the commenter suggested that, if we decided to adopt our proposal to base the definition of urban areas for SCH purposes on MSAs, we should at least adopt an exception to that rule under which a hospital that is the only hospital in an MSA could still qualify as an SCH.

Response: We do not agree with the commenter that we should either abandon our longstanding policy of defining urban areas for SCH purposes based on MSAs or adopt the exception to that policy that the commenter suggests. Although the commenter is correct in pointing out that there has been recent litigation involving our definition of ''urban area'' for SCH purposes, we do not believe that our proposal was in any way misleading. Partly as a result of the litigation, we decided to reiterate and clarify our policy. Thus, we clearly stated in the proposed rule that we proposed to retain our longstanding definition in favor of other definitions based on the Census Bureau's urbanized areas or on HFPAs and explained the reasons for our proposal. We believe the proposed rule, therefore, gave interested parties more than adequate notice of the issue and afforded them the opportunity to comment.

We continue to believe that it is appropriate to adopt an MSA-based definition of urban areas for SCH purposes for the reasons stated in the proposed rule and in our earlier discussions of the MSA-based definition. The commenter gave an example of a situation in which an urban hospital is the nearest like hospital to a rural hospital, and the rural hospital is likewise the nearest hospital to the urban hospital. The commenter stated that the rural hospital could obtain SCH status, but the urban hospital could not, which, the commenter concluded, results in inequitable treatment of similarly situated hospitals.

We do not agree with this conclusion for several reasons. First, if the urban hospital was located more than 35 miles from the rural hospital, it could in fact qualify for SCH status under our rules. Moreover, the hospitals in this example are not similarly situated; one is urban and one is rural. As we have stated previously, urban areas generally have better roads, faster snow clearing, and more available hospitals, factors that affect access to inpatient hospital services. (See 56 FR 25483 (June 4, 1991).) Thus, even if the rural hospital in the commenter's example qualified as an SCH and the urban hospital did not, the difference in result is justified by the hospitals' different geographic circumstances.

The commenter's example does nothing to demonstrate that any other definition of an urban area for SCH purposes is preferable to an MSA-based definition. The somewhat unique situation the commenter described—an urban hospital that is closest to a rural hospital and vice versa—could arise no matter what definition of urban area we adopt.

Similarly, while the commenter objected to hospitals' ability to qualify for SCH status depending on possible shifting OMB definitions of MSAs, the same objection could be made of any definition of urban area that adopts geographic delimiters promulgated by another entity—including Census Bureau urbanized areas or HFPAs. In addition, we consider the fact that OMB occasionally revises the MSA boundaries to be a strength of that scheme. We think it is appropriate that any definition of urban areas for SCH purposes be reviewed periodically to take into account changes that have occurred in various areas' characteristics. Urban and rural areas do not remain static forever. Shifts in population and other changes can transform previously rural areas into urban ones, and vice versa. Because we believe the nature of an area as urban or rural is an important part of determining whether a hospital should qualify as an SCH, the mechanism for making those determinations should be able to account for changes in that nature.

As noted above and in our previous discussions of this issue, we believe that several factors make urban hospitals more accessible to patients than rural ones. Contrary to the commenter's statement that access is not affected by MSA boundaries, we proposed to adopt MSAs as the definition of urban areas for SCH purposes precisely because MSAs provided a good gauge of the presence of factors affecting access. The commenter's contentions fail to convince us that we should not adopt this proposal.

The commenter also argued that we have not properly considered reasonable alternatives to our proposed MSA-based definition of urban areas for SCH purposes. To the contrary, we specifically considered and proposed to reject two alternative definitions based on urbanized areas and HFPAs. The commenter offered no additional alternatives. Rather, the commenter questioned our reliance on OMB's use of commuting patterns in establishing MSAs, and stated that both urbanized areas and HFPAs also consider commuting patterns in the form of such factors as availability of roads and travel time and distance. Even if true, however, that means only that all three potential definitions consider commuting patterns in some form, and thus does not provide a basis for preferring a definition of urban areas other than one based on MSAs. The commenter pointed out that the

commuting patterns OMB analyzes pertain to commutes to workplaces, which, the commenter claimed, do not relate to access to hospital services. However, we have indicated that we deem commuting patterns important because they indicate access to areas in which hospitals are located. (See 48 FR 39780 (Sept. 1, 1983).) As such, they are a good indicator of access to hospital services.

The commenter questioned our reliance on the fact that MSAs are used as the basis for determining the standardized amounts that form the basis of prospective payment system payments. The MSAs also supply the definition of urban areas used for virtually every other purpose under the hospital inpatient prospective payment system, including other special status determinations, geographic reclassification, and calculation of the wage index. We continue to believe that it is appropriate to use a definition of urban areas for SCH purposes that is consistent with the definition used for almost all other components of the prospective payment rates.

In regard to the commenter's suggestion that, if we retain the MSA-based definition of urban areas for SCH purposes, we adopt an exception to that definition under which an urban hospital that is the only hospital in its MSA would qualify as an SCH if it would otherwise qualify absent its urban location. We note that, to a large extent, we already apply this rule. As noted above, an urban hospital that is more than 35 miles from the nearest like hospital may qualify as an SCH notwithstanding its urban location. Thus, urban hospitals, including those in a sole-hospital MSA, can in fact qualify as SCHs, provided they are not in close proximity to another like hospital.

We acknowledge that a small number of MSAs may contain only one hospital; however, we have stated that urban areas *generally* have more available hospitals (56 FR 25483 (June 4, 1991)). Again, urbanized areas, HFPAs, or an urban area defined under any other methodology might also contain only one hospital. As a result, there is nothing inherent in our adoption of an MSA-based definition that compels adoption of the exception the commenter has proposed. It continues to be our judgment that an urban hospital within 35 miles of another like hospital is not the ''sole'' source of inpatient hospital services in its community, given the close proximity of the other hospital and the other factors affecting increased access to inpatient hospital services that location in an urban area denotes. Thus, we have not adopted the commenter's proposed exception to the rule defining urban areas based on MSAs for SCH purposes.

B. Rural Referral Centers (§ 412.96)

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

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

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

1. Case-Mix Index

Section 412.96(c)(1) provides that HCFA will establish updated national and regional case-mix index values in each year's annual notice of prospective payment rates for purposes of determining rural referral center status. The methodology we use to determine the national and regional case-mix index values is set forth in regulations at § 412.96(c)(1)(ii). The proposed national case-mix index value in the May 7, 1999 proposed rule included all urban hospitals nationwide, and the proposed regional values were the median values of urban hospitals within each census region, excluding those with approved teaching programs (that is, those hospitals receiving indirect medical education payments as provided in § 412.105).

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

- 1.3438; or
- The median case-mix index value for urban hospitals (excluding hospitals with approved teaching programs as identified in § 412.105) calculated by HCFA for the census region in which the hospital is located. (See the table set forth in the May 7, 1999 proposed rule at 64 FR 24732–24733.)

Based on the updated FY 1998 MedPAR file, which contains data from additional bills received through March 31, 1999, the final national case-mix value is 1.3438 and the median case-mix values by region are set forth in the following table:

Region	Case-mix index value
1. New England (CT, ME, MA, NH, RI, VT)	1.2498
2. Middle Atlantic (PA, NJ, NY)	1.2499
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.3306
4. East North Central (IL, IN, MI, OH, WI)	1.2577
5. East South Central (AL, KY, MS, TN)	1.2795
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.1877
7. West South Central (AR, LA, OK, TX)	1.2994
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.3438
9. Pacific (AK, CA, HI, OR, WA)	1.3231

For the benefit of hospitals seeking to qualify as referral centers or those wishing to know how their case-mix index value compares to the criteria, we are publishing each hospital's FY 1998 case-mix index value in Table 3C in section VI of the Addendum to this final rule. In keeping with our policy on discharges, these case-mix index values are computed based on all Medicare patient discharges subject to DRG-based payment.

2. Discharges

Section 412.96(c)(2)(i) provides that HCFA will set forth the national and regional numbers of discharges in each year's annual notice of prospective payment rates for purposes of determining referral center status. As specified in section 1886(d)(5)(C)(ii) of the Act, the national standard is set at 5,000 discharges. In the May 7, 1999 proposed rule, we proposed to update the regional standards. The proposed regional standards were based on discharges for urban hospitals' cost reporting periods that began during FY 1997 (that is, October 1, 1996 through September 30, 1997). That is the latest year for which we have complete discharge data available.

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

- 5,000; or
- The median number of discharges for urban hospitals in the census region in which the hospital is located, as indicated in the following table. (See the table set forth in the May 7, 1999 proposed rule at 64 FR 24733.)

Based on the latest discharge data available for FY 1997, the final median number of discharges for urban hospitals by census region areas is as follows:

Region	Number of discharges
1. New England (CT, ME, MA, NH, RI, VT)	6733
2. Middle Atlantic (PA, NJ, NY)	8655
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	7845
4. East North Central (IL, IN, MI, OH, WI)	7499
5. East South Central (AL, KY, MS, TN)	6832
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	5346
7. West South Central (AR, LA, OK, TX)	5380
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	8026
9. Pacific (AK, CA, HI, OR, WA)	6151

We note that the number of discharges for hospitals in each census region is greater than the national standard of 5,000 discharges. Therefore, 5,000 discharges is the minimum criterion for all hospitals.

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

Comment: One commenter urged HCFA to reconsider its decision not to restore RRC status to those hospitals located in areas that have been redesignated as urban by the OMB. The commenter argued that the statute established only one qualification for having a hospital's RRC status restored; that is, a hospital must have been designated as an RRC in FY 1991. According to the commenter, the statute provides no other conditions, nor does it provide HCFA with the discretion to create other conditions. The commenter believes that our decision not to restore the RRC status of hospitals located in areas redesignated as urban by OMB effectively requires affected hospitals to satisfy an additional condition that they be located in a rural area.

Response: We responded to a comment raising the same issue in the May 12, 1998 final rule (63 FR 26326). We addressed our interpretation of section 4202(b)(1) of the BBA in the August 29, 1997 final rule with comment period (62 FR 45999 and 46000) as well as the May 12, 1998 final rule, and we refer the reader to those documents.

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

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

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

We did not receive any comments on this proposal and are adopting it as final.

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

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

We did not receive any comments on this proposal and are adopting it as final.

We note that the instructions for preparing applications for FY 2001 individual and group reclassifications, which are due to the MGCRB by September 1, 1999, are now available for downloading from the Internet at www.hcfa.gov/regs/appeals.

Comment: One commenter requested clarification about submitting an application for reclassification for the standardized amount when the payment rates had changed during the year for which the applicable cost report would be used. Specifically, the commenter was concerned that the revised average hourly wage data, wage index, and standardized amounts applicable for FY 1999 beginning on or after March 1, 1999 (see the final rule published on February 25, 1999 (64 FR 9378)) will require the MGCRB to determine which

wage index and standardized amount value to use when evaluating applications seeking standardized amount geographic reclassification. The commenter asserted that because the MGCRB must use historical national adjusted operating standardized amounts and wage indices, a problem potentially arises when HCFA calculates more than one standardized amount and wage index for an area in a year, as it did in FY 1999. The commenter suggested the MGCRB use prorated standardized amount and wage index values in evaluating applications.

Response: When the MGCRB evaluates an application for reclassification for the standardized amounts, it uses actual payment rates for actual periods. Therefore, if the payment rate changed during the year that applies to a hospital's application, those figures are incorporated into the calculation for the months during which they applied. The same policy holds true for wage data.

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

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

1. Approved Geriatric Programs

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

We received one comment in support of our proposed revision to § 413.86(b). We are adopting the revision as final.

2. Hospital Payment For Resident Training in Nonhospital Settings

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

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

Comment: Many commenters supported our technical change under the proposed § 413.86(f)(4)(iii), which provides that, in order to count residents training at a nonhospital site for purposes of direct and indirect GME payment, the hospital must actually incur all or substantially all of the costs for the training programs. However, we believe several commenters misunderstood our technical change. The commenters believed that the change was unnecessary because the existing regulations, which were issued in the July 31, 1998 final rule, provide adequate guidance for purposes of the hospital claiming direct and indirect GME for resident training in the nonhospital site.

Response: We proposed to make the technical change in § 413.86(f)(4)(iii) for two reasons. First, we stated in the preamble to the July 31, 1998 final rule that we are requiring the hospital to actually incur all or substantially all of the cost, but the regulation text only indicated that the hospital must have an agreement to incur the cost; that is, the regulation text did not include specific language requiring that the hospital actually incur the cost. Second, we defined the phrase ''all or substantially all'' in § 413.86(b) but inadvertently omitted using the phrase in the policy specified in § 413.86(f)(4).

Comment: In regard to our proposed technical change to the nonhospital payment policy as specified in § 413.86(f)(4)(iii), one commenter asked us to define the difference, if any, in our use of ''nonprovider'' entity and ''nonhospital'' entity. In addition, the commenter asked whether a skilled nursing facility or a unit excluded from the prospective payment system is considered to be a nonhospital setting.

Also, similar to the public comments addressed in the in July 31, 1998 final rule, several commenters asked us to clarify whether hospitals would still be eligible to receive payments in situations where the teaching faculty volunteers their services and neither the hospital nor the nonhospital entity

incurs costs for supervisory teaching physicians. The commenters asked us to continue to support the following statement that we included in the July 31, 1998 final rule (63 FR 40996) allowing hospitals to remain eligible for payment in such situations where supervisory physicians in the nonhospital site are volunteering their time: ''for the purposes of satisfying the requirement of a written agreement, the written agreement between a hospital and a nonhospital site may specify that there is no payment to the clinic for supervisory activities because the clinic does not have these costs.''

Response: For purposes of our nonhospital payment policy for GME in § 413.86(f)(4), we use the terms ''nonhospital'' and ''nonprovider'' interchangeably. A free-standing SNF (that is, a SNF that is not part of a hospital) is a nonhospital site. An excluded unit of a hospital is not a nonhospital site because an excluded unit is still part of a hospital.

We will continue a volunteer supervisory physician policy consistent with the policy stated in the July 31, 1998 final rule, as requested by the commenter. Hospitals may receive payment for the costs of training residents in the nonhospital site even though the hospital might not be incurring any costs for supervisory physician activities.

3. New Residency Programs

In the regulations we published on August 29, 1997 and May 12, 1998, we established special rules for adjusting the full-time equivalent (FTE) resident caps for indirect and direct GME for new medical residency programs. In general, the special rules allow for adjustments to the caps based on the number of residents participating in the program in its third year of existence. In §§ 413.86(g)(6)(i) and 413.86(g)(6)(ii), we set forth a methodology for adjusting hospital FTE caps for new medical residency training programs established on or after January 1, 1995. In the May 7, 1999 proposed rule, we proposed the following clarifications, technical changes, and policy changes:

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

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

c. It was brought to our attention that the regulations do not explicitly address how to apply the cap during the first 3 years of a new program before the adjustments to the cap are established. In the May 7, 1999 proposed rule, we proposed to clarify our policy on new residency programs by adding language in §§ 413.86(g)(6)(i) and 413.86(g)(6)(ii) to specify how to determine the hospital's cap in the first 3 years of a new residency program, before the implementation of the hospital's permanent adjustment to its FTE cap effective beginning with the fourth year of the program. We proposed to specify that the cap may be adjusted during each year of the first 3 years of the hospital's new residency program, using the actual number of residents participating in the new program. The adjustment may not exceed the number of accredited slots available to the hospital for each program year.

d. As discussed above, on August 29, 1997, we implemented the hospital-specific caps on the number of residents that a hospital can count for purposes of GME payments in a final rule with comment period (62 FR 46002). In both the May 12, 1998 and July 31, 1998 final rules (63 FR 26327 and 63 FR 40954), we responded to comments we received on this provision. We did not receive any comments about hospitals that participated in residency training in the past, had terminated their participation before the hospitals' cost reporting period ending in calendar year 1996, and have now again begun a new residency program. After publication of the July 31, 1998 final rule, we were contacted by representatives of some hospitals that had a resident cap of zero because they had temporarily terminated their GME programs in the past and had no residents training during the cost reporting period ending in 1996. Based on the existing regulations, these hospitals have FTE caps of zero. There is no provision in the existing regulations for making adjustments to the cap to allow these hospitals to receive payment for indirect and direct GME for allopathic and osteopathic residents.

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

In addition, we proposed to make a change in § 413.86(g)(6)(ii) to make the language similar to that in § 413.86(g)(6)(i) to specify that hospitals that did have residents in the cost reporting period ending on or before December 31, 1996, are allowed adjustments to the cap for new programs begun on or after January 1, 1995, and

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

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

We received a number of comments on our proposals.

Comment: One commenter supported our technical changes to the new residency program adjustments under proposed §§ 413.86(g)(6)(i) and 413.86(g)(6)(ii). The commenter agreed with our technical change of referencing ''allopathic and osteopathic residents'' instead of simply ''residents.''

The proposed rule specified that the method for calculating the adjustment to the cap is based on the product of the highest number of residents in any program year during the third year of the newly established program and the number of years in which residents are expected to complete each year program based on the minimum accredited length for the type of program. One commenter requested an example of a calculation of this adjustment.

Response: In response to the commenter's request, we are providing the following example of how to calculate the new residency program adjustment under § 413.86(g)(6)(ii). This example was included in a Program Memorandum (Transmittal No. A–97–13 (p. 16), September 1997) that transmitted billing instructions to our fiscal intermediaries.

Example: Assume a hospital had an unweighted direct GME count of 100 FTE residents for its cost reporting period ending June 30, 1996 and the hospital, although it had 6 first year slots, began an internal medicine program on July 1, 1995 with 4 first year residents (who were included as part of the 100 FTE cap). On July 1, 1996, the program expands to 10 residents (6 first year and 4 second year residents.) On July 1, 1997, the program has 16 residents (6 first year residents, 6 second year residents, and 4 third year residents). Since the minimum accredited length for internal medicine program listed is 3 years, the hospital's unweighted FTE cap can be adjusted based on 18 residents in the internal medicine program (6 first year residents * 3 years). In the hospital's cost reporting period ending June 30, 1996, the hospital had a total of 100 FTE residents including 4 in internal medicine. The hospital's cap can be adjusted up to 14 residents (18 internal medicine residents less 4 already included in the fiscal year ending June 30, 1996 FTE count).

Comment: Several commenters expressed concern about our definition of ''new medical residency training program'' for purposes of determining the FTE cap adjustment under § 413.86(g). One commenter raised questions regarding the situation where the original sponsor of a residency program has been notified that it has lost its accreditation and a new sponsor assumes the training of all or most of the residents of an existing program. The commenter believed that the program under the new sponsor should be treated as ''new'' as well. Another commenter suggested we have interpreted ''new residency program'' to be simply a new site for a residency program that may have been in existence at other clinical sites in the past.

Response: Under the existing § 413.86(g)(7) (proposed to be redesignated as § 413.86(g)(9)), we define ''new medical residency training program'' to be a program ''that receives initial accreditation by the appropriate accrediting body or begins training residents on or after January 1, 1995.'' The language ''begins training residents on or after January 1, 1995'' means that the program may have been accredited by the appropriate accrediting body prior to January 1, 1995, but did not begin training in the program until on or after January 1, 1995. The language does not mean that it is the first time a particular hospital began training residents in a program on or after January 1, 1995, but the program was in existence at another hospital prior to January 1, 1995, as the commenter suggests.

We believe there may be some confusion on the part of the commenters as to how to determine when a hospital may receive an adjustment to its FTE cap for a new residency program. The definition can be more easily understood if we explain the application in two steps. First, determine if the hospital's residency program qualifies to be ''new'' under § 413.86(g)(9). Second, once the residency program is determined to meet the definition of ''new,'' apply the criteria under §§ 413.86(g)(6)(i) and 413.86(g)(6)(ii) to determine whether a hospital's new program qualifies for an adjustment to its FTE cap. A hospital's sponsorship of the program plays no role in determining whether a hospital qualifies to receive an adjustment under either § 413.86(g)(6)(i) or § 413.86(g)(6)(ii).

If two hospitals ''merge'' separate residency programs, the single residency program resulting from the merger would not be considered ''new'' for purposes of either hospital receiving an adjustment to its FTE cap. The programs have already been in existence and, presumably, the hospitals have been able to count the residents training in each individual program as part of the hospitals' respective FTE caps. If the hospital that is training the residents in the merged program would like to receive an adjustment to its FTE cap for the added residents it presumably now trains, that hospital may wish to affiliate for purposes of establishing an aggregate FTE cap.

Comment: We received several comments on our clarification on how to account for situations when residents spend an entire program year (or years) at one hospital and the remaining year (or years) of the program at another hospital (or hospitals) during the first 3

years of the new residency program. We stated that, in this situation, the adjustment to the FTE cap is based on the number of years the residents are training at each hospital, not the minimum accredited length of the program. One commenter asked us to clarify the adjustment to the cap in situations where the residents rotate to multiple sites in a single program year during the first 3 years of a new residency program—that is, the residents rotate to other hospitals for partial years. Another commenter requested that we give examples of how to calculate the FTE cap adjustment in these situations.

Response: In situations where residents spend an entire program year (or years) at one hospital and the remaining year (or years) of the program at another hospital during the first 3 years of the new residency program, each hospital that trains the residents receives an adjustment to its cap based on the product of the highest number of residents in any program years during the third year of the first program's existence and the number of years that the residents are training at each respective hospital. In situations where the residents spend partial years at different hospitals during the first 3 years of the new residency program, each hospital that trains the residents receives an adjustment to its cap based on product of the highest number of residents in any program year during the third year of the first program's existence and the minimum accredited length of the program.

In response to the second commenter's request, the following are some examples as to how to calculate the adjustment to the FTE cap for a new residency program in situations where residents spend an entire program year (or years) at one hospital and the remaining year (or years) at another hospital during the first 3 years of the program. In addition, we are including an example where residents spend partial years at different hospitals during the first 3 years of the new residency program:

Example 1

Assume Hospital A has 10 residents in a new internal medicine residency program. These 10 residents are trained at Hospital A for 2 years of the program. In the third year of the program, 5 of the 10 residents are rotated to Hospital B for training.

Hospital A would receive an adjustment to its cap of 10 FTE (5 residents * 2 years).

Hospital B would receive an adjustment to its cap of 5 FTE (5 residents * 1 year).

Example 2

Assume Hospital A has the following residents training in its new internal medicine residency program:

Year 1–10 new program year (PGY [1] 1) residents

Year 2—Hospital A rotates the 10 (now PGY 2) residents from Year 1 to Hospital B for training for 1 year and Hospital A also accepts 8 (PGY 1) new residents.

Year 3—The 10 (now PGY 3) residents who rotated to Hospital B in Year 2 return to Hospital A. Hospital A accepts 9 new (PGY 2) residents and also rotates the 8 (PGY 2) residents from Year 2 to Hospital B for training for 1 year. Thus, in the third year of the program, Hospital A has 10 (PGY 3) residents and 9 (PGY 1) residents and Hospital B has 8 (PGY 2) residents.

Hospital A would receive an FTE cap adjustment of 20 FTE (10 residents * 2 years).

Hospital B would receive an FTE cap adjustment of 8 FTE (8 residents * 1 year).

[1] PGY = Program Year

Example 3

Assume Hospital A has 10 residents in a new internal medicine program for one half of each of the three residency program years. Hospital B trains the 10 residents for the other half of each of the three residency years.

Hospital A would receive an FTE cap adjustment of 15 FTEs (10 residents * .5 FTE * 3 years).

Hospital B would receive an FTE cap adjustment of 15 FTEs (10 residents * .5 FTE * 3 years).

Both Hospital A and Hospital B train a total of 5 FTE residents each residency program year (.5 of 10 residents each year) and this number is multiplied by the minimum accredited length of the residency program (3 years for internal medicine).

Comment: One commenter suggested that only the hospital or hospitals that have received the accreditation for the new residency program should receive the adjustment to the FTE cap or caps.

Response: While Medicare will provide GME payment to a hospital for training a resident only if that resident is participating in an accredited program, it is irrelevant whether the accreditation for the program belongs to the hospital currently training the residents or some other entity. Thus, we disagree with the commenter's suggestion to allow only hospitals that received the new residency program accreditation to receive a new residency program adjustment.

Comment: Several commenters were concerned about our provision on the adjustment to the FTE cap during the first 3 years of a new residency program, as specified in proposed § 413.86(g)(6)(i)(B). One commenter stated that it seemed inconsistent to refer to ''adjusting the cap'' during these years when the cap is not actually adjusted until the third year. Another commenter suggested that, when looking at the number of residents training at the hospital during the first 3 years for purposes of deciding the cap adjustment in those 3 years, the FTE count for cost reporting purposes should be based on the number of residents for which the hospital has oversight and the time worked in locations within or outside the hospital complex to which they rotate.

Response: Section 413.86(g)(6)(i)(B) contains the provision that explains how a hospital is to adjust its FTE cap during the first 3 years of establishing a new residency program—the hospital's cap may be adjusted during each of the first 3 years using the actual number of residents participating in the new program. The ''number of residents participating in the new program'' means the number of residents actually training at that hospital. It does not mean the number of residents within the ''oversight'' of the hospital, which could include the time residents spend at other types of facilities during their training; it only includes the time the residents spend training at the actual hospital site.

When a hospital establishes a new residency program, the hospital's 1996 FTE cap for the first 3 years is adjusted. Thus, the 1996 FTE cap is also receiving an adjustment during those 3 years.

Comment: One commenter noted that while we made clarifications in our new residency program adjustment policy under §§ 413.86(g)(6)(i) and 413.86(g)(6)(ii), we failed to make consistent changes to § 413.86(g)(6)(iii).

Response: We agree that we inadvertently omitted the third change. We are revising § 413.86(g)(6)(iii) in this final rule.

Comment: One commenter suggested that our meaning is unclear concerning our provision in proposed redesignated § 413.86(g)(6)(i)(D) that allows a rural hospital that receives an adjustment to its FTE cap for establishing new residency programs to affiliate with other hospitals for the purpose of establishing an aggregate cap.

Response: We are revising the language in this section to state more clearly that, in the case of hospitals in urban areas, we limit the use of affiliations to provide for aggregate caps only to urban hospitals that did not receive a new residency program adjustment for a program begun on or after August 6, 1997 (the date after enactment of the BBA). Urban hospitals that had no program or programs reported for their most recent cost reporting period ending on or before December 31, 1996 and have received an FTE cap adjustment for a new program may not affiliate with other hospitals for purposes of establishing an aggregate FTE cap. However, rural hospitals that had no program or programs reported for the most recent cost reporting period ending on or before December 31, 1996 and have received an FTE cap adjustment for establishing a new program may affiliate with other hospitals for purposes of establishing an aggregate FTE cap.

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

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

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

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

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

Thus, we proposed to add a new § 413.86(g)(7) (existing § 413.86(g)(7) would be redesignated as § 413.86(g)(9)) to address application of the FTE caps with regard to a hospital that began construction of an entire facility prior to August 5, 1997, sponsored medical residency training programs, and temporarily trained those residents at another hospital(s) until the new facility was completed. For hospitals that meet these criteria, we proposed that the FTE caps will be determined in a manner similar to those hospitals that qualify for an adjustment to the FTE cap under § 413.86(g)(6)(i). That is, the hospital's cap would equal the lesser of (a) the product of the highest number of residents in any program year during the third year of the first program's existence for all new residency training programs at either the newly constructed facility or the temporary training site but sponsored by the newly constructed hospital and the number of years in which residents are expected to complete the programs based on the minimum accredited length for each type of program; or (b) the number of accredited slots available for each year of the program. If the medical residency training programs sponsored by the newly constructed hospital have been in existence for 3 years or more by the time the residents begin training at the newly constructed hospital, the newly constructed hospital's cap would be based on the number of residents training in the third year of the first of those programs begun at the temporary training site. If the medical residency training programs sponsored by the newly constructed hospital have been in existence for less than 3 years when the residents begin training at the newly constructed hospital, the hospital's cap would be based on the number of residents training at the newly constructed hospital in the third year of the first of those programs (including the years at the temporary training site). This provision would be effective for portions of cost reporting periods occurring on or after October 1, 1999.

Comment: With regard to our proposed change concerning our adjustment to the GME caps for newly constructed hospitals, one commenter suggested that while §§ 413.86(g)(7)(i)(A) and (B) appear to be clear and straightforward, §§ 413.86(g)(7)(ii) and (iii) are unclear and add confusion to the calculation of the newly constructed hospital's FTE cap. The commenter suggested that §§ 413.86(g)(7)(ii) and (iii) be removed.

Another commenter suggested that a newly constructed hospital under § 413.86(g)(7) should be able to affiliate with other hospitals for purposes of establishing an aggregate FTE cap.

Response: The purpose of both §§ 413.86(g)(7)(i)(B) and 413.86(g)(7)(ii)(B) is to clarify how to establish the newly constructed hospital's FTE cap in all possible situations. The regulation at ' 413.86(g)(7)(i)(B) addresses the calculation of the newly constructed hospital's FTE cap if the new program has been in existence for 3 or more years at the temporary training site by the time the residents begin training at the newly constructed hospital. The regulation at § 413.86(g)(7)(ii)(B) addresses the calculation of the cap if the new program has been in existence for 3 or fewer years at the temporary training site by the time the residents begin training at the newly constructed hospital.

We agree with the commenter's suggestion to allow a newly constructed hospital under § 413.86(g)(7) to affiliate for purposes of establishing an aggregate FTE cap. We currently allow teaching hospitals that receive a new residency program adjustment under § 413.86(g)(6)(ii) to affiliate with other hospitals if the teaching hospitals had established new programs prior to the enactment of the BBA. Teaching hospitals could not have known what policies would be enacted in the BBA. Therefore, they would not have had the opportunity to establish programs for purposes of affiliation in order to circumvent the FTE cap established by the BBA. The commenter notes that we used the same rationale when espousing

the policy on newly constructed hospitals in the proposed rule—we are allowing hospitals that began construction prior to August 5, 1997 to establish an FTE cap because the hospitals would not have had knowledge of the provisions of the BBA. For the same reason, we agree that the newly constructed hospital should be able to affiliate for purposes of establishing an aggregate cap because the hospital under construction would not have known the BBA restrictions. Therefore, we are revising the text of § 413.86(g)(7) to include this new policy.

In addition, consistent with this reasoning, we are allowing newly constructed hospitals under § 413.86(g)(7) to calculate their FTE cap using the same methodology as articulated in § 413.86(g)(6)(ii), the provision for teaching hospitals that establish new residency programs on or after January 1, 1995 and on or before August 5, 1997. We allow those teaching hospitals to receive a new residency program adjustment during that ''window'' because these hospitals could not have known what requirements would be enacted in the BBA if the teaching hospitals established new programs during that time. As stated above, we used the same rationale for allowing newly constructed hospitals to establish a cap—these hospitals could not have known about the BBA when the hospitals established residency programs. Therefore, we are adding language to § 413.86(g)(7) as follows: '' * * * a hospital that began construction of its facility on or before August 5, 1997, sponsored new medical residency training programs that were established on or after January 1, 1995 and on or before August 5, 1997, and either received initial accreditation by the appropriate accrediting body or temporarily trained those residents at another hospital(s) until the facility was completed, may receive an adjustment to its FTE cap.'' We note that we are clarifying the phrase ''prior to August 5, 1997'' to mean ''on or before August 5, 1997'' to make it consistent with this policy. We also are making conforming changes to §§ 413.86(g)(7)(i)(A) and (B) and 413.86(g)(7)(ii)(B) to allow the cap to be adjusted for each new program established within the ''window.'' Under the previous language, the adjustment was tied to the third year of the first new program. Under the new language, the adjustment is tied to each new program's establishment during the ''window.'' Therefore, for example, in a situation where a newly constructed hospital establishes a new residency program and the first new program began on July 1, 1995, and a second program began on July 1, 1997, the adjustment for the second program under the previous language would have been tied to the third year of the first new program (1997). However, under the new language, the adjustment for the second program is not established until the third year (1999) of the second program's existence.

Comment: Another commenter suggested that we include the word ''new'' when referring to medical residency training programs in § 413.86(g)(7)(ii) and (iii).

Response: We are making the revision as the commenter suggests. This revision will clarify that the provisions allowing an adjustment to the FTE cap for a facility constructed on or before August 5, 1997 applies to new residency programs.

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

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

Under current policies, we permit a temporary adjustment to the FTE cap for a hospital only if it assumed additional medical residents from a hospital that closed in the July 1996–June 1997 residency training year. In the May 7, 1999 proposed rule, we proposed to allow adjustments to address hospital closures after this period. Thus, we would allow an adjustment for a hospital if it trains additional residents from a hospital that closes at any time, on or after July 1, 1996. This adjustment is intended to account for residents who may have partially completed a medical residency training program and would be unable to complete their training without a residency position at another hospital.

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

Comment: Many commenters were generally pleased with our proposed policy concerning the temporary adjustment to FTE caps to reflect residents affected by hospital closures specified under proposed § 413.86(g)(8). However, various commenters asked us to define what we meant by a ''closed'' hospital.

Response: Section 413.86(g)(8) provides that a hospital may receive a temporary adjustment to its FTE cap to reflect residents added because of another hospital's closure which occurs on or after July 1, 1996. By hospital ''closure,'' we mean the hospital terminates its Medicare participation agreement with HCFA under the provisions specified in § 489.52. To ''close,'' a hospital would have to comply with the requirements as specified in this section to terminate its agreement. We are making conforming changes in § 413.86(g)(8) on the temporary adjustment to reference § 489.52.

Comment: Many of the commenters suggested that we include bankruptcy of a hospital and lost accreditation of a program, both acts that displace residents, as applicable to the temporary adjustment policy.

Response: We do not agree with the commenters. We do not believe it is appropriate to expand our policy to cover any acts other than hospital

closure because, unless the hospital actually terminates its Medicare agreement, it will retain its statutory FTE cap. For example, in the case where a hospital files for bankruptcy, it continues to retain its FTE cap. While the bankruptcy action may displace the hospital's residents, the hospital continues to be subject to the statutorily mandated cap on FTEs. Therefore, it can still decide to train residents at the hospital or affiliate with other hospitals for purposes of establishing an aggregate cap. The hospital may, in fact, use its ability to affiliate in order to place its residents at a new hospital.

Comment: One commenter explained that there were hospitals that had plans to close their doors earlier this year and deliberately remained open for various reasons until the start of the July 1, 1999 residency year. This commenter suggested that because hospitals are training these displaced residents beginning on July 1, 1999, we should change the effective date of the temporary adjustment provision to coincide with the July 1, 1999 date. Similarly, another commenter was concerned about affiliated groups, suggesting that because final regulations on affiliated groups were not published until May 12, 1998, some hospitals that would have liked to have participated in affiliations prior to the FY 1998 were not able to because there were no implementing regulations before the May 12, 1998 date.

Response: The effective date of the temporary adjustment policy, like the effective date for all changes in this final rule, is October 1, 1999.

Similarly, hospitals that choose to affiliate cannot do so before the effective date of the May 12, 1998 regulation.

Comment: Under the temporary adjustment provision, § 413.86(g)(8)(ii) requires a hospital to submit a request for the temporary adjustment to its fiscal intermediary at least 60 days before the hospital begins to train the residents. One commenter suggested that it was not appropriate for the fiscal intermediary to be in the position of granting requests for adjustments. In addition, several commenters suggested that submitting a request at least 60 days before the hospital begins to train the residents is ''problematic,'' since it is not always easy to estimate exactly when a hospital will close and other hospitals can then continue training the residents.

Response: The fiscal intermediaries have been delegated the authority to calculate Medicare program payments for hospitals, including GME payments. HCFA is not in a position to be able to respond to every request for a temporary FTE cap adjustment. As long as hospitals that request the adjustments meet each condition in our regulations, the hospitals will receive the adjustments.

We agree with the commenters who suggested that requiring a hospital to submit a request for a temporary adjustment to an intermediary at least 60 days before the hospital begins to train the residents might be problematic for hospitals. Therefore, we are revising our regulations to require a hospital to submit a request for a temporary adjustment to an intermediary no later than 60 days after the hospital first begins training the displaced residents.

Comment: One commenter requested that we clarify the provision at ' 413.86(g)(8)(ii) that hospitals must identify residents that come from closed programs in order to receive a temporary adjustment to their FTE caps.

Response: In order to receive a temporary adjustment to their FTE caps, hospitals must provide the social security numbers of the residents coming from the closed hospital and documentation that proves that the residents were training at the hospital that closed.

6. Determining the Weighted Number of FTE Residents

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

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

Comment: At § 413.86(g)(1), we proposed to update the provisions concerning what source to use when calculating the initial residency period for residencies. One commenter stated that one of the provisions that we updated, changing ''1985–1986 Directory of Residency Training'' to ''the most recently published edition of the Graduate Medical Education Directory,'' applies only when calculating the initial residency periods for allopathic residencies. The commenter suggests that initial residency periods for all residencies be published in the **Federal Register**. The commenter further suggested that, for determining the updates of initial residency periods for dental residencies, the most recent accreditation standards of the Commission on Dental Accreditation for advanced dental programs be used. Another commenter asked whether the most recently published edition of the Graduate Medical Education Directory or the initial residency periods is published in the **Federal Register** should be the guiding source when calculating the initial residency periods for residencies in the case where there is a discrepancy between the two.

Response: Generally, proposed redesignated § 413.86(g)(1)(i) defines the initial residency period as ''the minimum number of years of formal training necessary to satisfy the requirements for initial board eligibility in the particular specialty for which the resident is training, as specified in the most recently published edition of the Graduate Medical Education Directory.'' Proposed § 413.86(g)(1)(ii) provided that for residency programs in osteopathy, dentistry, and podiatry, ''the minimum number of years of formal training necessary to satisfy the requirements of the appropriate approving body listed in § 412.152 of this chapter.'' Section 412.152 lists all of the accreditation organizations for allopathy, osteopathy, podiatry, and dentistry, including the Commission on Dental Accreditation of the American Dental Association. In other words, while the Graduate Medical Education Directory only applies to allopathic residencies, as the first commenter suggests, the organization that the commenter encourages us to use as the accrediting organization for purposes of determining the initial residency period for dental residencies—the Commission on Dental Accreditation of the American Dental Association—is already used to determine the initial residency periods for dental residencies.

The first commenter also suggests that we publish the initial residency periods in the **Federal Register**. While we have already done so in the August 30, 1996 **Federal Register** (61 FR 46208), we plan to update the list of initial residency periods in upcoming regulations. The second commenter asked for guidance in the case where the initial residency periods listed in the August 30, 1996 (and in future regulations) differ from the information listed in the most recent edition of the Graduate Medical Directory. The information that we used to publish the initial residency periods in the August 30, 1996 **Federal Register** is based on the most recent edition of the Graduate Medical Directory. The Graduate Medical Directory is the most current and updated source of information on allopathic residencies. We agree that in some cases our latest listing in the **Federal Register** may not reflect the most recent update of the applicable directory. Thus, in the case where there is a discrepancy in the length of an initial residency period listed in what we publish in the **Federal Register** and what is published in the most recent edition of the Graduate Medical Education Directory (or other applicable publications for the other specialty areas), the Directory should be the guiding source.

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

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

Comment: Several commenters requested that we clarify that a nonteaching hospital that participates in an affiliated group agreement as specified under § 413.86(g)(4) is not precluded from later seeking an adjustment to its FTE cap for establishing a new residency program.

Response: We agree with the commenters' request. Consistent with our regulations at § 413.86(g)(6)(i), a nonteaching hospital that participated (or participates) in an affiliated group for purposes of establishing an aggregate FTE cap does not forego its opportunities to later establish new residency programs and accordingly receive an adjustment to its individual FTE cap. The requirements under § 413.86(g)(6)(i) specify that a hospital may receive an adjustment to its FTE cap for establishing a new residency program if the hospital had no allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996. In other words, the hospital must have a zero FTE cap based on its number of residents in its most recent cost reporting period ending on or before December 31, 1996 in order to qualify to receive an adjustment under this provision. The fact that a nonteaching hospital has affiliated with other hospitals does not change the fact that in determining the aggregate cap for the affiliated group the nonteaching hospital still has an FTE cap of zero. Accordingly, consistent with our regulations, a nonteaching hospital that affiliates is not precluded from later seeking a new residency program adjustment.

Comment: The BBA specifically required the Secretary to give special consideration to facilities that meet the needs of underserved rural areas. With this mandate in mind, several commenters requested that we consider recognizing new family practice programs that are classified as rural by the Residency Review Committee for the purpose of establishing a cap and receiving GME payment under Medicare.

Response: We will consider the suggestion to apply our rules for rural hospitals to all hospitals with the new family practice programs for purposes of GME in developing future regulations.

Comment: We received several other comments suggesting GME policy changes concerning rural hospitals. One commenter suggested that we allow rural hospitals that received a new residency program adjustment under § 413.86(g)(6)(ii) to affiliate with other hospitals for purposes of establishing an aggregate FTE cap. Another commenter suggested that we allow rural hospitals a new residency program adjustment for expansions of already established residency programs at the rural hospitals.

Response: Any hospital, rural or urban, that receives a new residency program adjustment under § 413.86(g)(6)(ii) is permitted to affiliate for purposes of establishing an aggregate cap. As for allowing an FTE cap adjustment for expansions of already established residency programs at rural hospitals, we will take this policy suggestion into consideration in future regulations.

Comment: We received many comments on various other GME issues. One commenter asked what level of documentation is needed to demonstrate for purposes of our nonhospital payment policy that a particular hospital and nonhospital site are a single legal entity. Another commenter asked for a cost report change to account for situations when a hospital could have one FTE cap for one-half of the year and a different cap for the second half of the year. One commenter suggested that, in a situation when two hospitals affiliate for purposes of establishing an aggregate cap, the hospital that is the sponsor of the residency program should be given the ability to better control the limited number of training slots as established under the aggregate cap. Another commenter suggested that we consider allowing a new residency program adjustment for family practice programs beginning on or after July 1, 1994. Finally, one commenter made two suggestions: (1) that we increase a particular hospital's FTE count because when the cap was set, some of the hospital's residents were rotated out to other hospitals to meet a Residency Review Committee (RRC) program requirement, and are now brought back into the hospital after the BBA because the hospital can now meet the RRC requirement, and (2) that we allow payment to a hospital that had established an ambulatory care rotation prior to the BBA.

Response: We will consider all of these suggestions made by the commenters in future regulations.

Comment: One commenter suggested that we discuss what happens to hospitals' FTE caps in situations where there is a merger of two or more hospitals.

Response: We discussed the merger of hospitals and FTE caps in the May 12, 1998 **Federal Register** (63 FR 26329). Where two or more hospitals merge after each hospital's cost reporting period ending during FY 1996, the merged hospital's FTE cap will be an aggregation of the FTE cap for each hospital participating in the merger.

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

Section 1886(g) of the Act requires the Secretary to pay for hospital capital-related costs ''in accordance with a

prospective payment system established by the Secretary.'' Under the statute, the Secretary has broad authority in establishing and implementing the capital prospective payment system. We initially implemented the capital prospective payment system in 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).

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

In the August 30, 1991 final rule, we also established a capital exceptions policy, which provides for exceptions payments during the transition period (' 412.348). Section 412.348 provides that, during the transition period, a hospital may receive additional payment under an exceptions process when its regular payments are less than a minimum percentage, established by class of hospital, of the hospital's reasonable capital-related costs. The amount of the exceptions payment is the difference between the hospital's minimum payment level and the payments the hospital would receive under the capital prospective payment system in the absence of an exceptions payment. The comparison is made on a cumulative basis for all cost reporting periods during which the hospital is subject to the capital prospective payment transition rules. The minimum payment percentages for regular capital exceptions payments by class of hospitals for FY 2000 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.

We indicated that we would carefully monitor the impact of the capital prospective payment system in order to determine whether some type of permanent exceptions process was necessary and the circumstances under which additional payments would be made.

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

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

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

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

payments so we could determine if any changes in the special exceptions criteria or process were necessary.

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 CON approval was received, the start date of the project, and the anticipated completion date.

The hospitals suggested changing a number of the requirements of the special exception provision, including (1) changing the project completion date requirement; (2) revising the project size requirement; (3) lowering the DSH qualifying percentage from 20.2 percent to 15 percent; (4) changing the minimum payment level from 70 percent to 85 percent; and (5) revising the qualifying criteria so that only capital payment margins are considered instead of both capital payment margins and operating margins (as is now the case). In addition, hospitals suggested capping special exceptions payments that result from changes to the special exceptions process at $40 million annually.

When we issued the May 7, 1999 proposed rule, we had no specific proposal to revise the special exceptions process. However, we invited comments from hospitals and other interested parties on the suggestions and recommendations discussed above. We noted that, since the capital special exceptions process is budget neutral, any liberalization of the policy would require a commensurate reduction in the capital rate paid to all hospitals. That is, even after the end of the capital prospective payment system transition, we will continue to make an adjustment to the capital Federal rate in a budget neutral manner to pay for exceptions, as long as an exceptions policy is in force. Currently, the limited special exceptions policy will allow for exceptions payments through September 30, 2011. We also noted 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 May 7, 1999 proposed rule, we indicated that we had little information about the impact of any of the suggested changes discussed in the proposed rule, since no hospitals are currently being paid under the special exceptions process. Until FY 2001, the special exceptions provision currently pays either the same as the regular exceptions process or less for high DSH and sole community hospitals. We indicated that we would attempt to obtain information on projects that might qualify for special exceptions payments through our fiscal intermediaries during the comment period. However, we noted that we were reluctant to impose a burden on the fiscal intermediaries at this time, since it could interfere with our major efforts to make the Medicare computer systems Y2K compliant prior to January 1, 2000.

We received six comments on potential changes to the special exceptions process. Three were in favor of changing the process in various ways, and two were opposed to making any changes. In addition, MedPAC opposed expanding the process until we have a better estimate of the impact of any expansion.

Comments: Three commenters that supported changing the special exception process made various suggestions as to what those changes should be.

Two of the commenters believe that the way HCFA formulated the special exceptions process is inconsistent with Congressional intent because the Conference Report that accompanied the Omnibus Budget Reconciliation Act (OBRA) of 1993 (Public Law 103–66) indicated the conferees' expectation that HCFA would assess information and make appropriate changes to ''. . . address the problems of hospitals subject to lengthy CON review processes or subject to other circumstances which are not fully addressed in the current rules'' (H.R. Rep. No. 103–213, at 744 (1993)). The commenters noted that Congress used a separate sentence to state a belief that the Secretary should ''. . . evaluate whether current policies provide adequate protection to sole community hospitals and hospitals that serve a disproportionate share of low income patients.'' Thus, the commenters believe that Congress did not intend to limit the special exceptions process to any particular type of hospital and that Congress intended HCFA to deal separately with the problems of high DSH hospitals and to make the special exceptions process available to all hospitals.

One commenter stated that eligibility for special exceptions payments should be based solely on when a hospital had to begin a capital project and the size of the project, rather than ''noncapital-related'' tests such as the operating offset and the DSH requirement. The commenter argued that, if the purpose of the special exceptions process was to help hospitals that could not benefit from old and obligated capital provisions, then HCFA did not act consistently with that premise when it adopted criteria that limited qualifying hospitals. The commenter believes that HCFA may have adopted some criteria, such as the requirement that urban hospitals must have a DSH percentage of at least 20.2 and the offset of positive operating margins, to limit the cost of the special exceptions program. If that is the case, then the commenter suggested that a cap on total payments made under the special exceptions authority would accomplish the same result more fairly.

One commenter requested that the DSH percentage requirement for urban hospitals (20.2 percent) be lowered. The commenter believes that the current requirement is not a natural result of the rationale we used for limiting the special exceptions process, and that, if a hospital builds a project during the transition, it is disadvantaged relative to other hospitals regardless of its DSH percentage. This commenter suggested that, if we do decide to retain the DSH requirement, the requirement be lowered to 15 percent, and that we adopt a sliding scale payment floor of between 15 and 20.2 DSH percentages in which the minimum payment level at the 15 DSH percentage would be 70 percent and the maximum payment level at 20.2 DSH percentage would be 85 percent.

One commenter supported lowering the project size requirement from 100 percent of the hospital's FY 1992 operating costs to 45 percent of those costs.

All three commenters who advocated changes to the special exceptions process supported changing the offset provision so that eligibility for special exceptions does not take into account positive operating margins. They argued that the operating and capital payment methodologies were separately developed and that payments are separately calculated. If the offset against operating payments is not eliminated, they believe it should be modified to include outpatient margins as well. One of these commenters noted that a similar offset was not required for ''old capital.''

Two of the commenters recommended that, if a hospital had received CON approval by September 1, 1995 and expended $750,000 or 10 percent of total project cost, then the project completion date should be extended to December 31, 2003. They believe that a hospital could have started planning a major capital project early in the transition, but, because of events beyond the hospital's control, the completion date might extend beyond the end of the transition.

Two commenters suggested that we should establish a cap on special exceptions payments, and indicated that HCFA has the authority to set and implement such a cap because of the authority given the Secretary under section 1886(g) of the Act to implement the capital prospective payment system. The legislation provided for an exceptions process, as the Secretary determined to be appropriate. The commenter asserted that the ''regular'' capital exceptions process already includes a ''cap'' of 10 percent. The commenters recommended a cap of 1 percent of total capital prospective payments in a given fiscal year, and that, if aggregate eligibility for payments exceeds the cap, the payments would be reduced on a pro rata basis.

The commenters also recommended that any exception payments a hospital qualifies for but does not receive because of the cap should be rolled over into future years so that those payments could be made in later years. Without a rollover provision, the commenters advocate setting the cap at 1.5 percent. They believe that with the expiration of hold harmless provisions and the exceptions floors in FY 2001, the suggested cap would result in lower budget neutrality adjustments than is currently the case.

Using 1992 through 1996 cost report data, one of the commenters prepared an estimate of the number of hospitals it believes will be eligible for special exception payments if the criteria were changed as suggested by the commenter. Based on the commenter's estimate, aggregate eligibility for special exceptions payments would exceed the recommended 1 percent cap for approximately 5 years (FY 2002 through FY 2006). The commenter also suggested that hospitals that believe they are eligible for special exceptions be required to submit an application to their fiscal intermediary in January of each year, and to update their application by June of each year, so that an estimate could be prepared of the number of hospitals that will qualify for special exceptions. The data could also be used to estimate the amount of reductions that will be required to stay within the cap. The commenter suggests that hospitals that did not submit the information could be precluded from receiving special exceptions payments in the following fiscal year.

All three commenters who advocated changes to the special exceptions process supported raising the 70 percent minimum payment level to 85 percent. One commenter objected to the 70 percent minimum payment level, arguing that it offers little improvement over the Federal rate and guarantees that hospitals will take a 30-percent loss on their actual capital costs for each Medicare discharge. This commenter believes that special exceptions should be paid at the rate of 85 percent, which is what hospitals eligible for old capital hold harmless payment received.

In addition, two of the commenters supported finalizing changes to the special exceptions process in the FY 2000 final rule so that affected hospitals can plan more effectively.

Two national hospital associations were opposed to changing the special exceptions policy. They believe that the special exceptions process was intended to be limited in scope, and although some hospitals may be disadvantaged by some aspects of the fully Federal capital prospective payment system, they have had a number of years to plan for it. All other hospitals will be receiving payments based on the Federal rate beginning in FY 2002 and the commenters do not believe that the majority of hospitals should have their payments further reduced to expand the special exceptions process to a few hospitals. One of the commenters noted that Congress considered a similar proposal to expand the special exceptions process as part of the BBA deliberations and, ultimately, did not include the proposal. The commenter believes this failure to act was an indication of Congressional intent, and that HCFA has no authority to disregard it and adopt these changes by regulation. The other commenter stated that since HCFA has no reliable estimate of the number of hospitals that would be affected by changes to the special exceptions process, it would be capricious to make a change absent an impact analysis.

Response: When we proposed the special exceptions process in 1994 (May 27, 1994, **Federal Register** (59 FR 27746)), we stated ''* * * we are therefore proposing at § 412.348 to provide special protection for some hospitals that are undertaking major projects to renovate or replace aging plant during the transition period. This special protection, which will provide a 70 percent minimum payment level for up to 10 years beyond the transition period, will be available only to * * * [s]ole community hospitals * * *; [u]rban hospitals with at least 100 beds that either have a DSH percentage of 20.2 percent or receive at least 30 percent of their revenue from State or local funds for indigent care * * *; [h]ospitals with a combined inpatient Medicare and Medicaid utilization of at least 70 percent. * * *'' We believe this strict set of qualifying criteria makes it clear that we intended to make the special exception process limited in scope.

Since publication of the proposed rule, we have attempted 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. Because of the impracticality of obtaining data timely from every State in the country, we focused our efforts on certain States. Using information obtained from the Department of Housing and Urban Development (HUD) and the Health Resources and Services Administration (HRSA), we developed a list of States in which a large concentration of hospital construction occurred during the capital transition period. For several States, we contacted the State Department of Health's Facility and Planning Staff, who provided us with information on the hospital construction projects in their State, including the name and location of the hospital, the cost of the construction project, the date of CON approval (if required), the start date of the project, and the completion or anticipated completion date of the project. In conjunction with the most recent cost report data readily available (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 hospital's 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. It is also difficult to predict whether particular hospitals will be able to meet all of the special exceptions eligibility criteria (DSH percentage, inpatient margins, completion date, project size, and project need requirements) in future years based on the earlier cost report data.

Based on our research, we were able to identify a universe of 266 possible hospital construction projects from two States (New York and Illinois) that

might possibly qualify for special exception payments. Our data largely understate the total number of eligible projects that may qualify for special exception payments nationally since our estimate is based on data from only 2 of the 50 States in the country. Our estimate includes all inpatient hospital construction projects in those two States, of which only a subset of projects will qualify for special exception payments. Extrapolating our estimate to the large numbers of hospital construction projects nationally, 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 and our evaluation of the comments and after careful consideration of all the issues, we have concluded, as suggested by one commenter, that the more appropriate forum for addressing the capital special exception is the legislative process in Congress rather than the regulation process.

Based on this conclusion, we are generally not addressing the specific changes recommended for the special exceptions process or eligibility criteria. However, there are some comments on the general policies of the special exception process that we would like to address individually. These include our efforts to address the OBRA 1993 Conference Report language concerning the obligated capital provisions of the capital prospective payment system, the rationale for the 70 percent minimum payment level for the special exceptions process, and the administrative feasibility of capping special exception payments and rolling over unfunded special exceptions to future years.

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

In the May 27, 1994 proposed rule (59 FR 27744), we described our analysis of provisions related to obligated capital for hospitals subject to lengthy CON processes. We also proposed a change to the deadline for putting an asset into use for patient care (§ 412.302(c)(2)(i)(D)) and addressed recommendations that we had received from hospitals to change the capital exceptions policy, which would provide exceptions payments after the conclusion of the capital prospective payment transition period. These hospitals had asked that the minimum payment level for urban hospitals with at least 100 beds and a DSH percentage of at least 20.2 percent be guaranteed through the rest of the transition and extended for at least 10 years after the transition.

In the September 1, 1994 final rule (59 FR 45376), we adopted the proposed change to the deadline for putting an asset into use in the obligated capital regulations (§ 412.348) from ''the earlier of'' September 30, 1996, or 4 years from the date of CON approval to ''the later of'' September 30, 1996, or 4 years from the date of CON approval. We also implemented the capital special exceptions process and expanded the qualifying criteria for the classes of eligible hospitals to include sole community hospitals; urban hospitals with at least 100 beds that have a DSH percentage of at least 20.2 percent or that receive at least 30 percent of their revenue from State or local funds for indigent care; and hospitals with a combined inpatient Medicare and Medicaid utilization of at least 70 percent.

Because we adopted changes to both the obligated capital criteria and finalized the special exceptions process, we believe that we have appropriately addressed the issues raised in the Conference Report language concerning hospitals in States with a lengthy CON process as well as SCHs and hospitals that serve a disproportionate share of low-income patients.

Second, in response to the commenters' suggestion that the 70 percent minimum payment level for special exceptions be raised to 85 percent, we believe that this change would expand the special exceptions process beyond its original narrow focus. The commenters' comparison of the special exceptions process to hold harmless payments for old capital is not appropriate. Paying hospitals for 85 percent of the cost of old capital was reasonable to account for the change from a cost-based system to a prospective payment system for capital. Since hospitals had committed to these costs years prior to the implementation of the capital prospective payment system, it was reasonable to allow relief to hospitals for these costs. In addition, during the prospective payment system transition, all hospitals, based on their costs, were eligible for exception payments to account for high costs that exceed the prospective payment rate. Except for sole community hospitals and hospitals with a DSH percentage of at least 20.2, hospitals received exceptions payments at the 70-percent minimum payment level. A 70-percent minimum payment level for special exceptions continues exceptions payments for qualifying hospitals with high costs after the transition at the same level most hospitals received under the regular exceptions process during the transition.

Third, it would be extremely difficult administratively to implement a cap and roll-over provision such as the one advocated by the commenters. Hospitals are not eligible for special exception payments until assets are put into use for patient care. A lag time exists before completed and settled cost reports are available to determine special exception payments once eligibility has been demonstrated. Information taken from cost reports cannot be used to accurately determine whether a hospital meets all of the special exceptions eligibility criteria. Specifically, date of CON approval (if applicable) and DSH percent are not determined based on cost report information. Other criteria, such as project size and age of asset (if applicable) requirements, and their accuracy will need to be reported by the hospital and verified by the fiscal intermediaries.

Even when we have a more accurate assessment of qualifying special exception projects, we do not believe a cap and roll-over process such as the commenter suggests would be administratively feasible. We intend to administer the existing special exception process in the post-transition period in a manner similar to the regular exception process. Based on data received, we will make an estimate of special exception payments in the

coming year. If our model shows that special exception payments are projected to be more than 10 percent of total capital payments under the existing 70 percent payment level, we would reduce the minimum payment level to ensure that projected payments do not exceed the 10 percent threshold. If, however, when cost reports were settled for that fiscal year, payments for eligible projects were determined to be more or less than the amount estimated, they would still be eligible for special exception payments, even if actual payments exceeded the amount we initially estimated. Each year's exception payments are determined separately. It would be extremely difficult to maintain an estimate of actual qualifying projects, given varied dates on which hospitals' fiscal years end, and increase or decrease the exception payment amount each hospital was eligible to receive. We would not know whether the amount budgeted for a project was more or less than the amount the project actually qualified for until the cost report was settled. Since hospitals have different cost report ending dates, it would be some time before all the cost reports for a given fiscal year would be finalized. At that time, it would be necessary for each fiscal intermediary to determine how much was actually paid for special exception, and any carryover amount for each project to a future fiscal year. We believe that this process would be very cumbersome, if not impossible, to administer.

It is our intention in the FY 2001 proposed and final rules to discuss a data collection effort to assist us in modeling special exception payments for the FY 2002 proposed rule.

Comment: MedPAC commented that they share HCFA's desire to keep special exceptions narrowly targeted. The Commission stated that many of the suggestions for changing the special exception process and criteria would unnecessarily expand payments beyond clearly disadvantaged hospitals whose financial health is important to maintaining access to care for Medicare beneficiaries. MedPAC recommends that, since so few hospitals responded to our request for information on potentially qualifying projects, we should not change the current special exceptions policy until we receive more information about the extent of financial problems hospitals are having. However, MedPAC does believe that we should consider increasing the special exceptions payment for SCHs and urban hospitals with a DSH percentage of at least 20.2 percent to equal the amount they receive under the regular exceptions policy (that is, 90 and 80 percent, respectively). MedPAC suggests that these increases are necessary to continue to provide financial protection to institutions that safeguard access to care for Medicare beneficiaries.

MedPAC supports offsetting special exceptions payments against both capital and operating margins, because it is consistent with their belief that at the end of the transition the two payment systems should be combined.

Response: We agree with MedPAC that, in determining eligibility for special exception payments, it is appropriate to examine a hospital's operating margins as well as its capital margins. We believe it is reasonable to provide an additional limit on exceptions payments for the period 10 to 20 years after the beginning of capital prospective payments. In addition, we agree that since inpatient operating and capital costs are so inherently intertwined in providing inpatient care, it is appropriate to have an operating payment offset for the capital special exception. It is not appropriate to consider any outpatient services when determining eligibility for the inpatient special exception payment. Any outpatient capital-related costs are paid to hospitals under Medicare Part B.

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

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

1. Updated Caps

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

A discussion of how the caps on the target amounts were calculated can be found in the August 29, 1997 final rule with comment period (62 FR 46018); the May 12, 1998 final rule (63 FR 26344); and the July 31, 1998 final rule (64 FR 41000). For purposes of calculating the caps on existing facilities, the statute requires us to calculate the 75th percentile of the target amounts for each class of hospital (psychiatric, rehabilitation, or long-term care) for cost reporting periods ending during FY 1996. Under section 1886(b)(3)(H)(iii) of the Act, the resulting amounts are updated by the market basket percentage increase applicable to the fiscal year.

In the May 7, 1999 proposed rule, we proposed the following caps on target amounts for cost reporting periods beginning in FY 2000:

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

These proposed caps reflected an update of 2.6 percent, the projected market basket increase for excluded hospitals and units.

The final projection of the market basket percentage increase for excluded hospitals and units for FY 2000, based on the most recent data available, is 2.9 percent. Accordingly, the final caps on the target amounts for existing hospitals and units for cost reporting periods beginning during FY 2000 are as follows:

- Psychiatric hospitals and units: $11,100
- Rehabilitation hospitals and units: $20,129
- Long-term care hospitals: $39,712

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

a. Updated Caps for New Hospitals and Units

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

The amounts included in the following table reflect the updated 110 percent of the wage neutral national median target amounts for each class of excluded hospitals and units for cost reporting periods beginning during FY 2000. These figures are based on the final FY 1999 figures updated by the projected market basket increase of 2.9

percent. (The proposed amounts were based on an estimated market basket increase of 2.6 percent.) For a new provider, the labor-related share of the target amount is multiplied by the appropriate geographic area wage index and added to the nonlabor-related share in order to determine the per case limit on payment under the statutory payment methodology for new providers.

Class of excluded hospital or unit	Labor-related share	Nonlabor-related share
Psychiatric	$ 6,394	$ 2,544
Rehabilitation	12,574	4,999
Long-term Care	16,206	6,443

As specified at § 413.40(c)(4), for purposes of determining the hospital's target amount for the hospital's third 12-month cost reporting period, the target amount for the preceding cost reporting period is equal to the payment amount in the second 12-month cost reporting period as determined in accordance with § 413.40(f)(2)(ii)(A). The payment amount is the lesser of (1) the operating costs per case, or (2) 110 percent of the national median of target amounts for the same class of hospitals for cost reporting periods ending during FY 1996, updated to the first cost reporting period in which the hospital receives payments and adjusted for differences in area wage levels. It has come to our attention that § 413.40(c)(4)(v) does not specify how to apply the update factors to the amount of payment for the second 12-month cost reporting period in order to calculate the target amount in subsequent cost reporting periods. Therefore, we are revising §§ 413.40(c)(4)(v) and 413.40(f)(2)(ii)(A) to clarify the application of the update factors and the base period for new psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals.

b. Multicampus Excluded Hospitals

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

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

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

We did not receive any comments on this proposed revision. Therefore, we are adopting the proposed change to § 413.40(b)(1)(iii) as final.

3. Exceptions

The August 29, 1997 final rule with comment period (62 FR 46018) specified that a hospital that has a hospital-specific target amount that is capped at the 75th percentile of target amounts for hospitals in the same class (psychiatric, rehabilitation, or long-term care) would not be granted an adjustment payment (also referred to as an exception payment) based solely on a comparison of its costs or patient mix in its base year to its costs or patient mix in the payment year. Since the hospital's target amount would not be determined based on its own experience in a base year, any comparison of costs or patient mix in its base year to costs or patient mix in the payment year would be irrelevant.

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

Similarly, for hospitals and units with a FY 1998 hospital-specific revised target amount established under the rebasing provision at § 413.40(b)(1)(iv), in determining whether the hospital qualifies for an adjustment and the amount of the adjustment, we compare the hospital's operating costs to the average costs and statistics for the cost reporting periods used to determine the FY 1998 revised target amount. Since the rebased FY 1998 target amount is an average of three cost reporting periods, as described in § 413.40(b)(1)(iv), comparisons of costs from the cost year

to the FY 1998 cost period would be inaccurate. Therefore, as specified in the August 29, 1997 final rule with comment period (62 FR 46018), a determination of whether the hospital qualifies for an adjustment, and the amount of an adjustment, are based on a comparison of the hospital's operating costs and its costs used to calculate the FY 1998 rebased target amount. For hospitals that have been rebased under the provisions of § 413.40(b)(1)(iv) and qualify for an adjustment under the provisions of § 413.40(g), the base year figures used for such items as costs, utilization, and length-of-stay should be determined based on the average of the costs and utilization statistics from the same 3 cost reporting years used in calculating the FY 1998 rebased target amount.

In the proposed rule, we proposed to revise § 413.40(g)(1) to clarify these limitations on the adjustment payments.

We received no comments on this clarification and, therefore, are adopting it in this final rule.

4. Report on Adjustment Payments to the Ceiling (§ 413.40(g))

Changes in the types of patients served or inpatient care services that distort the comparability of a cost reporting period to the base year are grounds for requesting an adjustment payment in accordance with section 1886(b)(4) of the Act. Section 4419(b) of the BBA of 1997 requires the Secretary to publish annually in the **Federal Register** a report describing the total amount of adjustment (exception) payments made to excluded hospitals and units, by reason of section 1886(b)(4) of the Act, during the previous fiscal year. However, the data on adjustment payments made during the previous fiscal year are not available in time to publish a report describing the total amount of adjustment payments made to all excluded hospitals and units in the subsequent year's final rule published in the **Federal Register**.

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

The table below includes the most recent data available from the fiscal intermediaries and HCFA on adjustment payments that were adjudicated during FY 1998. By definition these were for cost reporting periods ending in years prior to FY 1998. The total adjustment payments awarded to excluded hospitals and units during FY 1998 are $95,676,720. The table depicts for each class of hospital, in aggregate, the number of adjustment requests adjudicated, the excess operating cost over the ceiling, and the amount of the adjustment payment.

Class of hospital	Number	Excess cost over ceiling	Adjustment Payment
Psychiatric	235	$112,437,640	$55,784,497
Rehabilitation	93	67,353,452	26,487,095
Long-term care	7	10,326,069	6,085,941
Children's	7	6,893,393	2,898,679
Cancer	3	10,463,245	4,420,508

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

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

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

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

Existing regulations (§ 412.25(b) and (c)) specify that, for purposes of payment to a psychiatric or rehabilitation unit that is excluded from the prospective payment system, changes in the bed size or the status of excluded hospital units will be recognized only at the beginning of a cost reporting period. These regulations have been in effect since the inception of the hospital inpatient prospective payment system and were intended to simplify administration of the exclusion provisions of the prospective payment system by establishing clear rules for the timing of changes in these excluded units. The statutory basis and rationale for these rules are explained more fully in the preamble to the proposed rule (64 FR 24740).

To provide more flexibility to hospitals while not recognizing changes that undermine statutory requirements and principles, we proposed to revise § 412.25(b) and (c) to provide that, for purposes of exclusion from the prospective payment system, the number of beds and square footage of an excluded unit may be decreased, or an excluded unit may be closed in its entirety, at any time during a cost reporting period under certain conditions. The hospital would be

required to give the fiscal intermediary and the HCFA Regional Office a 30-day advance written notice of the intended change and to maintain all information needed to accurately determine costs attributable to the excluded unit and proper payments. However, any unit that is closed during a cost reporting period could not be paid again as a unit excluded from the prospective payment system until the start of the next cost reporting period. If the number of beds or square footage of a unit excluded from the prospective payment system is decreased during a cost reporting period, that decrease would remain in effect for the remainder of that period.

We noted that the number of beds and square footage of the part of the hospital paid under the prospective payment system may also be affected by a change in the size or status of a unit that is excluded from the prospective payment system. If the bed capacity and square footage were previously part of the excluded unit and are then included in the part of the hospital paid under the prospective payment system and are used to treat acute patients rather than excluded unit patients, the additional bed capacity and square footage would, starting with the effective date of the change, be counted as part of the hospital paid under the prospective payment system. We would count the bed capacity and square footage for purposes of calculating available bed days and the number of beds under §§ 412.105 and 412.106, relating to payments for the indirect costs of medical education and hospitals that serve a disproportionate share of low-income patients. On the other hand, if the bed capacity and square footage are taken out of service or added to another hospital-based provider, such as a distinct-part skilled nursing facility, they would not be counted as part of the hospital paid under the prospective payment system.

We received six comments on our proposal.

Comment: Several commenters expressed support for the proposed change and indicated that it would increase hospital flexibility. No commenters opposed the change. However, one commenter noted that some California hospitals may need to temporarily vacate certain facilities to allow renovation and construction necessary to comply with new State seismic code requirements, and stated that such a relocation of a facility may necessitate a change in its number of beds or square footage. The commenter recommended that our regulations be revised to account for this possibility or for relocations that are necessary due to catastrophic occurrences such as earthquakes, floods, tornadoes, or other natural disasters.

Response: We appreciate the commenters' support of our proposal and are adopting it as final with one change. To address the types of compliance or catastrophic situations described by one of the commenters, we are revising § 412.25(b) to allow reductions in the number of beds in an excluded unit, or increases or decreases in the square footage of the excluded unit, if these changes result from relocation of the unit made necessary because of construction or renovation needed to bring a facility into compliance with changes in Federal, State, or local law affecting the physical facility, or because of catastrophic events such as fires, floods, earthquakes, or tornadoes. We understand that these relocations may necessitate a change in the square footage of a unit, although it is not clear that any increase in bed size would be required. We also are allowing corresponding exceptions to the requirements that a grandfathered satellite facility be operated under the same terms and conditions in effect on September 30, 1999 under §§ 412.23(h)(3) and 412.25(e)(3)).

C. Payment for Services Furnished at Satellite Hospital Locations

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

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

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

In the preamble to the proposed rule, we explained in detail our reason for concern that satellite arrangements could lead to circumvention of several Medicare payment provisions. To prevent inappropriate Medicare payment for services furnished in satellite facilities, we proposed to revise §§ 412.22 and 412.25 to provide for payment to satellite facilities of hospitals and units that are excluded from the prospective payment system under specific rules. With respect to both hospitals and units, we proposed to define a ''satellite facility'' as a part of a hospital that provides inpatient services in a building also used by another hospital, or in one or more buildings on the same campus as buildings also used by another hospital but is not a ''hospital-within-a-hospital,'' since it is also part of another hospital. We proposed that, if the satellite facility is located in a hospital that is paid under the prospective payment system, Medicare would pay for services furnished at the satellite facility by using the same rates that apply to the prospective payment hospital within which the satellite is located. As explained in the proposed rule, we reasoned that, if the satellite facility is effectively ''part of'' the prospective payment system hospital, then it should be paid under the prospective payment system.

We proposed that if the satellite facility is located in a hospital excluded from the prospective payment system, then Medicare would pay for the services furnished in the satellite facility as follows: we proposed to examine the discharges of the satellite facility and to apply the target amount for the excluded hospital *in which the hospital is located,* subject to the

applicable cap for the hospital *of which the satellite is a part.* Also, when the satellite facility is established, we proposed to treat it as a new hospital for payment purposes. That is, for the satellite's first two 12-month cost reporting periods, the satellite would be subject to the cap that applies to new hospitals of the same class as the hospital of which the satellite is a part. We believed that the proposed application of the cap for new hospitals was appropriate because we believe that a number of hospitals are attempting to avoid the hospital caps by characterizing entities as satellites rather than new hospitals.

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

We also solicited comments on a possible further exception. In section 4417 of the BBA, Congress extended the long-term care hospital exclusion to a hospital ''that first received payment under this subsection [subsection 1886(d)(1)(B)(iv) of the Act] in 1986 which has an average inpatient length of stay (as determined by the Secretary) of greater than 20 days and that has 80 percent or more of its annual Medicare inpatient discharges with a principal diagnosis of neoplastic disease in the 12-month cost reporting period ending in fiscal year 1997.'' In view of the specific provision made for a hospital meeting these requirements, we indicated that we were considering whether a satellite facility opened by such a hospital should be exempt from the proposed rules on satellites. We requested comment on this issue and on whether this exclusion could be implemented without compromising the effectiveness of the proposed changes.

We noted that there may be some operational difficulties differentiating services, costs, and discharges of the satellite facilities from those of the existing hospital that is excluded from the prospective payment system. We indicated that, if these operational problems cannot be overcome, we would consider revising the regulations to prohibit exclusion of any hospital or hospital unit from the prospective payment system that is structured, entirely or in part, as a satellite facility in a hospital paid under the prospective payment system.

We received 18 comments on this proposal.

Comment: Several commenters objected to the proposal to pay satellite facilities of excluded hospitals or units under a different methodology than that used for the excluded hospital or unit itself. These commenters argued that the potential abuses described in the preamble to the proposed rule are likely to occur rarely, if at all, and that differential payment for satellite facilities would interfere with hospitals' flexibility to use their facilities efficiently and to take advantage of economies of scale. Other commenters suggested that the proposal, if adopted, could lead to a shortage of crucial rehabilitation or long-term hospital services.

Most of the commenters suggested that the proposed changes be withdrawn and that no limitations be placed on the ability of excluded hospitals or units to establish satellite facilities and claim payment for their services on the same basis as services in the rest of the excluded hospital or unit. Other commenters suggested that we permit services in satellite facilities to be paid on the same basis as services in the remainder of the excluded hospital or unit only if satellite facilities were created and operated under certain rules. Some commenters, including a national health care association, suggested that our concerns could be addressed if we limit the number of satellite beds that an excluded hospital or unit could establish or require that the satellite independently meet exclusion criteria.

Response: We have reviewed these comments and concluded that we can address the concerns raised in the proposed rule, especially our concerns with the application of the appropriate BBA cap on the hospital target amount, without resorting to making payments for the services provided in the satellite under a different methodology than used for the original hospital or unit.

We have decided that, for purposes of payment, the satellite facility of an excluded hospital or unit may be treated as a part of the excluded hospital or unit and may receive payment on the same basis as the excluded hospital or unit, but only if the following specific criteria are met:

- In the case of a hospital (other than a children's hospital) or unit that was excluded from the prospective payment system before the effective date of section 4414 of the BBA (cost reporting periods beginning on or after October 1, 1997), the number of beds in the hospital or unit (including both the base hospital or unit and the satellite location) does not exceed the number of State-licensed and Medicare-certified beds in the hospital or unit on the last day of the hospital's or unit's last cost reporting period beginning before October 1, 1997. Thus, while an excluded hospital or unit can ''transfer'' bed capacity from a base facility to a satellite, it cannot, through the establishment of a satellite, increase total bed capacity beyond the level it had in the most recent cost reporting period prior to the effective date of section 4414.
- The satellite facility independently complies with selected prospective payment system exclusion requirements applicable to the type of hospital unit. Specifically, a satellite of a children's hospital must meet the requirement with respect to treatment of inpatients who are predominantly individuals under age 18, as stated in § 412.23(d)(2); a satellite of a long-term care hospital must meet the average length of stay requirement of § 412.23(e)(1) through (3)(i); a satellite of a rehabilitation hospital or unit must treat an inpatient population meeting the requirement in § 412.23(b)(2); and a satellite of a psychiatric unit must meet the requirement regarding admission of only psychiatric patients in § 412.27(a).
- The satellite facility complies with certain requirements designed to ensure that costs are reported accurately for both the hospital in which the satellite is located and the hospital of which the satellite is a part. Specifically, a satellite of an excluded hospital or unit must (1) have admission and discharge records that are separately identified from those of the hospital in which it is located and are readily available; (2) have beds that are physically separate from (that is, not commingled with) the beds of the hospital in which it is located; (3) be serviced by the same fiscal intermediary as the hospital of which it is a part; (4) be treated as a separate cost center of the hospital of which it is a part, for cost reporting and apportionment purposes; (5) use an accounting system that properly allocates costs; (6) maintain

adequate statistical data to support the basis of allocation; and (7) report its costs in the cost report of the hospital of which it is a part, covering the same fiscal period and using the same method of apportionment as the hospital of which it is a part.

If an excluded hospital or unit has a satellite location and fails to meet these requirements, the entire hospital or unit would lose its exclusion from the prospective payment system. Under §§ 412.22(d) and 412.25(c), the change in status from excluded to included in the prospective payment system would be effective at the start of the first cost reporting period after the cost reporting period in which the hospital or unit failed to meet the requirements. Loss of exclusion status means that payment to the entire hospital or unit would then be made under the prospective payment system.

Thus, under our policy, we permit a satellite facility to be excluded (and treated as part of an excluded hospital) if certain criteria are met, but deny excluded status to the entire hospital if the criteria are not met. We are adopting this policy primarily because of concerns about preventing inappropriate Medicare payments. As explained above and in the proposed rule, we believe that hospitals might be seeking satellite arrangements so that the services furnished in the satellite facility are paid on an excluded basis when they should be paid on a prospective payment basis. We also believe that hospitals are seeking satellite arrangements in order to avoid the effects of the payment caps that apply to new excluded hospitals under the BBA. Therefore, we believe it is necessary and appropriate to establish criteria for determining when a satellite facility may be treated as part of the excluded hospital and paid on an excluded basis, and to deny exclusion to the satellite facility if the satellite fails to meet those criteria.

Another significant concern underlying our policy is administratively feasibility. We believe it would be administrative cumbersome, if not infeasible, to pay a satellite facility on a different basis than the rest of the excluded hospital or unit. Therefore, we believe that, if the satellite does not qualify for exclusion, then it is necessary and appropriate to deny exclusion to the entire hospital. If a hospital is considering whether to establish a satellite facility, it should keep these payment rules in mind.

We note that these exclusion criteria would be administered in the same manner as the general rules for excluded hospitals and hospital units at § 412.22 and the common requirements for excluded hospital units at § 412.25. Specifically, the HCFA Regional Office will assess a hospital's or unit's compliance with the requirements before the start of a cost reporting period and will implement the decision at the start of the cost reporting period, effective for all of that period.

One of the major concerns we had with payments for services at satellites was the ability of a hospital to circumvent the intent of the BBA by applying the higher cap for existing hospitals and units to the beds in the new satellite. By requiring that the number of beds in the expanded hospital or unit (including both the base hospital or unit and the satellite location) cannot exceed the number of State-licensed and Medicare-certified beds in the excluded hospital or unit at the time the BBA was enacted, we ensure that the excluded hospital or unit does not inappropriately circumvent the payment caps for new hospitals enacted by the BBA. For hospitals and units first excluded from the prospective payment system after the enactment date of the BBA, we would not limit the number of beds in the hospital or unit, including all satellites, since all beds in the hospital or unit necessarily will be subject to the lower cap for new excluded hospitals and units. We are not applying this requirement to children's hospitals since those hospitals are not subject to caps established by the BBA.

Furthermore, by requiring that the satellite meet the prospective payment system exclusion requirements applicable to the type of hospital or unit, we are applying a policy to satellites that is similar to that currently applicable to a hospital-within-a-hospital. This policy, which is consistent with the suggestion of a national health care association, will ensure that the satellite retains the identity of the type of excluded hospital of which it is a part. For example, if we allowed the 25-day length of stay for long-term care hospital designation to be determined based on an examination of the base long-term care hospital including the satellite, the satellite could be excluded from the prospective payment system even if its patients all had short lengths of stay. By calculating the length of stay for patients exclusively at the satellite, we are ensuring that it is, in fact, a long-term care facility that warrants being excluded from the prospective payment system and receiving payment on a reasonable cost basis. Under this approach, if the satellite facility and the rest of the hospital or unit independently meet the applicable exclusion criteria, then the entire entity will be treated as one facility in making payments.

We also believe it is essential to be able to identify the costs of satellite facilities separately from the costs of the host hospitals in which they are located, so that services in both facilities are paid for accurately and Medicare does not pay two facilities for the same costs. To accomplish this, we will require the satellite to meet a number of requirements relating to separate identification of the beds, patients, and costs of the satellite. We note that these requirements closely parallel similar requirements applicable to all excluded units under § 412.25(a)(3) and (a)(7) through (12).

We are revising §§ 412.22(h) and 412.25(e) to implement this policy.

Comment: Some commenters argued that paying satellite facilities of excluded hospitals or units under a different methodology than that used for the excluded hospital or unit itself would be inconsistent with the Medicare law, in particular, sections 1886(b)(1) and (d)(1)(A) and (D) of the Act.

Response: We believe that our policies are consistent with the statutory scheme and the considerations underlying exclusions under the prospective payment system, as well as our rulemaking authority under section 1871 of the Act. Our policies addressing payments to satellite facilities are designed to prevent inappropriate payments to hospitals and to address potential fraud and abuse, and, at the same time, to permit exclusion from the prospective payment system when the circumstances warrant exclusion. As we discussed in the proposed rule, we believe that a number of excluded hospitals are seeking satellite arrangements so that the services furnished in the satellite facility are inappropriately paid on an excluded basis when they should be paid on a prospective payment basis; we also believe that a number of excluded hospitals are seeking satellite arrangements in order to avoid the effect of the payment caps that apply to new excluded hospitals. Even if hospitals are not *intentionally* trying to ''game'' the system, treating a satellite facility as ''part of'' the excluded hospital for payment purposes might lead to inappropriate payments in a number of ways.

We believe that Congress did not contemplate satellite arrangements when it enacted section 1886(d) of the Act. Section 1886(d) does not specifically address satellite

arrangements; also, section 1886(d) does not mandate that certification status equate to payment status. The statute does, however, establish a scheme under which entities may be excluded from the prospective payment system. The purpose of exclusions is to recognize situations in which the principles of the prospective payment system do not apply. As we explained in the proposed rule, the considerations underlying exclusions from the prospective payment system might not apply to satellite facilities, which might be ''part of'' excluded hospitals only ''on paper.'' Thus, we believe it is necessary and appropriate to address Medicare payment for services furnished in satellite facilities.

Comment: Several commenters approved of our proposal to grandfather excluded hospitals or units structured as satellite facilities on September 30, 1999, to the extent that they operate under the same terms and conditions in effect on that date.

Response: We agree that grandfathering these facilities is appropriate and are adopting this part of the proposed rule without change. However, we wish to emphasize that this policy does not extend to satellites established after September 30, 1999, even if they are established by an excluded hospital or unit that has another satellite that was grandfathered.

Comment: Two commenters expressed support for our proposal to not apply the new satellite rules to any hospital excluded from the prospective payment system by section 4417 of the BBA, as implemented under § 412.23(e)(2) (that is, a hospital that was first excluded in 1986, that had an average inpatient length of stay of greater than 20 days, and that demonstrated that at least 80 percent of its annual Medicare inpatient discharges in the 12-month cost reporting period ending in FY 1997 had a principal diagnosis that reflected a finding of neoplastic disease).

Response: We agree with the commenters that this is appropriate and are revising § 412.22(h)(3) to reflect this policy.

In addition, as discussed earlier under section VI.B of this preamble, we are including in §§ 412.22(h)(4) and 412.25(e) a corresponding exception to the requirement that a grandfathered satellite facility be operated under the terms and conditions in effect on September 30, 1999. The corresponding change would allow for increases or decreases in square footage, or decreases in the number of beds, of the satellite facility necessitated by changes for compliance with Federal, State, and local law affecting the physical facility or because of catastrophic events such as fires, floods, earthquakes, or tornadoes.

D. Responsibility for Care of Patients in Hospitals-within-Hospitals

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

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

We believe it is important to address possible financial incentives for inappropriate early discharges from excluded hospitals-within-hospitals to prospective payment system hospitals. Therefore, in the proposed rule, we discussed several approaches for preventing inappropriate Medicare payments to an excluded hospital-within-a-hospital for inappropriate discharges to the prospective payment system hospital in which it is located. One approach was to provide that, if an excluded hospital-within-a-hospital transfers patients from its beds to beds of the prospective payment system hospital in which it is located, the hospital-within-a-hospital would not qualify for exclusion in the next cost reporting period. A second possible approach was to provide that the hospital-within-a-hospital would qualify for exclusion if it transfers patients to the prospective payment system hospital only when the services the patients require cannot be furnished by the hospital-within-a-hospital.

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

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

We received 30 comments in response to our proposal and solicitation.

Comment: Several commenters argued that the choice of a 5-percent limit on discharges to the host prospective payment system hospital was arbitrary, and that we did not cite any study or other empirical evidence in support of it. Other commenters stated that the proposal could discourage excluded

hospitals-within-hospitals from admitting medically complex cases, thus contributing to a shortage of certain types of care. Other commenters, including a number of physicians, respiratory therapists, and other clinical personnel, expressed concern that the proposed rule could discourage medically appropriate transfers and thus limit patients' ability to receive needed care. One commenter indicated that the proposed rule was stated only in terms of transfers from the excluded hospital-within-a-hospital to the host prospective payment system hospital, while the problems described in the preamble involve transfers of patients from the excluded hospital-within-a-hospital to the host prospective payment system hospital, followed by readmission of the patient to the excluded hospital-within-a-hospital. Other commenters suggested that while these transfers might be abusive, the sanction identified in the proposed rule—loss of the exclusion from the prospective payment system of the hospital-within-a-hospital—is disproportionate to the problem.

Response: After review of all comments on this issue, we have decided to modify our approach. First, we agree with those commenters who stated that the primary focus of concern should not be discharges from the excluded hospital-within-a-hospital to the host prospective payment system hospital, but rather should include situations in which the discharges are then followed by readmissions to the excluded hospital-within-a-hospital, without any intervening movement of the patient from the host hospital to a skilled nursing facility, his or her home, or another hospital. Thus, we are revising the regulations to address only the latter situations.

We also agree that there is a better way to address inappropriate transfers and readmissions. When the level of inappropriate transfers exceeds the threshold level described below, we will, instead of terminating a hospital's exclusion, simply not consider the earlier discharge in these cases to have occurred, for purposes of calculating the payment to the hospital or unit. That is, if a patient is discharged from an excluded hospital-within-a-hospital to the host prospective payment system hospital and is then readmitted to the excluded hospital-within-a-hospital directly from the host hospital, the readmission would mean that the earlier discharge(s) from the excluded hospital will not be taken into account in calculating payments to the hospital-within-a-hospital under the excluded hospital payment provisions and their implementing regulations in § 413.40.

We also considered whether this policy should be applied in all cases or only if a specific threshold is exceeded. We continue to believe that the types of cases described (discharge of the patient to the host prospective payment system hospital, followed by readmission directly to the excluded hospital-within-a-hospital) are potentially vulnerable to abuse and that, in principle, we should adopt a policy of ''zero tolerance'' for these cases. At the same time, we are aware that this stringent approach might be difficult and controversial to implement and could have the unintended effect of discouraging some medically necessary or appropriate discharges to the host hospital. Therefore, we will allow a 5-percent margin to hospitals for these cases, in that we would not count the first discharge for purposes of payment as an excluded hospital only when the excluded hospital's number of these cases in a particular cost reporting year exceeded 5 percent of the total number of its discharges. If a hospital exceeds this 5-percent threshold, we would, with respect to these cases, not include any previous discharges to the host prospective payment system hospital in calculating the excluded hospital's cost per discharge. That is, the entire stay would be considered one ''discharge'' for purposes of payments to the hospital.

For example, assume that a patient was discharged from the excluded hospital-within-a-hospital to the prospective payment system hospital in which it is located and then was readmitted to the excluded hospital-within-a-hospital from the prospective payment system hospital (the ''host''). If the total number of discharges (to all locations) of the hospital-within-a-hospital in the cost reporting period is 100 and the number readmitted from the host after having been previously discharged to it is 3, the percentage would be 3 percent (3 divided by 100), and all of the discharges, including the previous discharge to the host, would be taken into account. However, if the total number of discharges had been only 50, and of those, 3 patients had been readmitted from the host after a previous discharge to it, the percentage would be 6 percent (3 divided by 50) and the first discharge of the patients readmitted to the host would not be counted. Therefore, payment would be based on 47 discharges. In determining whether a patient had previously been discharged and then readmitted, we would consider all prior discharges, even if the discharge occurred late in one cost reporting period and the readmission occurred in the next cost reporting period.

Thus, in the May 7, 1999 proposed rule, we proposed to deny exclusion to a hospital-within-a-hospital if, during the most recent cost reporting period for which information is available, the excluded hospital-within-a-hospital transferred more than 5 percent of its inpatients to the prospective payment system hospital in which it is located. After considering the public comments, in this final rule we are implementing a policy that differs from the proposed policy in two significant ways. First, rather than focusing solely on discharges to the host hospital, we are examining situations involving a discharge to the host hospital followed by a readmission to the excluded hospital. Second, if the 5-percent threshold is triggered, we would not deny exclusion to the hospital-within-a-hospital; instead, the hospital-within-a-hospital could continue to receive payment as an excluded hospital-within-a-hospital, but, for purposes of determining the amount of payment, we would not count the first discharge for those cases involving a discharge followed by readmission. (If the 5-percent threshold is not triggered, then all discharges would be counted.)

We continue to believe that the 5-percent threshold is appropriate to trigger special payment rules. We are trying to prevent inappropriate payments to hospitals for inappropriate transfers, and a 5-percent threshold reflects a balance of a number of considerations. As indicated in the proposed rule, a 5-percent threshold would (1) avoid the need for administratively burdensome case review (to determine whether discharges or readmissions were inappropriate), (2) provide adequate flexibility for transfers in those cases in which the hospital-within-a-hospital is not equipped or staffed to provide the services required by the patient, and (3) address possible incentives for hospitals to transfer patients inappropriately.

The rationale for this policy is largely conceptual in nature, and the 5-percent threshold is not based solely on any one source of statistics or data available to us. If we tried to set a threshold based solely on such statistics, it might be extremely difficult and time-consuming to distinguish between appropriate transfers and inappropriate transfers. Given the importance of preventing inappropriate payments, we believe it would not be prudent to delay implementing this policy. At this time, we believe that a 5-percent ''allowance'' reflects an appropriate balance of the considerations discussed above and is

consistent with information available to us. However, we will continue to monitor this issue and review data, and we might revise the threshold in a future rulemaking if information indicates that a revision is appropriate.

We are revising the definition of ''ceiling'' in § 413.40(a)(3) to implement our revised policy.

Comment: Some commenters asked whether the intent of the proposed rule was to exclude hospitals-within-hospitals described under § 412.22(f) from the provision on responsibility for care of patients, since the proposed rule would have added a new paragraph (e)(6), and existing § 412.22(f) states that the rules in paragraph (e) do not apply to hospitals described in paragraph (f).

Response: As discussed above, we are not proceeding with the proposed changes at § 412.22(e)(6) and are instead implementing our revised policy by amending the definition of ''ceiling'' in § 413.40(a)(3). The hospitals described in § 412.22(f) will be subject to the new policy on the same basis as other hospitals-within-hospitals.

E. Critical Access Hospitals (CAHs)

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

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

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

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

In order to recognize the special needs of sparsely populated rural areas in meeting beneficiaries' health needs, and at the same time to protect patients' health and safety, in the May 7, 1999 proposed rule, we proposed to revise § 485.618(d) to allow a response time of up to 60 minutes for a CAH if (1) it is located in an area of the State that is defined as a frontier area (that is, having fewer than six residents per square mile based on the latest population data published by the Bureau of the Census) or meets other criteria for a remote location adopted by the State and approved by HCFA under criteria specified in its rural health care plan under section 1820(b) of the Act; (2) the State determines that, under its rural health care plan, allowing the longer emergency response time is the only feasible method of providing emergency care to residents of the area; and (3) the State maintains documentation showing that a response time of up to 60 minutes at a particular CAH it designates is justified because other available alternatives would increase the time required to stabilize the patient in an emergency. The criteria for remote location would, like other parts of the rural health care plan, be subject to review and approval by the HCFA Regional Office, as would the State's documentation regarding the emergency response time.

We noted that, under the terms of the Montana State Code applicable to MAFs, at times when no emergency response person is available to come to the facility, a MAF's director of nursing is permitted to come to the facility and authorize the transfer of a patient seeking emergency services to another facility. Under one possible reading of the State requirement, this activity could be seen as an alternative way of complying with the emergency services requirement and the MAF's (and CAH's) responsibilities under section 1867 of the Act (the Emergency Medical Treatment and Active Labor Amendments Provision) to provide emergency medical screening and stabilization services to patients who come to the hospital seeking emergency treatment. We requested comments on whether the Medicare regulations in §§ 485.618(d) and 489.24 should be further revised to explicitly permit this practice to continue following the transition of a MAF to CAH status. We were particularly interested in obtaining comments from practitioners on the risks and benefits involved in adoption of this practice.

We received three comments on our proposal.

Comment: Two commenters supported our proposal to allow a 60-minute emergency response time for frontier areas.

Response: We appreciate the commenters' support and are adopting this proposal as final without change.

Comment: One commenter believed that the 60-minute response timeframe in the proposed rule is too long considering the importance of timely provision of emergency care even in remote areas. The commenter believes that if a facility wants to function as a CAH, it should have appropriate personnel onsite within 30 minutes to provide care.

Response: As we have indicated above, we believe that we must recognize the special needs of sparsely populated rural areas in meeting beneficiaries' health needs and at the same time protect patients' health and safety. We believe our proposed change accomplishes this goal.

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

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

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

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

Comments: We received three comments on this proposal. One commenter supported our proposal and stated that the clarification would help eliminate the confusion that has existed in the industry. Another commenter noted that we do not have a comparable requirement for screening patients in swing beds located in all other rural hospitals and therefore believes it is inappropriate to implement a standard for CAHs that exceed normal practice. Another commenter objected to the proposed clarification as inflexible and biased and urged us to defer implementing the screening policy for swing beds for CAHs until we have established overall policy for swing beds.

Response: We believe that the changes we have proposed have revised the rules to allow for flexibility for CAHs. As stated above, CAHs with swing-bed approval are not paid for their services to SNF-level patients under the SNF prospective payment system but are paid under the payment method described in § 413.114, which does not include a case-mix adjustment. However, swing beds in rural hospitals are paid under the SNF prospective payment system. As explained above, the changes proposed to the reporting requirements for CAHs are intended to allow the policy to be consistent with the payment policy for swing beds in CAHs. With the change, we are making it explicit that the patient assessment timeframes required under §§ 413.343(b) and 483.20 do not apply to CAHs.

3. Additional Comments Received on CAH Issues

We received comments on two separate issues regarding CAHs on which we did not propose policy changes.

Comment: One commenter believes that the definition of CAH is prohibitive in one State and recommended that we change the criteria for CAHs to allow a hospital that meets all the criteria except for being located in an urban (versus a rural) area to be considered a CAH.

Response: We would need a change in the statute to authorize a change in the requirements for CAH designation, as the commenter recommended. Section 1820(c)(2)(B)(i) of the Act provides that a State may designate a facility as a CAH only if the hospital is located in a rural area as defined in section 1886(d)(2)(D) of the Act. Thus, we did not revise our regulations to address this comment.

Comment: One commenter suggested that the reasonable cost payment methodology for CAHs should extend to ambulance services and requested that HCFA address this in the final rule.

Response: The provision of law governing payment for outpatient CAH services, section 1834(g) of the Act, states that reasonable cost payment is to be made for outpatient CAH services. These services are defined, at section 1861(mm)(3) of the Act, as medical and other health services furnished by a CAH on an outpatient basis. Consistent with our policy on ambulance services, these services are treated under a separate benefit and are covered and paid for under separate statutory authority and a separate payment method. Therefore, we have no basis on which to authorize reasonable cost payment for ambulance services .

VII. MedPAC Recommendations

As required by law, we reviewed the March 1, 1999 report submitted by MedPAC to the Congress and gave its recommendations careful consideration in conjunction with the proposals set forth in the May 7, 1999 proposed rule. We also responded to the individual recommendations in the proposed rule. The comments we received on the treatment of the MedPAC recommendations are set forth below, along with our responses to those comments. However, if we received no comments from the public concerning a MedPAC recommendation or our response to that recommendation, we have not repeated the recommendation. Recommendations concerning the update factors for inpatient operating cost and for hospitals and hospital distinct part units excluded from the prospective payment system are discussed in Appendix C of this final rule.

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

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

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

Comment: We received two comments on our response to the MedPAC recommendation regarding the wage related portion of the excluded hospital target amount cap. Specifically, MedPAC commented that it would encourage HCFA to seek legislative authority to adjust the target amount caps for area wages. The other commenter asserted that such adjustments should be made since they are used for new facilities and because the exclusion of an adjustment is unfair to regions with higher labor costs.

Response: In the May 12, 1998 final rule, we explained our decision not to wage adjust the caps on the target amounts. The decision was based on our analysis of the statutory language, the statutory scheme, the legislative history, and policy considerations. First, we noted that section 4414 of the BBA, which provides that ''* * * in the case of a hospital or unit that is within a class of hospital described in clause (iv), the Secretary shall estimate the 75th percentile of the target amounts for such hospitals within such class for cost reporting periods ending during fiscal year 1996,'' directs the Secretary to examine target amounts and calculate a single number for each of three classes of hospitals. In addition, we stated that while the statutory language directs the Secretary to calculate the 75th percentile of target amounts, it does not explicitly direct or even authorize the Secretary to make adjustments to that