

payments is that the average standardized charges of cases involving the new technology must be demonstrated to exceed one standard deviation beyond the mean standardized charges of the DRG to which the new technology will be assigned. When we established this threshold in the September 7, 2001 final rule, we expressed our belief that it is important to establish a threshold that recognizes the variability in costs per case within DRGs and maintains the fundamental financial incentives of the IPPS (66 FR 46917).

In its comments on this approach, MedPAC supported the one standard deviation threshold. However, others, particularly representatives of the manufacturers of new technology, have argued this threshold is too high, and that virtually no new technology would qualify for the special payment provision.

We are concerned that establishing higher payments for a great number of new technologies may be inflationary because the add-on payments reduce the efficiency incentives hospitals face when new technologies must otherwise be financed out of current payments for similar cases. Traditionally, new technologies were required to compete with existing treatment methods on clinical and cost criteria. Add-on payments are intended to give new technologies a competitive boost relative to existing treatment methods with the goal of encouraging faster and more widespread adoption of new technologies.

Much of the current variation around the mean within any particular DRG is due to the range of procedures contained within each DRG. Generally, some of these procedures will be more expensive than the mean and some will be less expensive. The threshold should be set high enough to ensure that it identifies truly high-cost technologies. If the threshold were set too low (for example, at \$2,500, as some have suggested), additional technologies may qualify merely by association with a procedure only slightly more costly than the mean for the DRG.

For example, consider a DRG with five different procedures and mean charges of \$15,000. The mean charges for each procedure are distributed around \$15,000, as illustrated in the following table. A qualifying threshold of \$2,500 would result in any new technology that is only used for the fifth procedure automatically qualifying for new technology add-on payments (unless the new technology had the unlikely effect of lowering the mean cost for cases with this procedure by at

least \$2,500). This is because the average charge of \$20,000 for cases in this procedure already exceeds the mean charges for the DRG plus \$2,500.

Procedure	Mean charge
1 .....	\$10,000
2 .....	12,000
3 .....	15,000
4 .....	17,000
5 .....	20,000

At the same time, we recognize that the very limited number of applications that have been submitted the past 2 years (five for FY 2003; two for FY 2004) may indicate that only a very small number of the new technologies that come onto the market every year are costly enough even to apply for new technology add-on payments. Therefore, for FY 2005 and subsequent Fiscal Years, we are proposing to reduce the threshold to 75 percent of one standard deviation beyond the geometric mean standardized charge for all cases in the DRG to which the new medical service or technology is assigned (proposed § 412.87(b)(3)).

Based on our analysis of the thresholds for FY 2004, this proposed change would reduce the average threshold across all DRGs to qualify for the add-on payments from approximately \$9,900 above the mean standardized charges for each DRG to approximately \$7,400. This reduction would maintain the averaging principles of the IPPS while easing the requirement somewhat to allow more technologies to qualify. Furthermore, the situation illustrated above, where a technology qualifies on the basis of its association with a high cost procedure, is much less likely to occur as a result of this reduction than if the threshold were reduced dramatically.

#### 5. Technical Changes

Subpart H of part 412 describes payments to hospitals under IPPS. We have become aware of references to the calculation of IPPS payments in this subpart that inadvertently omit references to new technology add-on payments. For example, § 412.112(c) describes the basis for per case payments. This section refers to outlier payments under subpart F, but was not revised to reflect the implementation of the new technology add-on payments. Therefore, we are proposing to amend § 412.112(c) to add a new paragraph (d) to include a reference to additional payments for new medical services or technologies under subpart F.

Section 412.116(e) currently states that payments for outlier cases are not made on an interim basis. That is, for

hospitals receiving payments under a biweekly, lump-sum payment methodology, outlier payments are not included in the calculation of the lump-sum payment amounts. Rather, outlier payments are calculated on a case-by-case basis. Similarly, due to the unique nature of the new technology add-on payments, we are proposing that they would also be calculated on a case-by-case basis rather than included in the calculation of interim payment amounts. Therefore, we are proposing to revise § 412.116(e) to include this policy.

### III. Proposed Changes to the Hospital Wage Index

#### A. Background

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

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