DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 405, 412, and 413

[HCFA–1003–F]

RIN 0938–AI22

Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 1999 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 applicable statutory requirements, including section 4407 of the Balanced Budget Act of 1997 (BBA), as well as 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, 1998. We also set forth rate-of-increase limits as well as changes for hospitals and hospital units excluded from the prospective payment systems. Finally, we are implementing the provisions of section 4625 of the BBA concerning payment for the direct costs of graduate medical education.

DATES: The provisions of this final rule are effective October 1, 1998. 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 the Congress on this rule on July 31, 1998.

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FOR FURTHER INFORMATION CONTACT:
Nancy Edwards, (410) 786–4531, Operating Prospective Payment, DRG, and Wage Index Issues.
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SUPPLEMENTARY INFORMATION:

I. Background

A. Summary

Sections 1886(d) and (g) of the Social Security Act (the Act) set forth a system of payment for the operating and capital costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively-set rates. Under these prospective payment systems (PPS), 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 units are excluded from PPS: 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 certain limits.

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

The regulations governing the hospital inpatient prospective payment system are located in 42 CFR part 412. The regulations governing excluded hospitals are located in both parts 412 and 413, and the graduate medical education regulations are found in part 413.

B. Summary of the Provisions of the May 8, 1998 Proposed Rule

On May 8, 1998, we published a proposed rule in the **Federal Register** (63 FR 25576) setting forth proposed changes to the Medicare hospital inpatient prospective payment systems for both operating costs and capital-related costs, which would be effective for discharges occurring on or after October 1, 1998. We also proposed changes in payments for excluded hospitals and payments for graduate medical education costs. The following is a summary of the major issues addressed and changes we proposed to make:

- We proposed changes to the FY 1999 DRG classifications and relative weights, as required by section 1886(d)(4)(C) of the Act.
- We proposed to update the hospital wage data for FY 1999. We also proposed changes to the data categories included in the wage index and revisions to the wage index based on hospital redesignations.
- We discussed several provisions of the regulations in 42 CFR parts 412 and 413 and set forth certain proposed changes concerning definition of transfer cases, rural referral centers, disproportionate share adjustment, bad debts, and direct graduate medical education programs.
- We discussed several provisions of the regulations in 42 CFR Part 412 and set forth certain proposed changes and clarifications concerning capital indirect medical education payments and payments to new hospitals.
- We discussed the criteria governing excluded hospitals including caps on the target amounts for FY 1999 and exceptions.
- In the addendum to the proposed rule, we set forth proposed changes to the amounts and factors for determining the FY 1999 prospective payment rates for operating costs and capital-related costs. We also proposed update factors for determining the rate-of-increase limits for cost reporting periods

beginning in FY 1999 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 1999 capital cost model.
- In Appendix C, as required by section 1886(e)(3)(B) of the Act, we set forth a report to Congress on our initial estimate of a recommended update factor for FY 1999 for both hospitals included in and hospitals excluded from the prospective payment systems.
- In Appendix D of the proposed rule, we set forth our recommendation of the appropriate percentage change for FY 1999 for the large urban area and other area average standardized amounts (and hospital-specific rates applicable to sole community and Medicare-dependent, small rural hospitals) for hospital inpatient services paid for under the prospective payment system for operating costs.
- In Appendix D of the proposed rule, we also set forth our recommendation of the appropriate percentage change for FY 1999 for 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 in detail the March 1, 1998 recommendations concerning hospital inpatient policies made by the Medicare Payment Advisory Commission (MedPAC) as well as 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

A total of 214 items of correspondence containing comments on the proposed rule were received timely. The main areas of concern addressed by the commenters were the change in the definition of transfer cases and the revisions to the wage index. We also received a number of comments on the proposal to pay qualified nonhospital providers for the direct costs of graduate medical education.

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

II. Changes to DRG Classifications and 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 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. The changes to the DRG classification system and the recalibration of the DRG weights for discharges occurring on or after October 1, 1998 are discussed below.

B. DRG Reclassification

1. General

Cases are classified into DRGs for payment under the prospective payment system based on the principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay, as well as age, sex, and discharge status of the patient. The diagnosis and procedure information is reported by the hospital using codes from the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD–9–CM). The Medicare fiscal intermediary enters the information into its claims 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 496 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 transplant (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 (hereafter 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 1999. The proposed changes, the comments we received concerning them, our responses to those comments, and the final DRG changes are set forth below. Unless otherwise noted, our DRG analysis is based on the full (100 percent) FY 1997 MedPAR file based on

bills received through September 30, 1997.

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

In the August 29, 1997 hospital inpatient final rule with comment period (62 FR 45974), we noted that, because of the many recent changes in heart surgery, we were considering conducting a comprehensive review of the MDC 5 surgical DRGs. We have begun that review, and based upon our analysis thus far, we proposed the following DRG changes.

a. Coronary Bypass. There are two DRGs that capture coronary bypass procedures: DRG 106 (Coronary Bypass with Cardiac Catheterization) and DRG 107 (Coronary Bypass without Cardiac Catheterization). The procedures that allow a coronary bypass case to be assigned to DRG 106 include percutaneous valvuloplasty, percutaneous transluminal coronary angioplasty (PTCA), cardiac catheterization, coronary angiography, and arteriography.

In analyzing the FY 1997 MedPAR file, we noted that, of cases assigned to DRG 106, the average standardized charges for coronary bypass cases with PTCA were significantly higher than those cases without PTCA. There were approximately 4,400 cases in DRG 106 where PTCA is performed as a secondary procedure. These cases had an average standardized charge of approximately $69,000. The average charge of the approximately 95,000 cases in DRG 106 without PTCA was approximately $52,000.

Based on this analysis, we proposed to create a new DRG for coronary bypass cases with PTCA. The cases currently in DRG 106 without PTCA would be assigned to another DRG and the cases currently assigned to DRG 107 would be unmodified. Because we would replace two DRGs with three new DRGs, we proposed to revise the DRG numbers and titles accordingly. The new DRGs and their titles are set forth below:

DRG 106 Coronary Bypass with PTCA
DRG 107 Coronary Bypass with Cardiac Catheterization
DRG 109 Coronary Bypass without Cardiac Catheterization

We note that DRG 109 has been an empty DRG for the last several years.

We received several comments regarding this proposal.

Comment: While the commenters supported the creation of a new DRG to capture coronary bypass surgeries with PTCA, some of the commenters were concerned about the renumbering of the current DRGs 106 and 107. They believe splitting the cases currently assigned to DRG 106 into new DRGs 106 and 107 and reassigning the cases currently assigned to DRG 107 to DRG 109 will make it difficult to conduct DRG trend analyses. The commenters suggested that DRGs 106 and 107 should not be modified and that DRG 109 be used to capture coronary bypass with PTCA. Two commenters stated that a DRG that has been invalidated (109) should not be reintroduced.

Response: Although we understand the commenters' concern, we also believe that the sequencing of surgical DRGs in hierarchy order is appropriate. In this case, our alternative to the proposed revision would have been to delete DRGs 106 and 107 and create three new DRGs that would have been placed at the end of the DRG table, that is, after current DRG 503. Because we did have an empty surgical DRG in MDC 5 and it was numerically close to DRGs 106 and 107, we believed our proposed retitling was the best alternative.

We note that the surgical DRGs in MDC 5 have been renumbered and retitled several times since they were first introduced in 1983. As stated above, we are currently conducting a comprehensive review of the MDC 5 surgical DRGs. If that review results in the reclassification of procedures among the current DRGs, we will probably renumber and retitle those DRGs.

Comment: We received one comment requesting clarification of the DRG assignment for PTCA and cardiac catheterization procedures when performed in conjunction with coronary bypass. The commenter suggested that we add the phrase ''without PTCA'' to the titles of DRGs 107 and 109 to more aptly describe the cases assigned to those DRGs.

Response: Coronary bypass performed in conjunction with single or multiple PTCA or percutaneous valvuloplasty will be assigned to DRG 106. The procedure codes for PTCA and percutaneous valvuloplasty are as follows: 35.96, 36.01, 36.02, and 36.05. Procedures assigned to DRG 107 would include any coronary bypass with cardiac catheterization, coronary angiography, or coronary arteriography, and DRG 109 is for cases with the coronary bypass procedure only. We believe that the proposed titles accurately describe the cases assigned to each of the DRGs and that adding the phrase ''without PTCA'' to the titles of DRGs 107 and 109 is unnecessary. We are incorporating our proposed DRG changes and DRG numbers and titles in the final DRG classifications.

b. Implantable heart assist system and annuloplasty. In the August 29, 1997 final rule with comment period, we moved implant of an implantable, pulsatile heart assist system (procedure code 37.66) from DRGs 110 and 111 (Major Cardiovascular Procedures)[1] to DRG 108 (Other Cardiothoracic Procedures). Although this move improved payment for these procedures, they were still much more expensive than the other cases in DRG 108 ($96,000 for heart assist versus an average of $54,000 for all other cases in the FY 1996 MedPAR file). We stated that we would continue to review the MDC 5 surgical DRGs in an attempt to find a DRG placement for these cases that would be more similar in terms of resource use.

As discussed in the proposed rule, in reviewing the FY 1997 MedPAR file, we noted that heart assist system implant continues to be the most expensive procedure in DRG 108. In fact, other than heart transplant, heart assist system implant is the most expensive procedure in MDC 5. The average FY 1997 charge for these cases, when assigned to DRG 108, is over $150,000 compared to about $53,000 for all cases in DRG 108. Obviously, the charges for heart assist implant are increasing at a much greater rate than the average charges for DRG 108. In addition, the length of stay for cases coded with 37.66 is approximately 32 days compared to about 11 days for all other DRG 108 cases.

One possibility for improving payment for these cases is to move them to DRGs 104 and 105 (Cardiac Valve Procedures). Those DRGs, which split on the basis of the performance of cardiac catheterization, have average charges of approximately $66,000 and $51,000, respectively. While heart assist implant cases are still more expensive than the average case in these DRGs, payment would be improved. Clinically, placement of heart assist implant in DRGs 104 and 105 is not without precedent. Effective with FY 1988, we placed implant of a total automatic implantable cardioverter defibrillator (AICD) in these DRGs. In addition, the vast majority of procedures assigned to DRG 108 involve surgically splitting open the sternum to perform the procedure. However, implant of the heart assist device does not require this approach.

While reviewing the DRG 108 cases, we also noted that procedure code 35.33

[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.

(annuloplasty) is assigned to this DRG. Annuloplasty is a valve procedure and is clinically more similar to the cases assigned to DRGs 104 and 105 than it is to the cases assigned to DRG 108. In addition, the average standardized charge for annuloplasty cases assigned to DRG 108 is about $67,000, well above the overall average charge of approximately $53,000 for cases in DRG 108. Therefore, we proposed to move annuloplasty from DRG 108 to DRGs 104 and 105.

In order to more accurately reflect the cases assigned to DRGs 104 and 105, we proposed to retitle them as follows:

DRG 104 Cardiac Valve and Other Major Cardiothoracic Procedures with Cardiac Catheterization

DRG 105 Cardiac Valve and Other Major Cardiothoracic Procedures without Cardiac Catheterization.

We received only supportive comments for our proposal to move annuloplasty to DRGs 104 and 105; therefore, that change is included in the final DRGs.

Comment: Commenters generally appreciated any improvement in the payment for heart assist devices. However, some of them continue to urge HCFA to reclassify these cases to DRG 103 (Heart Transplant) or to their own DRG. Two commenters were unsure if we had proposed a classification change which was reflected in the proposed DRG weights or had merely requested comment on such a change. Another commenter was concerned that cases reassigned to DRG 105 (those in which there is no cardiac catheterization performed) would receive a lower payment than they currently do in DRG 108.

Response: First, we note that the proposed DRG weights did include this change; that is, we moved over 2,000 heart assist implant cases from DRG 108 to DRGs 104 and 105 before recalibrating the proposed weights. In addition, although the final FY 1999 weight for DRG 105 is slightly lower than the weight for DRG 108 (5.7099 and 5.9764, respectively), the much higher DRG 104 weight (7.3690) results in an overall improvement in payment for these cases when reclassified. Using the FY 1997 MedPAR cases, we estimate that at least 40 percent of the heart assist implant cases will be assigned to DRG 104. Thus, as long as a hospital treats a mix of heart assist implant cases, with and without the cardiac catheterization procedure, its overall payment should be higher under the revised classification. We presume this will be the case for virtually all hospitals.

With regard to the comments concerning reclassification of this procedure to DRG 103 or a new DRG, we refer the reader to our response to a similar comment in the August 29, 1997 final rule (62 FR 45967).

3. MDC 22 (Burns)

Under the current DRG system, burn cases are assigned to one of six DRGs in MDC 22 (Burns), which have not been revised since 1986. In our FY 1998 hospital inpatient proposed rule (June 2, 1997; 62 FR 29912), in response to inquiries we had received, we indicated that we would conduct a comprehensive review of MDC 22 to determine whether changes in these DRGs could more appropriately capture the variation in resource use associated with different classes of burn patients. We solicited public comments on this issue, particularly asking for recommendations on ways to categorize related diagnosis and procedure codes to produce DRG groupings that would be more homogeneous in terms of resource use.

In our May 8, 1998 proposed rule (63 FR 25579), we discussed in detail the results of our review of MDC 22. We received a proposal (endorsed by the American Burn Association (ABA)) for restructuring the DRGs based on several statistical and clinical criteria, including age, severity of the burn, and the presence of complications or comorbidities. Subsequently, we worked closely with representatives of the ABA and with the clinicians who developed the proposal in order to refine it for Medicare purposes. Based on this work, we proposed to replace the six existing DRGs in MDC 22 with eight new DRGs. For ease of reference and classification, the current DRGs in MDC 22, DRGs 456 through 460 and 472, would no longer be valid, and we would establish new DRGs 504 through 511 to contain all cases that currently group to MDC 22. (The complete titles of the new DRGs are set forth below.)

In reviewing the Medicare burn cases, we found that the most important distinguishing characteristic in terms of resource use was the amount of body surface affected by the burn and how much of that burn was a 3rd degree burn. The second most important factor was whether or not the patient received a skin graft. Thus, a patient with burns covering at least 20 percent of body area, with at least 10 percent of that a 3rd degree burn, consumed the most resources. However, if a patient met these criteria and did not receive a skin graft, then the case was much less expensive and the average length of stay fell from over 30 days to 8 days. The first two proposed burn DRGs reflect these distinctions (DRGs 504 and 505).

After classifying the most extensive burn cases, we found that the patients with 3rd degree burns that did not meet the criteria to be assigned to DRGs 504 and 505 were the most expensive of the remaining cases (that is, those patients whose burns did not meet the at least 20 percent body area or at least 10 percent 3rd degree criteria). These burns are referred to clinically as ''full-thickness burns.'' A subset of these full-thickness burn cases, those with skin graft or an inhalation injury, were much more expensive than the other cases. After dividing these patients into two groups, with or without skin graft or inhalation injury, we examined whether other factors had an influence on resource use. We found that patients who had a CC (complication or comorbidity) or a concomitant significant trauma consumed more resources whether or not they had a skin graft or inhalation injury. Thus, the next four proposed DRGs were defined as full-thickness burns with skin graft or inhalation injury with or without CC or significant trauma, or full-thickness burns without skin graft or inhalation injury with or without CC or significant trauma (DRGs 506 through 509).

Finally, the last two proposed DRGs (510 and 511) were for cases with nonextensive burns. These cases are also split on the basis of CCs or concomitant significant trauma.

Consistent with the recommendations of several commenters on last year's proposed rule, the new burn DRGs would no longer include a separate DRG for cases in which burn patients were transferred to another acute care facility.

The specific diagnosis and procedure codes that were included in each of the eight proposed DRGs and their titles are as follows.

DRGs 504 and 505—Extensive 3rd Degree Burns with and without Skin Graft. DRGs 504 and 505 include all cases with burns involving at least 20 percent of body surface area combined with a 3rd degree burn covering at least 10 percent of body surface area. Thus, these cases have diagnosis codes of 948.xx, with a fourth digit of 2 or higher (indicating that burn extends over 20 percent or more of body surface) and a fifth digit of 1 or higher (indicating a 3rd degree burn extending over 10 percent or more of body surface). Cases with the appropriate diagnosis codes are classified into DRG 504 if one of the following skin graft procedure codes is present:

85.82 Split-thickness graft to breast
85.83 Full-thickness graft to breast
85.84 Pedicle graft to breast
86.60 Free skin graft, NOS
86.61 Full-thickness skin graft to hand

86.62 Other skin graft to hand
86.63 Full-thickness skin graft to other sites
86.65 Heterograft to skin
86.66 Homograft to skin
86.67 Dermal regenerative graft (new code in FY 1999—see Table 6A in section VI. of the Addendum)
86.69 Other skin graft to other sites
86.70 Pedicle of flap graft, NOS
86.71 Cutting and preparation of pedicle grafts or flaps
86.72 Advancement of pedicle graft
86.73 Attachment of pedicle or flap graft to hand
86.74 Attachment of pedicle or flap graft to other sites
86.75 Revision of pedicle or flap graft
86.93 Insertion of tissue expander

DRGs 506 and 507—Full Thickness Burn with Skin Graft or Inhalation Injury with or without CC or Significant Trauma. These DRGs include all other cases of 3rd degree burns that also have either a skin graft or an inhalation injury. Thus, these cases have diagnosis codes of 941.xx through 946.xx, and 949.xx, with a fourth digit of 3 or higher, as well as cases with codes of 948.xx that did not group into DRGs 504 or 505 (that is, 948.00, 948.01, and 948.1x through 948.9x with a fifth digit of 0). In addition, cases classified into DRGs 506 and 507 must have either one of the skin graft procedure codes listed above or one of the following diagnosis codes for inhalation injuries:

518.5 Pulmonary insufficiency following trauma and surgery
518.81 Respiratory failure
518.84 Acute and chronic respiratory failure (new code in FY 1999—see Table 6A in section VI. of the Addendum)
947.1 Burn of larynx, trachea, or lung
987.9 Toxic effect of gas, fume, or vapor, NOS

Cases that meet both of these coding criteria are assigned to DRG 506 if there is a diagnosis code indicating either a CC (based on the standard DRG CC list) or concomitant significant trauma (based on the significant trauma diagnosis codes, listed by body site, used for classification in MDC 24).

DRGs 508 and 509—Full Thickness Burn without Skin Graft or Inhalation Injury with or without CC or Significant Trauma. These DRGs include all other cases of 3rd degree burns. Thus, these DRGs include all cases without a skin graft or inhalation injury that have diagnosis codes of 941.xx through 946.xx, and 949.xx, with a fourth digit of 3 or higher, as well as cases with codes of 948.xx that did not group into DRGs 504 or 505. DRG 508 also requires a secondary diagnosis from the standard CC list or the trauma list based on the significant trauma diagnosis codes, listed by body site, used for classification in MDC 24.

DRGs 510 and 511—Nonextensive Burns with and without CC or Significant Trauma. The remaining burn cases would be classified into one of these two proposed DRGs, depending on whether or not the claim included a diagnosis code reflecting the presence of a CC or a significant trauma, as explained above.

Comment: We received five comments on this proposed change. In general, the commenters, including the ABA, strongly supported the proposed restructuring of MDC 22. The commenters agreed that the new burn DRGs should bring about meaningful improvements to the clinical coherency and payment equity for the cases assigned to the MDC 22 DRGs. One commenter noted that under the new DRGs, diagnosis codes in the 948.xx series (that is, the codes used to identify the extent of body surface involved in a burn and the percentage of the body surface with a 3rd degree burn) would take on added importance and emphasized the need for coder education in this area. Another commenter submitted several suggestions for additional procedure codes that should be added to the list of procedure codes that would result in assignment to DRG 504 and to DRGs 506 and 507. These codes include both additional codes that the commenter believes should be considered as skin grafts (such as procedure codes 08.61 through 08.69, reconstruction of eyelid with flaps or grafts) as well as codes for other procedures (for example, limb reattachments or eyeball enucleations) that, as the commenter pointed out, are now considered a related operating room procedure under existing DRG 472, Extensive Burns with Operating Room Procedure. This commenter also suggested that DRGs 506 and 507 be identified as surgical DRGs in Table 5 of the addendum to the final rule.

Response: We appreciate the positive responses generated by this proposal. We agree that our proposed changes will place greater emphasis on the need for accurate use of the series 948.xx diagnosis codes. We note that this issue has been addressed in the American Hospital Association's quarterly publication, ''Coding Clinic for ICD–9–CM.'' In the 1994, 4th quarter issue, Coding Clinic stated ''It is advisable to use category 948 as additional coding when needed to provide data for evaluating burn mortality, such as that needed by burn units. It is also advisable to use category 948 as an additional code for reporting purposes when there is mention of a third-degree burn involving 20 percent or more of the body surface.'' We believe the vast majority of burn cases already include the 948.xx coding if appropriate, especially those treated in burn centers. However, we will be pleased to work with other hospital groups that are interested in developing educational materials related to the accurate coding of burn cases.

In developing the coding classifications used to assign cases under the burn DRGs, we worked closely with the ABA and its medical consultants to identify the most significant distinguishing characteristics in terms of resource use in burn cases. This process involved both grouping cases that were clinically similar as well as conducting a series of test runs to maximize the amount of variation in resource use that could be explained using varying groups of diagnosis and procedure codes. As stated in the May 8 proposed rule (63 FR 25579), we estimate that the proposed changes to the burn DRGs would increase by more than 25 percent the amount of variation in resource use explained by the DRGs in MDC 22, as well as improve the clinical coherence of the cases within each DRG. As recommended by the ABA, the procedure codes used to identify skin grafts coincide with the procedure codes now in use under existing DRG 458, Non-Extensive Burns with Skin Graft, and we believe that these codes represent the most resource-intensive skin grafts. Therefore, we are not adding the codes suggested by the commenter.

We recognize that some procedures now listed under DRG 472 will no longer affect DRG assignment under the restructured burn DRGs. However, we believe that the substantially increased ability of the new DRGs to explain the variation in resource use among burn cases clearly indicates the appropriateness of narrowing the focus of the classification system to emphasize the extent and severity of the burn, in conjunction with skin grafts or inhalation injury. Our analysis indicated that the presence of skin grafts or inhalation injuries had a much more consistent effect on the consumption of hospital resources than the presence of one of the numerous operating room procedures now listed under DRG 472. We also note that, since the skin graft procedures now classified to DRG 504 were classified to former DRG 472, many DRG 472 cases will now be assigned to DRG 504, which has a higher weight than 472 did (14.1153 versus 10.2429). When the FY 1999 cases become available, we will review them to assess the revisions to MDC 22 and the possible need for the type of changes suggested by the commenter.

Finally, we note that we do not classify DRGs 506 and 507 as surgical DRGs because they include not only cases involving skin grafts, which are considered surgical procedures, but also cases involving inhalation injuries, which would not necessarily involve any surgical procedures. Thus, in this final rule, we are adopting the changes to the burn DRGs as proposed.

4. Legionnaires' Disease

Effective with discharges occurring on or after October 1, 1997, a new diagnosis code was created for pneumonia due to Legionnaires' disease (code 482.84). In the August 29, 1997 final rule with comment period, we assigned this code to DRGs 79, 80, and 81 (Respiratory Infections and Inflammations) (62 FR 46090). However, we did not include this code as a human immunodeficiency virus (HIV) major related condition in MDC 25 (HIV Infections). Because pneumonia due to Legionnaires' disease is a serious respiratory condition that has a deleterious effect on patients with HIV, we proposed to assign diagnosis code 482.84 to DRG 489 (HIV with Major Related Condition) as a major related condition. In addition, we did not assign the code as a major problem in DRGs 387 (Prematurity with Major Problems) and 389 (Full Term Neonate with Major Problems). These DRGs are assigned to MDC 15 (Newborns and Other Neonates with Conditions Originating in the Perinatal Period). Again, as a part of the proposed rule, we assigned diagnosis code 482.84 as a major problem in DRGs 387 and 389 because of its effect on resource use in treating newborns.

Commenters supported these proposed revisions, and we are incorporating them into the final DRGs.

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 weighing 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 weigh the average charge of each DRG by frequency (that is, by the number of cases in the DRG) to determine average resource consumption for the surgical class. The surgical classes would then be ordered from the class with the highest average resource utilization to that with the lowest, with the exception of ''other OR procedures'' as discussed below.

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

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

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

Based on the preliminary recalibration of the DRGs, we proposed to modify the surgical hierarchy as set forth below. However, in developing the proposed rule, we were unable to test the effects of the 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 test the proposed surgical hierarchy changes after the revised GROUPER is received and reflect the final changes in the DRG relative weights in the final rule.

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

- We would reorder Sinus and Mastoid Procedures (DRGs 53–54) above Myringotomy with Tube Insertion (DRGs 61–62).
- We would reorder Mouth Procedures (DRGs 168–169) above Tonsil and Adenoid Procedure Except Tonsillectomy and/or Adenoidectomy Only (DRGs 57–58).

We received two comments in support of our surgical hierarchy proposals. However, for this final rule, we tested the proposed changes using the most recent MedPAR file and the revised GROUPER software, and we found that the proposal to move Sinus and Mastoid Procedures (DRGs 53–54) above Myringotomy with Tube Insertion (DRGs 61–62) is not supported. Therefore, this change will not be made in this final rule. The proposed reordering of DRGs 53 and 54 above Cleft Lip and Palate Repair (DRG 52) (DRG 52 is currently ordered below DRGs 61 and 62 but above DRGs 53 and 54) is still supported and will be

incorporated in the final GROUPER, as will the proposed reordering of DRGs 168 and 169 above DRGs 57 and 58.

6. Refinement of Complications and Comorbidities List

There is a standard list of diagnoses that are considered CCs. We developed this list using physician panels to include those diagnoses that, when present as a secondary condition, would be considered a substantial complication or comorbidity. In previous years, we have made changes to the standard list of CCs, either by adding new CCs or deleting CCs already on the list. 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); and the August 29, 1997 final rule for the FY 1998 revisions (62 FR 45966)).

We proposed a limited revision of the CC Exclusions List to take into account the changes that will be made in the ICD–9–CM diagnosis coding system effective October 1, 1998. (See section II.B.8, below, for a discussion of ICD–9–CM changes.) These proposed changes were made in accordance with the principles established when we created the CC Exclusions List in 1987. We received no comments on these proposed changes and we are incorporating them as final changes.

Tables 6F and 6G in section VI of the Addendum to this final rule contain the revisions to the CC Exclusions List that would be effective for discharges occurring on or after October 1, 1998. Each table shows the principal diagnoses with changes to the excluded CCs. Each of these principal diagnoses is shown with an asterisk and the additions or deletions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.

CCs that are added to the list are in Table 6F—Additions to the CC Exclusions List. Beginning with discharges on or after October 1, 1998, the indented diagnoses will not be recognized by the GROUPER as valid CCs for the asterisked principal diagnosis.

CCs that are deleted from the list are in Table 6G—Deletions from the CC Exclusions List. Beginning with discharges on or after October 1, 1998 the indented diagnoses will be recognized by the GROUPER as valid CCs for the asterisked principal diagnosis.

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

Users should be aware of the fact that all revisions to the CC Exclusions List (FYs 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, and 1998) and those in Tables 6F and 6G of this document must be incorporated into the list purchased from NTIS in order to obtain the CC Exclusions List applicable for discharges occurring on or after October 1, 1998.

Alternatively, the complete documentation of the GROUPER logic, including the current CC Exclusions List, is available from 3M/Health Information Systems (HIS), which, under contract with HCFA, is responsible for updating and maintaining the GROUPER program. Version 16.0 of this manual, which will include the final FY 1999 DRG changes, will be available in October 1998 for $225.00, which includes $15.00 for shipping and handling. This manual may be obtained by writing 3M/HIS at the following address: 100 Barnes Road; Wallingford, Connecticut 06492; or by calling (203) 949–0303.

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

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

DRGs 468, 476, and 477 are reserved for those cases in which none of the OR procedures performed is related to the principal diagnosis. These DRGs are intended to capture atypical cases, that is, those cases not occurring with sufficient frequency to represent a

distinct, recognizable clinical group. DRG 476 is assigned to those discharges in which one or more of the following prostatic procedures are performed and are unrelated to the principal diagnosis.

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

All remaining OR procedures are assigned to DRGs 468 and 477, with DRG 477 assigned to those discharges in which the only procedures performed are nonextensive procedures that are unrelated to the principal diagnosis. The original list of the ICD–9–CM procedure codes for the procedures we consider nonextensive procedures, if performed with an unrelated principal diagnosis, was published in Table 6C in section IV. of the Addendum to the September 30, 1988 final rule (53 FR 38591). As part of the final rules published on September 4, 1990, August 30, 1991, September 1, 1992, September 1, 1993, September 1, 1994, September 1, 1995, August 30, 1996, and August 29, 1997, we moved several other procedures from DRG 468 to 477, as well as moving 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.)

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 did not identify any necessary changes; therefore, we did not propose to move any procedures from DRGs 468 and 477 to one of the surgical DRGs.

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 discussed above 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 charged with the mission of maintaining and updating the ICD–9–CM. 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 Committee is co-chaired by the National Center for Health Statistics (NCHS) and HCFA. 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 fields, 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 at public meetings held on June 5 and December 4 and 5, 1997, and finalized the coding changes after consideration of comments received at the meetings and in writing within 30 days following the December 1997 meeting. The initial meeting for consideration of coding issues for implementation in FY 2000 was held on June 4, 1998. Copies of the minutes of the 1997 meetings can be obtained from the HCFA Home Page @ http://www.hcfa.gov/pubaffr.htm, under the ''What's New'' listing. Paper copies of these minutes are no longer available and the mailing list has been discontinued. We encourage commenters to address suggestions on coding issues involving diagnosis codes to: Donna Pickett, Co-Chairperson; ICD–9–CM Coordination and Maintenance Committee; NCHS; Room 1100; 6525 Belcrest Road; Hyattsville, Maryland 20782. Comments may be sent by E-mail to: dfp4@cdc.gov.

Questions and comments concerning the procedure codes should be addressed to: Patricia E. Brooks, Co-Chairperson; ICD–9–CM Coordination and Maintenance Committee; HCFA, Center for Health Plans and Providers, Plan and Provider Purchasing Policy Group, Division of Acute Care; C4–05–27; 7500 Security Boulevard; Baltimore, Maryland 21244–1850. Comments may be sent by E-mail to: pbrooks@hcfa.gov.

The ICD–9–CM code changes that have been approved will become effective October 1, 1998. The new ICD–9–CM codes are listed, along with their proposed DRG classifications, in Tables 6A and 6B (New Diagnosis Codes and New Procedure Codes, respectively) in section VI. of the Addendum to this proposed rule. As we stated above, the code numbers and their titles were presented for public comment in the ICD–9–CM Coordination and Maintenance Committee meetings. Both oral and written comments were considered before the codes were approved. Therefore, we solicited comments only on the proposed DRG classifications.

Further, the Committee has approved the expansion of certain ICD–9–CM codes to require an additional digit for valid code assignment. Diagnosis codes that have been replaced by expanded codes, other codes, or have been deleted are in Table 6C (Invalid Diagnosis Codes). These invalid diagnosis codes will not be recognized by the GROUPER beginning with discharges occurring on or after October 1, 1998. The

corresponding new or expanded diagnosis codes are included in Table 6A. Procedure codes that have been replaced by expanded codes, other codes, or have been deleted are in Table 6D (Invalid Procedure Codes). Revisions to diagnosis code titles are in Table 6E (Revised Diagnosis Code Titles), which also include the proposed DRG assignments for these revised codes. For FY 1999, there are no revisions to procedure code titles.

We received several comments about our proposed DRG assignments of new and revised codes.

Comment: One commenter believes that revised diagnosis code 518.81 (acute respiratory failure) should be assigned as a ''major complication'' in DRG 121 since it was classified in this manner prior to the code revision. In addition, new diagnosis codes 518.83 (chronic respiratory failure) and 518.84 (acute and chronic respiratory failure) each should also be classified as a ''major complication'' in DRG 121. Several commenters stated that new procedure code 37.67 (implantation of cardiomyostimulation system) should not be classified to DRGs 442, 443, and 486 since the procedure is not performed for either injuries or trauma. Commenters also noted that the DRG assignments as set forth in Tables 6A through 6E in the May 8, 1998 proposed rule (63 FR 22576) were not always aligned properly with the appropriate MDC number.

Response: We agree with the commenter that diagnosis codes 518.81, 518.83, and 518.84 should be included on the ''major complication'' list for DRG 121. As noted in the comment, code 518.81 is currently designated as a major complication and the assignment remains valid. In addition, the expanded codes 518.83 and 518.84 should be assigned to the major complication list because these conditions were formerly assigned to code 518.81. We also agree that procedure code 37.67 should not have been assigned to DRGs 442, 443, and 486 for the reasons cited by the commenter. We have revised Tables 6A, 6C, and 6E to reflect these changes. In addition, we have reformatted the tables to correct any alignment problems. Finally, we note that in Table 6B, the DRG assignment of procedure code 86.67 should list only DRGs 504, 506, and 507 under MDC 22. DRGs 458 and 472, which were listed in the proposed rule, have been deleted as a result of our restructuring of the burn DRGs (see section II.B.3 of this preamble).

9. Other Issues

a. Palliative care. Effective October 1, 1996 (FY 1997), we introduced a diagnosis code to allow the identification of those cases in which palliative care was delivered to a hospital inpatient. This code, V66.7 (Encounter for palliative care), was unusual in that there had been no previous code assignment that included the concept of palliative care. Since this was a new concept, instructional materials were developed and distributed by the AHA as well as specialty groups on the use of this new code. With new codes, it sometimes takes several years for physician documentation to improve and for coders to become accustomed to looking for this type of information in order to assign a code. There is an inclusion note listed under V66.7 which indicates that this code should be used as a secondary diagnosis only; the patient's medical problem would always be listed first. Currently, use of diagnosis code V66.7 does not have an impact on DRG assignment. Consistent with prior practice, we have waited until the FY 1997 data became available for analysis before considering any possible modifications to the DRGs.

As discussed in the proposed rule, in analyzing the FY 1997 bills received through September 1997, we found that 4,769 discharges included V66.7 as a secondary diagnosis. These cases were widely distributed throughout 199 DRGs. The vast majority of these DRGs included five or fewer discharges with use of palliative care. Only 12 DRGs included more than 100 cases. These were the following:

DRG	Title	Number of cases
10	Nervous System Neoplasms with CC	144
14	Specific Cerebrovascular Disorders Except TIA	272
79	Respiratory Infections and Inflammations Age >17 with CC	139
82	Respiratory Neoplasms	526
89	Simple Pneumonia and Pleurisy Age >17 with CC	200
127	Heart Failure and Shock	184
172	Digestive Malignancy with CC	226
203	Malignancy of Hepatobiliary System or Pancreas	285
239	Pathological Fractures and Musculosketal and Connective Tissue Malignancy	218
296	Nutritional and Miscellaneous Metabolic Disorders Age >17 with CC	173
403	Lymphoma and Non-Acute Leukemia with CC	178
416	Septicemia Age >17	147

Six of these DRGs are cancer-related; however, the other DRGs are quite diverse. Upon further analysis, we found that, for the most part, discharges with code V66.7 do not significantly differ in length of stay from the discharges in the same DRG without code V66.7. The length of stay for discharges with code V66.7 are sometimes longer and sometimes shorter and the comparative length of stay for a given DRG tends to vary by only one day. In general, the average charges for a palliative care case discharge with a secondary code of V66.7 were lower than the charges for other discharges within the DRG. However, these differences were relatively small and were well within the standard variation of charges for cases in the DRG.

One approach we could take to revise the DRGs would be to divide those DRGs with a large number of cases coded with V66.7 into two different DRGs, with and without palliative care. However, the relatively small proportion of cases in each DRG argues against this approach; no DRG has more than 1 percent of its cases coded with palliative care and, in most cases, the percentage is well under 1 percent. An alternative approach would be to group all palliative care cases, regardless of the underlying disease or condition, into one new DRG. However, the charges of these cases are so varied that this is not a logical choice. In addition, there is a lack of clinical coherence in such an approach. The underlying diagnoses of these cases range from respiratory conditions to heart failure to septicemia.

Because there are so few cases in the FY 1997 data and they are so widely dispersed among different DRGs, we did not propose any DRG modification. We will make a more detailed analysis of these cases over the next year based on a more complete FY 1997 data file as well as review of the FY 1998 cases that will be available later this year. As time goes by, hospital coders and physicians should become more aware of this code and we hope that more complete data will assist our decision-making process.

We received a few comments supporting our decision to make no DRG changes at this time for palliative care cases. One commenter agreed with our statement that it may take several years for use of this code to spread through the medical community.

b. PTCA. Effective with discharges occurring on or after October 1, 1997, we reassigned cases of PTCA with coronary artery stent implant from DRG 112 (Percutaneous Cardiovascular Procedures) to DRG 116 (Other Permanent Cardiac Pacemaker Implant or PTCA with Coronary Artery Stent Implant). In the August 29, 1997 final rule with comment period, we responded to several commenters who contended that PTCA cases treated with platelet inhibitors were as resource intensive as the PTCA with stent implant cases and that these cases should also be moved to DRG 116. However, there is currently no code that describes the infusion of platelet inhibitors. Therefore, we were unable to make any changes in the DRGs for FY 1998.

As set forth in Table 6B, New Procedure Codes in section VI. of the addendum to this final rule, a new procedure code for injection or infusion of platelet inhibitors (code 99.20) will be effective with discharges occurring on or after October 1, 1998. Our usual policy on new codes is to assign them to the same DRG or DRGs as their predecessor code. Because infusion of platelet inhibitors is currently assigned to a non-OR procedure code, we followed our usual practice and designated code 99.20 as a non-OR code that does not affect DRG assignment.

We will not have any data on this new code until we receive bills for FY 1999. Thus, we would be unable to make any changes in DRG assignment until FY 2001. We note, however, that the Conference Report that accompanied the Balanced Budget Act of 1997 contained language stating 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 MedPAR data in annually recalibrating and reclassifying the DRGs.'' (H.R. Rep. No. 105–217 at 734 (1997)). At the time the proposed rule was published, we had received no data that would have allowed us to make an appropriate modification of DRG 112 for PTCA cases with platelet infusion therapy. In that rule, we stated that we would review and analyze any data we received during the comment period about the use of platelet inhibitors for Medicare beneficiaries.

Since publication of the proposed rule, we received some data concerning the use of GPIIb/IIIa platelet inhibitor drug therapy as well as some comments on the issue. A discussion of the data and the comments and our responses are set forth below.

Comment: The data we received were provided by the pharmaceutical company that manufactures a GPIIb/IIIa platelet inhibitor. In its comment accompanying the data, the company states its belief that the data conclusively demonstrate that procedure code 99.20 should be assigned to DRG 116 effective for discharges occurring on or after October 1, 1998. We received two other comments from hospitals supporting this reassignment in order to improve payment for a beneficial drug therapy. Another hospital urged HCFA not to make the reassignment because the commenter believes that there is no evidence that use of the drug decreases mortality or the risk of need for emergency coronary bypass in patients undergoing stent implantation. In addition, this commenter believes that the price charged for platelet inhibitor is exorbitant and that HCFA should not directly subsidize a pharmaceutical company through a DRG change. Finally, two commenters, a drug company and a pharmaceutical association, were encouraged by HCFA's willingness to consider data other than MedPAR data for analyzing possible DRG changes.

The data we received comprise two different sets of Medicare beneficiaries who received PTCA, PTCA with implant of a coronary stent, PTCA with platelet inhibitor therapy, or PTCA with both implant of a stent and platelet inhibitor therapy. One set of data consists of just under 500 patients who received treatment in seven hospitals during a clinical trial conducted between January 1, 1996 and June 15, 1997. The other set consists of just over 6,200 patients treated in 83 hospitals between October 1, 1995 and December 31, 1996 (this is data from a health care information company that, among other products and services, performs clinical and financial analysis of data under contract with hospitals). For the first set of data, the hospitals are identified; however, for the second set of data, the hospital identifying information is confidential and was not released to HCFA. In order to provide HCFA with standardized charges, the information company obtained the HCFA provider-specific file and standardized the charges before providing them to HCFA.

According to the commenter, based on the data provided the approximate average standardized charges for the different classes of patients are as follows:

- PTCA alone—$17,000.
- PTCA and stent—$22,000.
- PTCA and platelet inhibitor—$24,000.
- PTCA and both stent and platelet inhibitor—$29,000.

Based on these data, the drug's manufacturer urges us to reassign procedure code 99.20 to DRG 116. The commenter also argues that failure to improve the payment for these cases may result in Medicare beneficiaries being denied equal access to potentially life-saving treatment.

Response: We have reviewed the data submitted as well as considered the comments we have received. Based on the data provided, it appears that the cost of a PTCA case with platelet inhibitor drug therapy is at least as expensive as a PTCA case with stent implant. However, the vast majority of the cases (over 90 percent) cannot be linked to a hospital. In addition, although the large data set does constitute a sample of cases, as claimed by the commenter, it is not a random sample, but rather a sample of those hospitals that contract with the health information company. The pharmaceutical company states that the 83 hospitals are representative of all hospitals in the country, but we have no way to verify that claim. Because the data cannot be verified, and do not reflect a complete data set or a random sample, HCFA cannot use the data to make a change in the DRG assignment.

The language that Congress included in the Conference Report that accompanied the Balanced Budget Act of 1997 stated that HCFA should ''* * * consider, to the extent feasible, reliable, validated data other than MedPAR data in annually recalibrating and reclassifying the DRGs.'' The data we have been given does not meet these requirements. We cannot validate whether the data are Medicare beneficiaries nor can we verify which hospitals provided the treatment or the amount of charges reported to Medicare. In addition, we do not believe that we

should base any DRG reclassification decisions that will increase payment for a set of cases on data that would not meet HCFA's strict requirements for making a DRG change that would lower the relative weight for a set of cases (see discussion below concerning radiosurgery procedures).

As we have stated in several proposed and final rules (most recently in the August 30, 1996 final rule in a discussion of the coronary artery stent implant (61 FR 46170) and the August 29, 1997 final rule in response to a comment on the DRG assignment for new diagnosis code 686.01) (62 FR 45982), our longstanding practice is to assign a new code to the same DRG or DRGs as its predecessor code. Our compelling reason for this practice is our inability to move the cases associated with the new code to a new DRG assignment as part of the DRG reclassification and recalibration process. Consequently, our policy is to wait until we have a full year of Medicare data upon which to base an analysis of what the most appropriate DRG assignment would be. We can then move any cases that we would reassign so we can revise the DRG relative weights accordingly. If we were to assign procedure code 99.20 to DRG 116 at this time, we would be unable to move the cases associated with that code from DRG 112 into DRG 116 based on the data provided. Thus, the relative weight of DRG 112 would still reflect the cases with procedure code 99.20. Since these cases presumably have much higher charges than the other PTCA cases, the relative weight for DRG 112 would be overstated, which means the payments to those cases would be overstated. In addition, the charges for PTCA cases with platelet inhibitor drug therapy would not be reflected in the DRG 116 relative weight.

Our practice of waiting until we have identifiable MedPAR data applies to all DRG changes, that is, both those changes that would enhance payment for a particular diagnosis or procedure, as well as, those that would decrease payment for a particular diagnosis or procedure. We note that, in FY 1996, when we created a new procedure code for stereotactic radiosurgery (92.3), we assigned the code to DRGs 1, 2, and 3, because that is where the predecessor procedure code was assigned. However, since code 92.3 is a nonoperating room procedure, we were relatively sure that the code would not remain assigned to DRG 1, 2, and 3 (which are the highest weighted surgical DRGs in MDC 1) once we had the actual charge data. As discussed in the August 29, 1997 final rule (62 FR 45971), procedure code 92.3 was reassigned to DRGs 7 and 8 once we had the FY 1996 data to analyze. Therefore, we ''overpaid'' those cases for 2 years; that is, their charges were much less than the average charges for DRGs 1, 2, and 3.

We believe that any data we use to reclassify and recalibrate DRGs must be comprehensive and valid, as well as verifiable by HCFA.

Concerning the commenter's argument that failure to change the DRG assignment for infusion of platelet inhibitor will compromise the availability of this treatment for Medicare beneficiaries, we note, as we have in several previous documents, that it is a violation of a hospital's Medicare provider agreement to place restrictions on the number of Medicare beneficiaries it accepts for treatment unless it places the same restrictions on all other patients.

c. Implantation of Muscle Stimulator

Comment: We received one comment arguing that the current DRG assignment for the implantation of a muscle stimulator and the associated tendon transfer for quadriplegics is inappropriate. The specific muscle stimulator device (an implanted neuroprosthesis that restores functional hand motion in people with quadriplegia who are 24 months post-injury) was approved by the Food and Drug Administration in August 1996. The device is designed to provide neuromuscular stimulation for certain patients with quadriplegia so that they can grasp with their hand and perform tasks such as holding eating utensils and pens and brushing their teeth. In many cases, the patient also undergoes a tendon transfer to the hand during the same admission or during a prior admission. The commenter notes that when the tendon transfer (procedure code 82.56 (other hand tendon transfer or transplantation)) and the insertion of the muscle stimulator (procedure code 83.92 (insertion or replacement of skeletal muscle stimulator)) are performed during the same admission, the case is assigned to DRG 7 or 8 (Peripheral and Cranial Nerve and Other Nerve System Procedures). However, when the procedures are performed during two separate admissions, the tendon transfer is assigned to DRGs 7 and 8 and the insertion of the muscle stimulator is assigned to DRG 468 (Extensive OR Procedure Unrelated to Principal Diagnosis). The commenter stated that although payment for DRGs 7, 8, and 468 are all significantly less than the cost of the hospital stay and the device, DRG 468 pays more and results in the hospital losing less money. The commenter noted that the device alone costs $24,500 and hospitals report losses of $11,000 to $26,000 when the device is inserted and a tendon transfer is performed during the same admission (resulting in assignment to DRGs 7 and 8). However, when the insertion of the device is performed in a separate admission, the cases are assigned to DRG 468 and hospitals' losses are limited to $4,000 to $18,000.

The commenter believes that hospitals will refuse to perform this very useful surgery unless the DRG assignment is revised. If the insertion of the muscle stimulator were assigned to a surgical DRG in MDC 1 where the diagnosis codes for quadriplegia are assigned, the highest paying DRG assignment would be DRGs 1, 2, and 3 (Craniotomy). Besides being clinically inappropriate, the commenter believes the weights for these DRGs are too low to adequately pay for this procedure.

The commenter recommended both a short and a long-term solution for this problem. For now, all cases with insertion of muscle stimulators performed in conjunction with tendon transfer should be assigned to DRG 468. In the long term, HCFA should establish a new DRG for the implantation of muscle stimulation devices and other stimulation devices as they become available.

Response: In examining the latest FY 1997 MedPAR file (bills received through March 1998), we found only three cases for implantation of muscle stimulators for quadriplegics. One case was assigned to DRG 7 and the other two to DRG 8. The standardized charge and length of stay for each case is set forth below.

DRG	Standardized charge	Length of stay (days)
7	$25,227	7
8	8,849	2
8	42,183	2

The average charge for all cases assigned to DRG 7 is approximately $21,000 and the average charge for DRG 8 cases is about $11,500.

With so few cases, we would prefer to review the data in the FY 1998 MedPAR file before making any reclassification. Therefore, we will add these cases to our FY 2000 DRG reclassification analysis agenda. We note that the charges reported for two of the three cases are significantly *less* than the costs that the commenter believes would be incurred for this surgery (approximately $35,000).

It would be inappropriate to assign the muscle stimulator insertions solely

to DRG 468. This DRG was created to capture a set of clinically unrelated cases where the only operating room procedures performed are unrelated to the patient's principal diagnosis. To permanently assign a procedure code only to DRG 468 would be contrary to the basic design and precepts of the DRG system.

C. Recalibration of DRG Weights

We proposed to use the same basic methodology for the FY 1999 recalibration as we did for FY 1998. (See the August 29, 1997 final rule with comment (62 FR 45982).) That is, we recalibrated the weights based on charge data for Medicare discharges. However, we used the most current charge information available, the FY 1997 MedPAR file, rather than the FY 1996 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 1997 MedPAR data, based on bills received by HCFA through March 1998, from all hospitals subject to the prospective payment system and short-term acute care hospitals in waiver States. The FY 1997 MedPAR file includes data for approximately 11.3 million Medicare discharges.

The methodology used to calculate the DRG relative weights from the FY 1997 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 costs, disproportionate share payments, and, for hospitals in Alaska and Hawaii, the applicable cost-of-living adjustment.
- The average standardized charge per DRG was calculated by summing the standardized charges for all cases in the DRG and dividing that amount by the number of cases classified in the DRG.
- We then eliminated statistical outliers, using the same criteria as was used in computing the current weights. That is, all cases that are outside of 3.0 standard deviations from the mean of the log distribution of both the charges per case and the charges per day for each DRG.
- The average charge for each DRG was then recomputed (excluding the statistical outliers) and divided by the national average standardized charge per case to determine the relative weight. A transfer case (including a postacute care transfer case as discussed in section IV.A of this preamble) is counted as a fraction of a case based on the ratio of its length of stay (plus one day to account for the double per diem payment for the first day) 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 0.6 of a total case. Transfers from DRGs 209, 210, or 211 to postacute care are counted as a fraction of a discharge based on the ratio determined by dividing the geometric mean length of stay for the DRG by the sum of half the geometric mean and half the length of stay for the case, plus one.
- 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 1995 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 proposed to use that same case threshold in recalibrating the DRG weights for FY 1999. Using the FY 1997 MedPAR data set, there are 37 DRGs that contain fewer than 10 cases. We computed the weights for the 37 low-volume DRGs by adjusting the FY 1998 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.

Comment: One commenter was concerned about the general trend in the relative weights. This commenter calculated average relative weights for each MDC as well as the overall average DRG weight. Based upon this calculation, the commenter noted that the average weight for the pre-MDC DRGs and MDCs 8 (Diseases and Disorders of the Musculoskeletal system and Connective Tissue) and 24 (Multiple Significant Trauma) are decreasing. Concerning MDC 8, the commenter believes the average weight is decreasing because of the use of postacute care for these DRGs, noting that 4 of them are included in the list of 10 DRGs affected by the transfer to postacute care provision (see section IV.A of this preamble for a discussion of this provision). The commenter suggested that we leave the FY 1998 weights intact for MDC 8 until we can assess the effect of postacute care transfers on average standardized amounts. For the pre-MDCs and MDC 24, the commenter believes that the cases assigned to these categories are extremely resource-intensive and that the average weights should not be decreasing. Finally, the commenter noted that, although the total weight increased for MDC 22 (Burns), the average weight decreased. The commenter believes this is inconsistent with the statement in the proposed rule that the changes being made to MDC 22 would improve the explanation of variation in resource use in those DRGs (63 FR 25579).

Response: We reviewed the table of average DRG weights presented in the comment, both overall and within MDCs, and we found that the commenter has mistakenly used a simple averaging methodology to determine the mean weight rather than a weighted averaging methodology, which is how the DRG relative weights are calculated. For example, suppose an MDC has three DRGs and there are 3 cases assigned to DRG 1, 6 cases assigned to DRG 2, and 7 cases assigned to DRG 3. The weights for the DRGs are

1.000, 2.000, and 3.000, respectively. The simple average weight for the three DRGs would be calculated by adding the weights and dividing by the number of DRGs as follows:

$$\frac{(1.000 + 2.000 + 3.000)}{3} = 2.0000$$

However, the weighted average would be calculated by first multiplying the weights of each DRG by the number of cases in that DRG and dividing by the number of cases as follows:

$$\frac{((1.0000 \times 3) + (2.000 \times 6) + (3.0000 \times 7))}{16} = 2.2500$$

Because of this mistake in average weight calculation, the commenter has made some incorrect conclusions. For example, the commenter states that the average DRG weight for FY 1998 is 1.3681 and the average of the proposed FY 1999 weights is 1.3895. In reality, the average FY 1998 weight is 1.4606 and the average of the proposed FY 1999 weights is 1.4673.

(Note: These average weights are based on the MedPAR cases used to recalibrate the weights; that is, the FY 1998 weights are based on FY 1996 cases reclassified into the FY 1998 DRGs and the proposed FY 1999 weights are based on FY 1997 cases reclassified into the FY 1999 DRGS).

The average weight of the final FY 1999 weights is 1.4679.

Contrary to the commenter's assertion, the average weight of the proposed FY 1999 MDC 22 DRGs did not decrease compared to the FY 1998 MDC 22 weights (4.6663 and 4.5234, respectively). In addition, although all of the FY 1999 proposed pre-MDC DRG weights except DRG 483 decreased relative to FY 1998, the increase in DRG 483 was large enough (coupled with an increase in cases) to result in an overall higher average weight for the pre-MDC DRGs. We note that the weights for DRGs 481, 482, and 483 have increased between the proposed and final FY 1999 recalibrations. As we have noted in the past, the weights for the transplant DRGs (481, 482, and 495) have gradually decreased over the years. In addition, the transplant DRGs have a relatively small number of cases with a large range of reported charges. A few very low or high charge cases can make a relatively dramatic difference in the weights from year to year (August 29, 1997; 62 FR 45983).

Finally, with regard to the commenter's request that we set the FY 1999 MDC 8 weights equal to the FY 1998 weights, we could refer the commenter to the discussion above concerning the steps we take in recalibrating the weights. Each year, when we recalibrate the DRG weights, we use charge data from the most recent Medicare cases available. That is, we use the charges reported by hospitals to establish the weights. In this way, we ensure that we are using the most recent hospital charging practices and patterns to set the new relative weights. Because each DRG weight is ''relative'' to all other DRG weights, we cannot arbitrarily freeze a set of those DRGs at the previous year's weights. In a relative system such as this, if some weights increase, others must decrease. Finally, as discussed above, when we recalibrate the weights, a transfer case is counted as a fraction of a case rather than a whole case.

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

III. Changes to the Hospital Wage Index

A. Background

Section 1886(d)(3)(E) of the Act requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts ''for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.'' In accordance with the broad discretion conferred under the Act, we currently define hospital labor market areas based on the definitions of Metropolitan Statistical Areas (MSAs), Primary MSAs (PMSAs), and New England County Metropolitan Areas (NECMAs) issued by the Office of Management and Budget (OMB). 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.

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.

Section 1886(d)(3)(E) of the Act also requires that the wage index be updated annually beginning October 1, 1993. 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. We also adjust the wage index, as discussed below in section III.F, to take into account the geographic reclassification of hospitals in accordance with sections 1886(d)(8)(B) and 1886(d)(10) of the Act.

B. FY 1999 Wage Index Update

The final FY 1999 wage index (effective for hospital discharges occurring on or after October 1, 1998 and before October 1, 1999) is based on the data collected from the Medicare cost reports submitted by hospitals for cost reporting periods beginning in FY 1995 (the FY 1998 wage index was

based on FY 1994 wage data). The FY 1999 wage index includes the following categories of data, which were also included in the FY 1998 wage index:

- Total salaries and hours from short-term, acute care hospitals.
- Home office costs and hours.
- Direct patient care contract labor costs and hours.

The wage index also continues to exclude the direct salaries and hours for nonhospital services such as skilled nursing facility services, home health services, or other subprovider components that are not subject to the prospective payment system. Finally, as discussed in detail in the August 29, 1997 final rule with comment period, 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.

For FY 1999 we proposed two changes to the categories of data included in the wage index: adding contract labor costs and hours for top management positions and replacing the fringe benefit category with the wage-related costs associated with hospital and home office salaries category. These two changes reflect changes to the Medicare cost report that were discussed in the September 1, 1994 final rule with comment period (59 FR 45355). The changes were made to the cost report for cost reporting periods beginning during FY 1995. Because we are using wage data from the FY 1995 cost report for the FY 1999 wage index, these two changes will be reflected in the wage index for the first time in FY 1999.

As discussed in detail in the September 1, 1994 final rule with comment period (59 FR 45355), we expanded the definition of contract services reported on the Worksheet S–3 to include the labor-related costs associated with contract personnel in a hospital's top four management positions: Chief Executive Officer/ Hospital Administrator, Chief Operating Officer, Chief Financial Officer, and Nursing Administrator. We also revised the cost report to reflect a change in terminology from ''fringe benefits'' to ''wage-related costs,'' to promote the consistent reporting of these costs. (See September 1, 1994 final rule with comment period (59 FR 45356–45359).) We made this change in terminology because we believed it would eliminate confusion regarding those wage-related costs that are incorporated in the wage index versus the broader definition of fringe benefits recognized under the Medicare cost reimbursement principles. Wage-related costs, which include core and other wage-related costs, are reported on the Form HCFA–339, the Provider Cost Report Reimbursement Questionnaire.

Finally, we analyzed the wage data for the following costs, which were separately reported for the first time on the FY 1995 cost reports:

- Physician Part A costs.
- Resident and Certified Registered Nurse Anesthetist (CRNA) Part A costs.
- Overhead cost and hours by cost center.

Our analyses and proposals concerning these data are set forth below in section III.C.

Comment: MedPAC submitted a general comment on the wage index. First, the Commission stated that several of the issues raised in the proposed rule stem from the failure of the wage index to account for the mix of occupational categories employed by each hospital and that if the wage index reflected this mix it would be more accurate. In addition, MedPAC, noted that new measures are needed to implement each new prospective system as well as for Medicare+Choice plans and suggested that attention should be given to alternative strategies for obtaining labor prices that could eliminate the need to collect data separately for each type of provider affected. MedPac intends to examine this issue during the upcoming year.

Response: We have addressed the issue of occupational mix in the past. In the May 27, 1994 **Federal Register**, we indicated we were not proposing to collect occupational mix data due to a lack of support from the hospital industry for an additional reporting burden with uncertain impact (59 FR 27724). However, certain segments of the industry continue to insist that an occupational mix would make the wage index fairer. We will continue to evaluate all the data and evidence that we receive on this issue. With respect to MedPAC's interest in examining alternative data collection strategies, we look forward to the results of its examination, and will provide whatever assistance we can.

C. Issues Relating to the FY 1999 Wage Index

1. Physician Part A Costs

Currently, if a hospital directly employs a physician, the Part A portion of the physician's salary and wage-related costs (that is, administrative and teaching services) is included in the calculation of the wage index. However, the costs for contract physician Part A services are not included. Our policy has been that, to be included in the wage index calculation, a contracted service must be direct patient care, or, beginning with the FY 1999 wage index, top level management (see discussion above). Because some States have laws that prohibit hospitals from directly hiring physicians, the hospitals in those States have claimed that they are disadvantaged by the wage index's exclusion of contract physician Part A costs. We began collecting separate wage data for both direct and contract physician Part A services on the FY 1995 cost report in order to analyze this issue. As we discussed in the September 1, 1994 final rule with comment period (59 FR 45354), our original purpose in collecting these data was to exclude all physician Part A costs from the wage index.

When we made the change to the cost report, there were five States in which hospitals were prohibited from directly employing physicians. We understand that only two States currently maintain this prohibition: Texas and California. Thus, the number of hospitals affected by our current policy has decreased. Nevertheless, the fact that hospitals in these two States are still prohibited from directly employing physicians for Part A services and, therefore, must enter into contractual agreements with physicians for these services, perpetuates the perceived inequity.

The main reason we planned to exclude all Part A physician costs rather than include the contract costs was our concern that it would be difficult to accurately attribute the Part A costs and hours of these contract physicians. In addition, we were concerned that including these costs could inappropriately inflate the hospitals' average hourly wages. That is, we anticipated that average costs for contract physicians would be significantly higher than the costs for those physicians directly employed by the hospital. However, our analysis of the data shows that the average hourly wages for contract physician Part A costs are very similar to, and, in fact slightly lower than, the costs for salaried physician Part A services.

Based on this result, we believe that continuing to include the directly employed physician Part A costs and adding the costs for contract physicians is the better policy. Thus, we proposed to calculate the FY 1999 wage index including both direct and contract physician Part A costs.

Of the 5,070 hospitals included in the FY 1995 wage data file, approximately 32 percent reported contract physician Part A costs. Including these costs would raise the wage index values for

2 MSAs (4 hospitals) by more than 5 percent and 7 MSAs (43 hospitals) by between 2 and 5 percent. Two MSAs and one Statewide rural area (74 hospitals) would experience a decrease between 2 and 5 percent. The wage index values for the remaining 365 areas (4,949 hospitals) would be relatively unaffected, experiencing changes of between −2 and 2 percent.

We received several comments regarding the inclusion of contract physician costs, and physician Part A costs generally. The specific comments and our responses are set forth below.

Comment: A national hospital association noted its concern about the inclusion of teaching-related costs in the wage index because Medicare pays separately for the salaries of teaching physicians through direct graduate medical education (GME) payments. Nevertheless, the commenter supports the inclusion of contract physician costs in the FY 1999 wage index. The commenter indicated that it would work to develop a consensus among hospital and health system representatives on which physician salaries, if any, should be included in future wage indexes. Another commenter supported the inclusion of contract physician costs but recommended that HCFA take swift action to remove teaching physician costs ''to achieve geographic equity in payments.''

Several commenters believe that all physician Part A costs, including teaching physician costs, should be recognized in calculating the wage index. The commenters asserted that these are costs of doing business, and including them in the wage index appropriately measures the geographic variations in what hospitals pay for labor. However, numerous commenters argued that it is inappropriate to include teaching physician costs in the wage index because, in effect, it results in double payment to teaching hospitals for these costs. Recognizing that HCFA does not have the data available to separately identify the portion of physician costs attributable to teaching physicians, these commenters believe it would be preferable to remove all Part A physician costs from the wage index calculation.

Response: As a conceptual matter, we believe that physician Part A costs other than teaching physician costs should be included in the wage index because these costs are paid under the prospective payment system. Further, in light of the data now available, we believe including contract physician Part A costs improves equity in the wage index by allowing hospitals that are prohibited by State law from directly employing physicians to include their costs of contracted physicians.

With regard to teaching physician costs, the 1995 cost report does not separate teaching physician costs from other physician Part A costs. Consequently, we are unable to exclude teaching physician costs from the FY 1999 wage index. We believe the optimal approach is to consider this issue directly in developing the FY 2000 wage index. To facilitate evaluation of this issue, we will instruct the fiscal intermediaries to separate teaching physician costs from hospitals' FY 1996 wage data. We will carefully analyze those data, and any changes we propose to make based on that analysis will be included in the FY 2000 proposed rule.

We do not agree with the commenters' suggestion that, in lieu of collecting data that would allow us to separately identify teaching physician costs, we should remove all physician salaries from the wage index. These physician Part A costs are incurred by the hospital for services related to such positions as medical director and clinical department heads. As such, they are legitimate labor costs included under the prospective payment system. Based on our analysis of the FY 1995 cost reports, we believe that the data reported for physician Part A costs are sufficiently reliable and complete that inclusion of physician Part A costs (direct as well as contract costs) for FY 1999 results in a wage index that better reflects relative hospital labor costs than a wage index that excludes all physician Part A costs. Moreover, as stated above, we believe the addition of contract physician Part A costs in the FY 1999 wage index improves the fairness and accuracy of the wage index relative to the FY 1998 wage index (which included direct physician Part A costs (salaries) but not contract physician Part A costs). Thus, rather than excluding all physician Part A costs, we believe the more responsible approach is to collect the necessary data as expeditiously as possible in order to analyze whether it is feasible to separate teaching physician costs from other physician Part A costs.

Comment: Several commenters favored not only including physician salaries in the wage index, but also continuing to include teaching physician salaries. Commenters believe that if Congress had known about the payment redistributions that would result from eliminating teaching physician salaries from the wage index before it had enacted the reductions applicable to teaching hospitals in the Balanced Budget Act of 1997, it may not have enacted such deep cuts. One commenter also suggested that if we excluded physician salaries, we would need to restandardize the large urban standardized amount to reflect the new wage index.

Another commenter stated that the costs of teaching physicians and residents should be included in the wage index because Medicare payments for GME are not sufficient to compensate hospitals for their GME costs. This commenter compared hospitals' direct GME costs on the Medicare cost report with the payments they receive and estimated a shortfall of $900 million. The commenter further noted that reductions in Medicare disproportionate share payments as a result of the Balanced Budget Act would have the effect of increasing the empirical estimate for the indirect graduate medical education adjustment, leading to a further shortfall in payments for GME.

Response: We cannot know what Congress would or would not have done if it had known about the impacts of future changes to wage index policy. Rather, refinements to the wage data should be evaluated on their individual merits in terms of whether they contribute to or detract from the fairness and accuracy of the wage index. We disagree that changes to the wage index may require restandardization of the large urban standardized amount. The large urban standardized amount was not created by a separate standardization of the costs of hospitals in large urban areas, but by applying differential update factors established by Congress.

We also disagree with the comment that the wage index should continue to include costs related to teaching physicians and residents because current and future GME payments are not fully compensating hospitals for their GME costs. The adequacy of direct GME payments is a separate issue by virtue of the fact that these costs are recognized separately and paid for through Medicare outside the prospective payment system. The amount Medicare pays for direct GME is based on policy considerations related to the nature of GME, and reflects Medicare's fair share of those costs. Similarly, indirect GME costs are distinct from hospitals' labor costs, and the level of IME payments is not relevant to the wage index.

Comment: Many commenters referred to an analysis done by one commenter showing the projected payment impacts by State of our proposed policy of including physician (both direct and contract), resident, and CRNA costs in the wage index. These commenters

referred to the large losses that, according to this analysis, certain States will allegedly suffer because of this policy (California: $79 million; Florida: $36 million; Texas: $10 million). Corresponding gains were cited among northeast hospitals. The suggestion of these comments was that we should revise our proposed policy and exclude all of these costs to redistribute these losses and gains.

Response: We disagree with the characterization of this analysis. With the exception of contract physician costs, all of these costs have been included in prior wage indexes. Therefore, the commenter's analysis does not reflect the impact of the proposed wage index relative to the current wage index. With respect to the losses in certain States cited by the commenter, our analysis indicates that, the projected payment impacts of including contract physician costs relative to a wage index without these costs are, respectively: a $13 million decrease, a $15 million decrease, and an $18 million increase. We note that these figures do not reflect the impact of changes to the wage indexes in these areas resulting from updating from the 1994 wage data to 1995 wage data, or the exclusion of allocated overhead. They do, however, present a clearer picture of the impacts in these States of including contract physician costs relative to current policy.

Comment: One commenter vigorously opposes the inclusion of contract physician Part A costs, arguing we should instead exclude all physician Part A costs. The commenter, a national association of health systems, argued that this proposal contradicts the objectives we identified in the May 27, 1994 proposed rule (59 FR 27720) and the September 1, 1994 final rule (59 FR 45354), where we discussed the need to separately collect physician Part A costs. The commenter raises the following points and ultimately recommends excluding all physician Part A costs from the calculation of the wage index.

First, the commenter contends that, by choosing to include physician Part A contract costs rather than exclude all physician Part A costs, we ''have expanded the unfair and unjustifiable policy tilt enjoyed by teaching hospitals.'' To emphasize this point, the commenter notes that over 70 percent of all contract physician costs stem from teaching hospitals (90 percent of salaried physician costs are also from teaching hospitals).

Second, the commenter states that our rationale for proposing to include contract physician costs focused narrowly on whether these costs would inappropriately inflate the wage data. This narrow focus, according to the commenter, left out any explanation of why it is better to include contract physician costs rather than to exclude all Part A physician costs.

Third, the commenter quotes liberally from our discussion in the proposed and final rules published in 1994, particularly our rationale for providing for separate reporting of physician Part A costs on the cost report. Referenced specifically are the three reasons why HCFA believed at that time that eliminating physician Part A costs would be preferable to including contracted physician costs. These reasons were: (1) Physician costs are not driven by normal labor market situations; (2) many hospitals indicated difficulties in accurately determining hours for these physicians' services; and (3) some hospitals have difficulty separating costs related to Part A from those related to Part B. The commenter specifically asks HCFA why it has changed its beliefs.

Finally, the commenter surmises that one reason we proposed to include contract physician costs is that few areas would experience a significant change in their wage index values. To refute this, the commenter describes the results of analysis of the impacts of the proposed policy. The analysis found ''a dramatic and damaging impact on California, the largest state in the nation in terms of hospitals and number of Medicare discharges.'' The commenter believes that ''HCFA's wage index policy should be based not on whether the outcome will result in little change, but on whether it is the right policy in the first place.''

Response: We appreciate the considered arguments and detailed analysis presented by the commenter and understand the importance of this issue to the hospitals represented by the association. We agree with the commenter that the primary consideration in developing and refining the hospital wage index should be the ''right policy.'' In the context of the hospital wage index, we believe we should promote the fair and accurate measurement of relative hospital wage levels across geographic areas. At the same time, we believe it is appropriate to consider the potential impact of possible courses of action, though we agree with the commenter that the potential impact should not be the driving force in policy decisions.

In the context of the hospital wage index, it is also critical to keep in mind that developing the ''right policy'' is a function not only of conceptual issues but also of data issues. If, for example, we believe *as a conceptual matter* that a certain type of cost should be included in the wage index, but the data on those costs are incomplete and unreliable, then including the costs in the wage index (which are conceptually right) could (because of the data problems) distort the measure of relative wage levels across geographic areas, and thus detract from the fairness and accuracy of the wage index; similarly, if we believe as a conceptual matter that a certain type of cost should be excluded from the wage index, but there is incomplete and unreliable data to separate those costs from other costs, then excluding the costs based on bad data could detract from the equity of the wage index. Thus, our ability to implement a ''conceptually right'' policy depends on the availability of reliable and complete data.

As indicated above in the response to another comment, we believe there is good reason to include all physician Part A costs, rather than exclude all physician Part A costs as the commenter recommends. Among other things, with the exception of teaching physician costs, physician Part A costs are Part A costs that are paid under the prospective payment system. In addition, physician Part A costs represent above-average costs, although only a small percentage of the total for most hospitals; therefore, excluding all physician Part A costs might understate the relative wages of some hospitals. Based on our analysis of the FY 1995 cost reports, we believe that data reported for physician Part A costs are sufficiently reliable and complete that inclusion of the costs results in a wage index that is more fair and accurate, relative to a wage index which would exclude all physician Part A costs, even if the data are not perfect.

As discussed above, although we have decided to adopt our proposal to include contract physician Part A costs in the wage index, we intend to direct the fiscal intermediaries to separately identify physician Part A costs (salaried and contracted) related to teaching for cost reports beginning during FY 1996. Although this information will not be reported separately on the Worksheet S, Part III until FY 1997 cost reports, we believe this issue merits undertaking a special auditing effort of the FY 1996 cost reports.

With regard to the high proportion of physician costs attributable to teaching hospitals, although the distribution of costs seems disproportionate (and this is a large part of the reason we are expediting our efforts to separate teaching physician costs from other physician costs), our analysis of these

data indicates that, among hospitals reporting these costs, there is little difference between teaching and nonteaching hospitals in terms of the relative impact of these costs on hospitals' average hourly wages. That is, among both teaching and nonteaching hospitals reporting physician Part A costs, these costs make up between 3 and 4 percent of their total wage costs. Therefore, although more teaching hospitals report these costs than nonteaching hospitals (47 percent of teaching hospitals versus 30 percent of nonteaching hospitals), the average hourly wages of teaching hospitals are not more heavily weighted by these costs than they are for nonteaching hospitals.

In fact, two of the MSAs that would be most negatively affected by excluding all physician costs from the wage data, Pittsburgh, PA and Rochester, NY, both have more nonteaching hospitals reporting physician costs than teaching hospitals. We believe the commenter's perception that we are tilting the wage index policy toward teaching hospitals is misguided and reflects an oversimplification of the issue. Based on our analysis of this issue, we are convinced the most prudent course is to focus on specifically developing data to further improve the fairness and accuracy of the wage index.

In describing the perceived problems from our discussion of the physician cost data in the May 27, 1994 proposed rule, the commenter fails to acknowledge that the discussion was in relation to a proposed change. In fact, it was in response to public comments on this proposed change where we agreed to revise the cost report to collect data on contract physician costs. In addition, the September 1, 1994 final rule clearly stated that HCFA intended to evaluate the physician cost data prior to proposing any changes for the FY 1999 wage index.

Regarding the problems associated with contract labor discussed in the FY 1995 proposed and final rules, we note that the separate physician cost data were not available at that time, and therefore the discussion was based on information provided from fiscal intermediaries and industry sources. Based on our analysis of the data available now, we believe that the problems are not as widespread as initially feared. Rather, these costs are similar to those reported for contracted medical providers that we do include, such as therapists and nursing staff. The commenter did not allege that there were widespread problems reporting these data.

The commenter's characterization of the impact of this change on California's hospitals is inaccurate. No California MSA experiences a decrease in their wage index of more than 0.6 percent as a result of this change. The dramatic impacts referenced by the commenter occur only under the assumption that the comparative baseline excludes all physician Part A costs, the course recommended by the commenter. While excluding all physician Part A costs would result in a significant redistribution of payments to certain States such as California, other areas would experience dramatic payment decreases relative to last year.

Comment: One commenter believes that, because the hospital wage index is used to adjust payments for various other types of providers, the wage data should be expanded to be as comprehensive as possible. Specifically, the commenter recommended that wage data related to excluded distinct part units, as well as all physician data, be included.

Response: We have convened workgroups, both internally and externally, to focus on future wage index policies, and we anticipate that we will continue to focus on the appropriate scope of the wage data in those workgroups. In addition, any significant changes in the types of data to be included in the wage index will be implemented through the annual rulemaking process with opportunity for public comment, as has been our policy in the past. For the record, we believe that the hospital wage index should reflect, to the greatest degree possible, the wage costs associated with the prospective payment areas of the hospital.

Comment: One commenter believes that there are ''evident problems with the quality and consistency of the physician contract labor data,'' which is evidenced by California's ranking as the 7th lowest State in terms of contract physician average hourly wage. This commenter also recommended that we begin a more rigorous audit mechanism of the wage data, stating that data reliability is still a problem.

Response: We do not include hospitals' data (other than wage-related costs) if either the salaries or hours reported for contract labor are zero. Applying this edit to the wage data, California ranks as the 12th highest State in terms of contract physician average hourly wages. The analysis provided by the commenters did not include such an edit; therefore, their results are different. We disagree with the general point of this comment that there are quality problems with these data. These data have been subjected to the same review and edit process as are all wage data. We will continue to monitor the process for collecting wage data in the future, and make improvements as necessary. We also encourage hospitals and their associations to feel free to provide specific recommendations for potential improvements.

Comment: One commenter noted that hospitals that acquire their physician Part A services through related organizations do not have an appropriate line on Worksheet S–3 to record these wage costs. Therefore, these hospitals are disadvantaged by the inclusion of costs only for directly employed and contract physician Part A services in the wage index calculation. The commenter recommended that we adjust the FY 1999 wage index to include related organization physician Part A costs for hospitals that were unable to include the costs on their Worksheet S–3s.

Response: The commenter's statements about Worksheet S–3 are incorrect. The cost report instructions at section 2806.3 of the Provider Reimbursement Manual, Part II, allow hospitals to include the costs for physician Part A services from related organizations on line 33 of Worksheet S–3. These costs are also included on the trial balance, Worksheet A, in column 2 (with any adjustments in column 6). Regarding the commenter's recommendation, we cannot adjust the final FY 1999 wage index to include costs that hospitals did not properly report on their cost reports.

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. However, 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, but, because they were not separately reported, we could not remove them.

In the September 1, 1994 final rule with comment period (59 FR 45355), we stated that we would begin collecting the resident and CRNA wage data separately and would evaluate the data before proposing a change in computing the wage index. However, there were data reporting problems associated with these costs on the FY 1995 cost report. The original instructions for reporting

resident costs on Line 6 of Worksheet S–3, Part III, erroneously included teaching physician salaries and other teaching program costs from Worksheet A of the cost report. Although we issued revised instructions to correct this error, we understand these revisions may not have been uniformly instituted. Another issue relating to residents' salaries stems from apparent underreporting of these costs by hospitals and inconsistent treatment of the associated wage-related costs.

In addition, the original Worksheet S–3 and reporting instructions did not provide for the separate reporting of CRNA wage-related costs. We believe that much of the CRNA Part A costs are reported under contract labor, rather than under salaried employee costs, due to the heavy use of contract labor by rural hospitals. We do not believe that it would be feasible at this time to try to remove these CRNA Part A costs from the contract labor costs in the FY 1995 cost report data. We improved the reporting instructions for CRNA costs on the FY 1996 cost report.

Our analysis of the CRNA and resident wage data submitted on the FY 1995 cost report convinces us that these data are inaccurately and incompletely reported by hospitals. For example, although there are over 900 teaching hospitals receiving graduate medical education payments, only about 800 hospitals reported resident cost data. Because we do not want to make a relatively significant change in the wage index data calculation without complete and accurate data upon which to base our decision, we proposed to delay any decision regarding excluding resident and CRNA costs from the wage index until at least next year. In the May 8 proposed rule, we announced our intention to review the FY 1996 data when it becomes available later this year and present our analysis and any proposals in next year's proposed rule.

Comment: Several commenters believe that HCFA should immediately exclude intern and resident and CRNA wage costs for the same reasons the commenters cited for excluding the teaching physician costs. One commenter objected to our statement that problems with the reporting of these data (stemming from inconsistent instructions) warranted a one-year delay. The commenter stated that ''it is better to exclude all clearly identified costs now rather than waiting some indeterminate time for all costs to be identified before excluding any of it.'' Analysis purporting to show a negative impact of $24 million on California due to including these data in the wage index was cited.

Response: As we stated above, the instructions to the FY 1995 cost report Worksheet S–3 for reporting resident costs did not specifically separate teaching physician salaries and other GME program costs from residents' costs. This may have inappropriately inflated resident costs on Line 6 of Worksheet S–3. As a result, removing the costs reported on Line 6 from the FY 1999 wage index calculation would distort the wage index. Our reasoning with respect to retaining the CRNA costs is similar; that is, if Line 2 was removed, it would result in distortions since these costs were reported inconsistently. Therefore, because the data for these costs are not sufficiently reliable and complete, we maintain our position that the more responsible approach is to delay removing these costs until more accurate data are available for the FY 2000 wage index. With regard to the negative impact on California, any analysis based on this data will be skewed by the reporting flaws noted. The FY 1999 wage index calculation will continue to include intern and resident and CRNA wage costs.

We also believe that several of the commenters are confused about the issue of CRNA costs. Currently, only the Part A portion of these costs are included in the wage index, and the only hospitals paid for these costs are small rural hospitals who employ the equivalent of no more than one full-time CRNA and are paid on the basis of reasonable costs. Therefore, they do not contribute to the concentration of physician costs in teaching hospitals.

Comment: One commenter noted that the hourly wage rates for residents are lower than the overall average hourly wage of the hospitals that pay their salaries, and that the inclusion of residents' salaries and wage-related costs actually results in a decrease in teaching hospitals' average hourly wages rather than an increase, as suggested by most other commenters. The commenter suggested that removing residents from the data used to calculate the wage index would increase the wage index values in areas with a high concentration of teaching hospitals.

Response: The FY 1995 data do not permit us to evaluate the accuracy of this comment because residents' salaries are commingled with teaching physicians' salaries for many hospitals. As with all changes to the wage data, the impacts cannot be evaluated properly until accurate data are available for all hospitals nationally.

3. Overhead Allocation

In the proposed rule, we discussed in detail our proposal to remove from the calculation of the FY 1999 wage index the overhead costs associated with certain subprovider components that are excluded from the prospective payment system (63 FR 25586). Although the overall impact on hospitals of this change is relatively small, we believe it is an appropriate step toward improving the overall consistency of the wage index. In addition, we believe this change will significantly increase the accuracy of the wage data for individual hospitals, especially hospitals that have a relatively small portion of their facility devoted to acute inpatient care.

We received several comments supporting this change, and none expressing opposition to it. One commenter referred to it as a step toward improving uniformity and overall consistency in the wage index process. We have, therefore, incorporated our proposal in the final wage index.

D. Verification of Wage Data From the Medicare Cost Report

The data for the FY 1999 wage index were obtained from Worksheet S–3, Parts III and IV of the FY 1995 Medicare cost reports. The data file used to construct the final wage index includes FY 1995 data submitted to the Health Care Provider Cost Report Information System (HCRIS). As in past years, we performed an intensive review of the wage data, mostly through the use of edits designed to identify aberrant data.

As a part of the August 29, 1997 final rule with comment period, we implemented a new timetable for requesting wage data corrections (62 FR 45990). We notified hospitals again of these changes through a February 1998 memorandum to the fiscal intermediaries and in the proposed rule. As noted in the proposed rule, beginning this year with the FY 1999 wage index, the wage index published in the final rule incorporates all corrections, including those to correct data entry or tabulation errors of the final wage data by the intermediary or HCFA.

To allow hospitals an opportunity to evaluate the wage data to be used to construct the proposed and the final FY 1999 hospital wage index, we made available to the public data files containing the FY 1995 hospital wage data. In memoranda dated February 2 and April 21, 1998, we instructed all Medicare intermediaries to inform the prospective payment hospitals they serve of the availability of the wage data files and the process and timeframe for requesting revisions. The proposed and the final wage data files were made available February 6 and May 14, 1998,

through the Internet at HCFA's home page (http://www.hcfa.gov). The intermediaries were also instructed to advise hospitals of the alternative availability of these data through their representative hospital organizations or directly from HCFA.

Table 3C in the Addendum to this final rule, as in the proposed rule, contains each hospital's adjusted average hourly wage used to construct the wage index values. A hospital can verify its adjusted average hourly wage, as calculated from Steps 4 and 5 of the computation of the wage index (see section III.E of this preamble) based on the wage data on the hospital's cost report (after taking into account any adjustments made by the intermediary), by dividing the adjusted average hourly wage in Table 3C by the applicable wage adjustment factors as set forth in Step 5 of the computation of the wage index. However, a hospital's average hourly wage using this calculation will vary from the average hourly wage shown on Line 32 of Worksheet S–3, Part III. (See Step 5 for a complete explanation.)

We created the correction process, as detailed in the proposed rule, to resolve all substantive wage data correction disputes before finalizing the wage data for the FY 1999 payment rates. Hospitals had until June 5, 1998, to submit requests to correct errors in the final wage data (released May 14, 1998) due to data entry or tabulation errors by the intermediary or HCFA. The correction requests considered were limited to errors in the final wage data that the hospital could not have known about prior to the availability of the final wage data public use file. If hospitals availed themselves of these opportunities to timely identify and bring errors in their wage data to their intermediaries' attention, the wage index implemented on October 1 should be free of such errors. Nevertheless, in the unlikely event that errors should arise 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 where 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 1999 (that is, by the June 5, 1998 deadline). As indicated earlier, since a hospital will have had the opportunity to verify its data, and the intermediary will notify the hospital of any changes, we do not foresee any specific circumstances under which midyear corrections would be made. However, should a midyear correction be necessary, the wage index change for the affected area will be effective prospectively from the date the correction is made.

E. Computation of the Wage Index

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

Step 1—As noted above, we based the FY 1999 wage index on wage data reported on the FY 1995 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 III and IV of the Medicare cost report for the hospital's cost reporting period beginning on or after October 1, 1994 and before October 1, 1995. In addition, we included data from a few hospitals that had cost reporting periods beginning in September 1994 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 particular labor market areas might be affected due to the omission of these hospitals. However, we generally describe these wage data as FY 1995 data.

Step 2—For each hospital, we subtracted the excluded salaries (that is, direct salaries attributable to skilled nursing facility services, home health services, and other subprovider components not subject to the prospective payment system) from gross hospital salaries to determine net hospital salaries. To determine total salaries plus wage-related costs, we added the costs of contract labor for direct patient care, certain top management, and physician Part A services; hospital wage-related costs, and any home office salaries and wage-related costs reported by the hospital, to the net hospital salaries. The actual calculation is the sum of lines 2, 4, 6, 32, and 33 of Worksheet S–3, Part III. This calculation differs from the one computed on line 32 of Worksheet S–3, Part III. Therefore, a hospital's average hourly wage calculated under this step will be different from the average hourly wage shown on line 32, column 5.

Step 3—For each hospital, we subtracted the reported excluded hours from the gross hospital hours to determine net hospital hours. To determine total hours, we increased the net hours by the addition of home office hours and hours for contract labor attributable to direct patient care, certain top management, and physician Part A salaries.

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 (Line 24 of Worksheet S–3, Part III) to revised total hours (Line 9 of Worksheet S–3, Part III, adding back CRNA Part A, physician Part A, and resident hours). Second, we 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 16 of Worksheet S–3, Part IV. 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 inflation adjustment, we estimated the percentage change in the employment cost index (ECI) for compensation for each 30-day increment from October 14, 1994 through April 15, 1996, for private industry hospital workers from the Bureau of Labor Statistics Compensation and Working Conditions. For previous wage indexes, we used the percentage change in average hourly earnings for hospital industry workers to make the wage inflation adjustment. For FY 1999 we used the ECI for compensation for private industry hospital workers because it reflects the price increase associated with total compensation (salaries plus fringes) rather than just the increase in salaries, which is what the average hourly earnings category reflected. In addition, the ECI includes managers as well as other hospital workers. We changed the methodology used to compute the monthly update factors. This new methodology uses actual quarterly ECI data to determine the monthly update factors. The methodology assures that the update factors match the actual quarterly and annual percent changes. The inflation factors used to inflate 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
10/14/94	11/15/94	1.032882
11/14/94	12/15/94	1.030771
12/14/94	01/15/95	1.028721

MIDPOINT OF COST REPORTING PERIOD—Continued

After	Before	Adjustment factor
01/14/95	02/15/95	1.026731
02/14/95	03/15/95	1.024776
03/14/95	04/15/95	1.022827
04/14/95	05/15/95	1.020886
05/14/95	06/15/95	1.018901
06/14/95	07/15/95	1.016822
07/14/95	08/15/95	1.014649
08/14/95	09/15/95	1.012446
09/14/95	10/15/95	1.010279
10/14/95	11/15/95	1.008146
11/14/95	12/15/95	1.006047
12/14/95	01/15/96	1.003981
01/14/96	02/15/96	1.001950
02/14/96	03/15/96	1.000000
03/14/96	04/15/96	0.998181

For example, the midpoint of a cost reporting period beginning January 1, 1995 and ending December 31, 1995 is June 30, 1995. An inflation adjustment factor of 1.016822 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 1995 and covers a period of less than 360 days or greater than 370 days, we annualized the data to reflect a 1-year cost report. Annualization is accomplished by dividing the data by the number of days in the cost report and then multiplying the results by 365.

Step 6—Each hospital was assigned to its appropriate urban or rural labor market area prior to 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 in Step 6 by the sum of the total hours (from Step 4) for all hospitals in each labor market area to determine an average hourly wage for the area.

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 data as described above, the national average hourly wage is $20.7325.

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 in June, 1998, OMB announced the designation of the Missoula, Montana MSA comprising Missoula, Montana.

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. 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 $9.5025 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 Public Law 105–33 provides that, for discharges on or after October 1, 1997, the area wage index applicable to any hospital that is not located in a rural area may not be less than the area wage index applicable to hospitals located in rural areas in that State. Furthermore, this wage index floor is to be implemented in such a manner as to assure that aggregate prospective payments are not greater or less than those which would have been made in the year if this section did not apply. For FY 1999, this change affects 118 hospitals in 32 MSAs. The MSAs affected by this provision are identified in Table 4A by a footnote.

F. Revisions to the Wage Index Based on Hospital Redesignation

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

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

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

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

The final wage index values for FY 1999 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, prior to the redesignation of hospitals, based on the FY 1995 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 1995 data (as calculated from 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 2000, unless that average hourly wage is later revised in accordance with the wage data correction policy described in § 412.63(w)(2). In such cases, the MGCRB will use the most recent revised data used for purposes of the hospital wage index.

Although we did not propose any changes to the reclassification guidelines, we received two comments on that issue.

Comment: One commenter was concerned that the number of hospitals participating in countywide reclassifications has declined over the years. The commenter believes that this is an indication that the criteria for hospitals in an urban county seeking reclassification to another urban county should be adjusted.

Response: When we implemented the MGCRB process, we anticipated that, over the years, the number of hospitals that would continue to qualify for reclassification would decrease due to better data reporting and efforts by hospitals to constrain costs. The reclassification process is an annual process in which a hospital or group of hospitals must meet the defined criteria on an annual basis in order to remain reclassified to an alternative area for either the wage index, the standardized amount, or both. We note that hospitals that do not meet the countywide criteria under § 412.234 may apply on an individual basis.

Comment: One commenter supports the policy that allows rural hospitals to reclassify to another area for purposes of the disproportionate share adjustment even if the standardized amount is the same for both areas. However, this commenter is also concerned that separate criteria have not been developed for this type of reclassification and that we continue to rely on the criteria set forth in § 412.230(d), which is the criteria for reclassification to another area for purposes of the standardized amount.

Response: Section 4203(a) of the Balanced Budget Act of 1997 provided that, for a limited period of time, a rural hospital may apply for reclassification to another area for purposes of receiving disproportionate share payments whether or not the standardized amount is the same for both areas. Section 4203(b) provides that the MGCRB will apply the guidelines for reclassification for purposes of the standardized amount until the Secretary establishes other guidelines.

We believe that the criteria in place for standardized amount reclassification are appropriate for determining whether hospitals should be reclassified for purposes of the disproportionate share payment. The criteria address the extent to which a hospital warrants reclassification by comparing the hospital's costs to its payments with and without reclassification. Nevertheless, we welcome specific suggestions for revising the DSH reclassification criteria.

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

A. Definition of Transfers (§ 412.4)

Pursuant to section 1886(d)(5)(I) of the Act, the prospective payment system distinguishes between ''discharges,'' situations in which a patient leaves an acute care (prospective payment) hospital after receiving complete acute care treatment, and ''transfers,'' situations in which the patient is transferred to another acute care hospital for related care. If a full DRG payment were made to each hospital involved in a transfer situation, irrespective of the length of time the patient spent in the ''sending'' hospital prior to transfer, a strong incentive to increase transfers would be created, thereby unnecessarily endangering patients' health. Therefore, our policy, which is set forth in the regulations at § 412.4, provides that, in a transfer situation, full payment is made to the final discharging hospital and each transferring hospital is paid a per diem rate for each day of the stay, not to exceed the full DRG payment that would have been made if the patient had been discharged without being transferred.

Currently, the per diem rate paid to a transferring hospital is determined by dividing the full DRG payment that would have been paid in a nontransfer situation by the geometric mean length of stay for the DRG into which the case falls. Hospitals receive twice the per diem for the first day of the stay and the per diem for every following day up to the full DRG amount. Transferring hospitals are also eligible for outlier payments. Two exceptions to the current transfer payment policy are transfer cases classified into DRG 385 (Neonates, Died or Transferred to Another Acute Care Facility) and DRG 456 (Burns, Transferred to Another Acute Care Facility), which receive the full DRG payment instead of being paid on a per diem basis.

Under section 1886(d)(5)(J) of the Act, which was added by section 4407 of the Balanced Budget Act of 1997, a ''qualified discharge'' from one of 10 DRGs selected by the Secretary to a postacute care provider will be treated as a transfer case beginning with discharges on or after October 1, 1998. Section 1886(d)(5)(J)(iii) confers broad authority on the Secretary to select 10 DRGs ''based upon a high volume of discharges classified within such group and a disproportionate use of'' certain postdischarge services. Section 1886(d)(5)(J)(ii) defines a ''qualified discharge'' as a discharge from a prospective payment hospital of an individual whose hospital stay is classified in one of the 10 selected DRGs if, upon such discharge, the individual—

- Is admitted to a hospital or hospital unit that is not a prospective payment system hospital;
- Is admitted to a skilled nursing facility; or
- Is provided home health services by a home health agency if the services relate to the condition or diagnosis for which the individual received inpatient hospital services and if these services are provided within an appropriate period as determined by the Secretary.

The Conference Agreement that accompanied the law noted that ''(t)he Conferees are concerned that Medicare may in some cases be overpaying hospitals for patients who are transferred to a post acute care setting after a very short acute care hospital stay. The Conferees believe that Medicare's payment system should

continue to provide hospitals with strong incentives to treat patients in the most effective and efficient manner, while at the same time, adjust PPS [prospective payment system] payments in a manner that accounts for reduced hospital lengths of stay because of a discharge to another setting.'' (H.R. Rep. No. 105–217, 740.) In its March 1, 1997 report, ProPAC expressed similar concerns: ''* * * length of stay declines have been greater in DRGs associated with substantial postacute care use, suggesting a shift in care from hospital inpatient to postacute settings' (pp. 21–22).

In fact, based on the latest available data, overall Medicare hospital costs per case have decreased during FYs 1994 and 1995. This unprecedented real decline in costs per case has led to historically high Medicare operating margins (over 10 percent on average). Along with these declining lengths of stay and costs per case, there has been an increase in the utilization of postacute care. In 1990, the rate of skilled nursing facility services per 1,000 Medicare enrollees was 19. By 1995, it had grown to 33. Corresponding numbers for home health agency services are 58 per 1,000 Medicare enrollees during 1990 and 93 per 1,000 enrollees during 1995. Although home health services are not always directly related to a hospitalization episode, there does appear to be a trend toward increased use of home health for the provision of postacute care rehabilitation services. Previous analysis of the percentage of hospital discharges that receive postacute home health care showed a 10.3 percent increase in 1994 compared to 1992.

In the May 8, 1998 proposed rule, we discussed our proposals to implement section 1886(d)(5)(J) of the Act. These proposals are set forth below.

1. Selection of 10 DRGs

Section 1886(d)(5)(J)(iii)(I) of the Act provides that the Secretary select 10 DRGs based on a high volume of discharges to postacute care and a disproportionate use of postacute care services. Therefore, in order to select the DRGs to be paid as transfers, we first identified those DRGs with the highest percentage of postacute care.

We used the FY 1996 MedPAR file because the complete FY 1997 MedPAR file was not available at the time we conducted our analysis. To identify postacute care utilization, we merged hospital inpatient bill files with postacute care bill files matching beneficiary identification numbers and discharge and admission dates. We created this file rather than depend on information concerning discharge destination on the inpatient bill because we have found that the discharge destination codes included on the hospital bills are often inaccurate in identifying discharges to a facility other than another prospective payment hospital.

Section 1886(d)(5)(J)(ii)(III) of the Act requires the Secretary to choose an appropriate window of days in which the home health services start in order for the discharge to meet the definition of a transfer. In order to include postdischarge home health utilization in our analysis, we identified all hospital discharges for patients who received any home health care within 7 days after the date of discharge. (As described below in section IV.A.2., we ultimately decided to propose 3 days as the window for home health services.)

Starting with the DRG with the highest percentage of postacute care discharges and continuing in descending order, we selected the first 20 DRG's that had a relatively large number of discharges to postacute care (our lower limit was 14,000 cases). In order to select 10 DRG's from the 20 DRG's on our list, for each of the DRG's we considered the volume and percentage of discharges to postacute care that occurred before the mean length of stay and whether the discharges occurring early in the stay were more likely to receive postacute care. The following table lists the 10 DRG's we proposed to include under our expanded transfer definition, their percentage of postacute utilization compared to total cases, and the total number of cases identified as going to postacute care.

DRG	Title and type of DRG (surgical or medical)	Percent of postacute utilization	Number of postacute cases
14	Specific Cerebrovascular Disorders Except Transient Ischemic Attack (Medical)	49.5	186,845
113	Amputation for Circulatory System Disorders Excluding Upper Limb and Toe (Surgical)	59.0	28,402
209	Major Joint Limb Reattachment Procedures of Lower Extremity (Surgical)	71.9	257,875
210	Hip and Femur Procedures Except Major Joint Age >17 With CC (Surgical)	77.8	111,799
211	Hip and Femur Procedures Except Major Joint Age >17 Without CC (Surgical)	74.2	19,548
236	Fractures of Hip and Pelvis (Medical)	61.2	24,498
263	Skin Graft and/or Debridement for Skin Ulcer or Cellulitis With CC (Surgical)	49.4	14,499
264	Skin Graft and/or Debridement for Skin Ulcer or Cellulitis W/O CC (Surgical)	39.3	1,328
429	Organic Disturbances and Mental Retardation (Medical)	45.4	19,314
483	Tracheostomy Except for Face, Mouth and Neck Diagnoses (Surgical)	45.3	18,254

We included DRG 263 on the list because of its ranking in the top 20 DRG's in terms of postacute utilization and volume of discharges to postacute care. DRG's 263 and 264 are paired DRG's; that is, the only difference in the cases assigned to DRG 263 as opposed to DRG 264 is that the patient has a complicating or comorbid condition. If we included only DRG 263 in the list, it would be possible for a transfer case with a relatively short length of stay that should be assigned to DRG 263 and receive a relatively small transfer payment to be assigned instead to DRG 264, and receive the full DRG payment, simply by failing to include the CC diagnosis code on the bill. Therefore, our choice was to either delete DRG 263 from the list or add DRG 264. We decided to include DRG 264 in the proposed list because DRG 263 fully meets all the conditions for inclusion on the list of 10 DRG's.

2. Postacute Care Settings

Section 1886(d)(5)(J)(ii) of the Act requires the Secretary to define and pay as transfers cases from one of 10 DRG's selected by the Secretary if the individual is discharged to one of the following settings:

- A hospital or hospital unit that is not a subsection [1886](d) hospital, that is, a hospital or unit excluded from the inpatient prospective payment system.
- A skilled nursing facility, that is, a facility that meets the definition of a skilled nursing facility set forth at section 1819 of the Act.
- Home health services provided by a home health agency, if the services are

related to the condition or diagnosis for which the individual received inpatient hospital services, and if the home health services are provided within an appropriate period (as determined by the Secretary).

Section 1886(d)(1)(B) of the Act defines the hospitals and hospital units that are excluded from the prospective payment system as the following: psychiatric, rehabilitation, childrens', long-term care, and cancer hospitals and psychiatric and rehabilitation distinct part units of a hospital. Therefore, any discharge from a prospective payment hospital from one of the 10 proposed DRG's that is admitted to one of these types of facilities on the date of discharge from the acute hospital, on or after October 1, 1998, would be considered a transfer and paid accordingly under the prospective payment systems (operating and capital) for inpatient hospital services.

We proposed that a discharge from a prospective payment hospital to a skilled nursing facility would include cases discharged from one of the 10 DRG's from an inpatient bed in the hospital to a bed in the same hospital that has been designated for the provision of skilled nursing care (a ''swing'' bed). The swing bed provision allows certain small rural hospitals to furnish services in inpatient beds which, if furnished by a skilled nursing facility, would constitute extended care services. In addition, any patient who receives swing-bed services is deemed to have received extended care services as if furnished by a skilled nursing facility. Thus, if swing beds were not included in the transfer policy, those hospitals with swing bed agreements could move patients assigned to one of the 10 selected DRG's from an inpatient bed to a swing bed and receive payment and receive the full DRG payment. In the proposed rule, we stated that we did not believe that this would be a fair policy in that it would create a payment advantage for swing bed hospitals. Therefore, we proposed that a discharge to a swing bed would be paid as a transfer when the patient is classified to one of the 10 selected DRG's.

Section 1886(d)(5)(J)(ii)(III) of the Act states that the discharge of an individual who receives home health services upon discharge will be treated as a transfer if ''such services are provided within an appropriate period (as determined by the Secretary) * * *.'' As discussed above in section IV.A.1, we began our analysis using 7 days (one week) as the time period we would consider. However, after conducting further analysis, we proposed that 3 days after the date of discharge would be a more appropriate timeframe. Based on our analysis of the FY 1996 bills, approximately 90 percent of patients began receiving home health care within 3 days.

With regard to an appropriate definition of ''home health services * * * relate[d] to the condition or diagnosis for which the individual received inpatient hospital services * * *'', we considered several possible approaches. Under one approach we could compare the principal diagnosis of the inpatient stay to the diagnosis code indicated on the home health bill, similar to our policy on the 3-day payment window for preadmission services. However, we believe that such a policy is far too restrictive in terms of qualifying discharges for transfer payment. In addition, a hospital would not know when it discharges a patient to home health what diagnosis code the home health agency will put on the bill. Therefore, the hospital would not be able to correctly code the inpatient bill as a transfer or discharge.

We also considered proposing that *any* home health care that begins within the designated timeframe be included ''as related'' in our definition. However, this definition might be too broad and the hospital would not be able to predict which cases should be coded as transfers because the hospital often may not know about home health services that are provided upon discharge but were not ordered or planned for as part of the hospital discharge plan.

We proposed that home health services would be considered related to the hospital discharge if the patient is discharged from the hospital with a written plan of care for the provision of home health care services from a home health agency. In this way, the hospital would be fully aware of the status of the patient when discharged and could be held responsible for correctly coding the discharge as a transfer on the inpatient bill. In general, this would mean that the home health service would qualify as a Part A home health benefit under section 1861(tt) of the Act as added by section 4611(b) of the BBA.

In the proposed rule, we noted that we plan to compare inpatient bills with home health service bills for care provided within 3 days after discharge. If we find that home health services were provided within the postdischarge window, the hospital will be notified and the hospital payment adjusted unless the hospital can submit documentation verifying the discharge status of the patient. This will alert hospitals if there are problems with their discharge/transfer billing and allow them to adjust their discharge planning process and billing practices. If we find a continued pattern of a hospital billing for cases from the 10 DRG's as discharges and our records indicate that the patients are receiving postacute care services from an excluded hospital, a skilled nursing facility, or within the 3-day home health service window, the hospitals may be investigated for fraudulent or abusive billing practices.

3. Payment Methodology

The statute does not dictate the payment methodology we must use for these transfer cases. However, section 1886(d)(5)(J)(i) of the Act provides that the payment amount for a case may not exceed the sum of half the full DRG payment amount and half of the payment amount under the current per diem payment methodology.

Based on our analysis comparing the costs per case for the transfers in the 10 DRG's with payments under our current transfer payment methodology, we found that most of the 10 DRG's are appropriately paid using our current methodology (that is, twice the per diem for the first day and the per diem for each subsequent day). In fact, this payment would, on average, slightly exceed costs. However, this is not true of DRG's 209, 210, and 211. For those three DRG's, a disproportionate percentage (about 50 percent) of the costs of the case are incurred on the first day of the stay. Therefore, we stated in the proposed rule that we would pay DRG's 209, 210, and 211 based on 50 percent of the DRG payment for the first day of the stay and 50 percent of the per diem for the remaining days of the stay. The other seven DRG's would be paid under the current transfer payment methodology.

We proposed to revise § 412.4 to reflect these policies. In addition, we proposed to delete the reference in § 412.4(d)(2) to DRG 456 (Burns, Transferred to Another Acute Care Facility) because we proposed to replace that DRG and there would no longer be any burn DRG with a transfer designation. As discussed in section II.B.3 of this preamble, we have adopted that DRG change effective for FY 1999.

We received a large number of comments concerning this proposal. In general, commenters were opposed to the implementation of any postacute care transfer policy. Acknowledging that the policy is required by statute, most commenters also disagreed with the manner in which we proposed to implement the policy. However, one association representing postacute care providers was supportive of the proposed policy, in general, and our

various policy proposals. As discussed in the specific comments and responses that follow, we are implementing the discharge to postacute care provision as set forth in the proposed rule except that we are not including swing beds in the definition of a postacute care setting and we are clarifying the payment methodology for DRGs 209, 210, and 211.

Comment: Commenters believed that the postacute care transfer provision penalizes hospitals for providing effective care and creates a perverse incentive for hospitals to keep patients longer. Some commenters suggested that this provision interferes with the practice of medicine by overriding the clinical decision-making process by physicians in determining the most appropriate level of care to provide to their patients. Many commenters stated that the postacute care transfer policy is contrary to the original intent of the prospective payment system. Several commenters urged us either to repeal the entire provision or to support efforts to have it repealed.

Response: We disagree that this provision penalizes hospitals for effective care. As noted in the May 8 proposed rule, the Conference Agreement accompanying Public Law 105–33 states that ''Medicare's payment system should continue to provide hospitals with strong incentives to treat patients in the most effective and efficient manner, while at the same time, adjust PPS payments in a manner that accounts for reduced hospital lengths of stay because of a discharge to another setting.'' The transfer provision adjusts payments to hospitals to reflect the reduced lengths of stay arising from the shift of patient care from the acute care setting to the postacute care setting. In addition, because Medicare also often pays for the postacute care portion of beneficiaries' care, the transfer provision appropriately adjusts hospitals' payments to avoid duplicate payments for the care provided during a patient's episode of care.

With respect to the payment incentives created by this provision, we would refer the reader to the tables set forth at Appendix D of this final rule. These tables graphically demonstrate payments compared to costs for transfer cases in each of the 10 selected DRGs. These tables show that, across virtually all lengths of stay for each of the DRGs, Medicare will pay in excess of costs even after the implementation of this provision. Thus, the argument that this provision creates perverse incentives and interferes with the appropriate practice of medicine is not persuasive. This policy does not require a change in physician clinical decision-making nor in the manner in which physicians and hospitals practice medicine; it simply addresses the appropriate level of payments once those decisions have been made.

We believe a stronger argument can be made that the incentives of the current policy, where hospitals receive the full DRG payment for these DRGs regardless of how long patients remain in the acute care hospital prior to being transferred for postacute care, potentially have a greater impact on clinical decision-making. Simply put, as costs rise with each additional acute care day and payments are fixed, hospitals have a financial incentive to discharge patients as soon as possible. The incentive is less clear, and can be argued to be neutral, to the extent that the marginal payments for an additional acute inpatient care day increase in proportion to the marginal costs of that day. Thus, the postacute care transfer policy does not create perverse incentives for hospitals to keep patients longer; instead, it addresses current incentives to discharge patients as soon as possible.

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

Comment: A commenter observed that our estimate of the impact of this transfer provision on hospitals' payments per case (a 0.6 percent decrease in payments) results in an overall payment reduction of $600 million for FY 1999. The commenter stated that the Congressional Budget Office (CBO) estimated the impact at $100 million for FY 1999. The commenter believed that this disparity in estimates substantiates claims that the new provision will have undesirable and unintended consequences.

Response: We believe the commenter's estimate of the impacts of this provision are overstated. Based on the 0.6 percent decrease in payment per case estimated in our impact analysis, the projected impact of this transfer provision is approximately a $480 million decrease in overall payments. Although this savings estimate is higher than CBO's estimate, we would note that CBO assumed hospitals would change their behavior by keeping patients longer. As we describe in our impact analysis, we do not make any assumptions regarding changes in hospitals' behavior. We would also note that the precision with which one can estimate the savings associated with a provision such as this is highly dependent on the specifications of the provision and the data available to generate an estimate. Unlike the CBO estimate, our estimate reflects the 10 actual DRGs to be included and the latest discharge data to identify which cases would qualify as transfers.

Comment: A large number of commenters objected to the inclusion of swing beds as a postacute care setting. Many of these commenters stated that they believed that Congress did not intend that discharges to swing beds be included in the postacute transfer provision. In addition, the commenters were concerned about the negative impact of this policy on rural hospitals and rural health care in general. Two commenters, including MedPAC, supported our proposal concerning swing bed discharges.

Response: We proposed to include discharges to swing beds because the services provided in swing beds are exactly the same as the services provided in skilled nursing facilities. That is, a swing-bed hospital is equivalent to a skilled nursing facility when it provides a swing-bed service. Thus, the policy rationale for including discharges to skilled nursing facilities in the postacute care provision would apply equally to discharges to swing beds.

Although we are not persuaded by the commenters that, from a payment policy perspective, our proposal to include swing beds in the transfer provision was inappropriate, we understand the commenter's concern that this policy could have an adverse impact on small rural hospitals. Although our analysis shows that the impact on these hospitals is negligible in the aggregate, the impact on individual hospitals may be more significant. We have decided not to include discharges to a swing bed in the expanded transfer definition at this

time. We will monitor these discharges closely and may reconsider this decision in the future. We note that section 1886(d)(5)(J)(iv) of the Act requires the Secretary to include a description of the effect of the postacute care transfer policy in the FY 2001 hospital inpatient prospective payment system proposed rule.

Comment: Commenters requested clarification of our policy concerning transfers to skilled nursing facilities. First, the commenters questioned the Secretary's authority to include as transfers those discharges to nursing homes that are not certified by Medicare. In addition, the commenters believed that patients discharged to a Medicare-certified skilled nursing facility for custodial care should not be included. The commenters also urged us to limit application of the transfer policy to discharges to skilled nursing facilities in cases where the patient receives Medicare-covered postacute care.

Response: Section 1886(d)(5)(J)(ii) of the Act defines a ''qualified discharge'' in part as a discharge of an individual from a prospective payment system hospital, if upon such discharge, the individual is ''* * * admitted to a skilled nursing facility. * * *'' There is no language in the statute that further defines skilled nursing facility. In the proposed rule, we stated that a discharge to a facility that meets the definition of a skilled nursing facility set forth at section 1819 of the Act would be considered a transfer. Discharges to nursing homes that are not certified by Medicare as skilled nursing facilities, or distinct parts of nursing homes that are not certified as skilled nursing facilities, would not be considered transfers.

However, we do not believe it would be appropriate from either a legal or policy perspective to limit the transfer definition to situations where a patient is transferred to a skilled nursing facility for noncovered services. The statute does not limit application of the transfer definition to ''covered'' skilled nursing facility services. Moreover, there are several policy reasons why we would not adopt such a policy. First, it would place an added administrative burden upon the hospital to evaluate the patient's eligibility for covered skilled nursing services. Second, it would create incentives for providing noncovered postacute care that could potentially place beneficiaries at medical and financial risk. Third, it would be inconsistent with existing transfer policy (from one acute care hospital to another acute care hospital), which does not limit the definition of a transfer to those cases in which a patient receives Medicare-covered services at the receiving hospital. Finally, the basic rationale for the transfer policy (that is, adjusting hospital payments to reflect reduced hospital costs due to discharge to a postacute care facility) applies regardless of whether the postacute care is covered by Medicare. Therefore, our final regulations provide that all discharges from the 10 specified DRGs admitted to a skilled nursing facility will be defined as transfers, regardless of the coverage status of that admission.

Comment: One commenter believes that patients who were admitted to a skilled nursing facility any time within 30 days after the date of discharge (the so-called 30-day skilled nursing facility eligibility window) and who received care related to the inpatient stay will be considered a transfer under this policy. The commenter is concerned that hospitals will be expected to track patients for this period of time and be held accountable for their actions in such situations.

Response: In order to be considered a transfer, the patient must be admitted directly from the hospital to the skilled nursing facility. If the patient is not admitted directly to a skilled nursing facility, it would not constitute a transfer situation, even if care begins within the 30-day eligibility window and is related to the acute care hospital stay.

Comment: One commenter suggested that the expanded transfer definition should apply only in cases where the patient is transferred within a hospital system, that is, the patient is discharged to an entity that is related to or owned by the hospital. A transfer to an independent postacute care entity would be defined as a discharge.

Response: Section 1886(d)(5)(J)(ii) of the Act defines a qualified discharge from a prospective payment hospital as one in which the individual, upon discharge, ''* * * is admitted as an inpatient of a hospital or hospital unit excluded that is not a subsection (d) hospital * * * is admitted to a skilled nursing facility * * * is provided home health services from a home health agency. * * *'' The statute or the conference report does not limit the applicability of this provision to postacute care providers that are owned by or related to the discharging hospital. In addition, we do not believe that ownership of or affiliation with the postacute care providers is the overriding concern that led to the enactment of this provision. Although a hospital that owns or is related to the postacute care provider has an even greater financial incentive to transfer a patient early in the hospital stay to that facility, the current incentive to the hospital itself to discharge the patient as soon as possible is the same whether or not it owns or is related to the postacute care provider. Finally, if the transfer definition were based on a hospital's affiliation with the postacute provider, it would create a strong incentive to reconfigure the hospital's corporate structure to avoid being included under the provision.

Comment: One commenter suggested that psychiatric hospitals and units be excluded from the provision because the postacute care services furnished by these facilities are unrelated to a medical hospitalization.

Response: As a legal matter, section 1886(d)(5)(J)(ii)(I) of the Act includes all hospitals and hospital units excluded from the prospective payment system. This definition covers psychiatric hospitals and units. As a policy matter, we also strongly believe that transfers to psychiatric hospitals and units should be included under this provision. Inpatient care furnished by hospitals is not limited to diseases and disorders of the body, but is also furnished to patients with mental diseases and disorders as evidenced by the nine DRGs devoted solely to these conditions. Furthermore, exempting psychiatric hospitals and units from the provision could create an incentive to temporarily transfer patients who need postacute care to a psychiatric hospital or unit setting as a way of avoiding the transfer payment, thus delaying the appropriate medical care for the patient.

Comment: Several commenters disagreed with our proposal to include as transfers all discharges from the 10 specified DRGs to home health care that begins within 3 days after the date of discharge. The commenters argued that postacute care that begins 3 days after discharge should not be considered a substitute for inpatient hospital care. Although MedPAC agreed with these commenters that home health services furnished after a delay of more than one day may not necessarily be regarded as substituting for inpatient acute care, they also noted that a 3-day window allows for the fact that most home health patients do not receive care every day as well as those occasions in which there may be a delay in arranging for the provision of planned care. The Commission also stated that a shorter period may create a stronger incentive to delay the provision of necessary treatment beyond the window so the hospital can receive the full DRG payment. Another commenter

supported 3 days as an appropriate period of time.

Those commenters who recommended an alternative number of days for the home health window universally stated that a discharge to home health care should be considered a transfer only if the patients begin to receive home health care on the day of discharge. One commenter argued that a 3-day window would lead to either needlessly prolonged hospital stays or delayed home health care. Another commenter questioned why we would not want patients transferred to home health care as soon as possible.

Response: The statute defines ''qualified discharge'' to include discharges where the individual is provided home health care ''within an appropriate period (as determined by the Secretary).'' We continue to believe a 3-day window for home health services is appropriate. Home health care is a less-structured and more flexible means of providing postacute care because it is provided not in an institutional setting but rather in the patient's home. We believe that a 3-day window provides flexibility in situations where home care may not be available or medically appropriate immediately upon discharge. It is also of sufficient length to discourage hospitals and physicians from delaying the initiation of necessary postacute care, while being short enough to avoid placing an undue burden upon hospitals that may want to delay submitting the inpatient hospital claim until they verify whether or not home health care has begun within the 3 days.

We do not believe that it is appropriate to limit the transfer definition to situations where home care begins on the same day as the patient is discharged from the hospital. Our analysis indicates that currently less than 8 percent of discharged patients who receive home health services begin receiving those services on the date of discharge. It is unreasonable to expect that patients who are discharged in the late afternoon or evening would receive a home health visit that same day. Furthermore, we believe the financial incentive to delay needed home care for only a matter of hours would be overwhelming if we limited the definition to the same day. As we noted in the proposed rule, approximately 90 percent of patients who receive home health services after an inpatient hospital stay began their treatment within 3 days after the date of discharge. We believe 3 days accommodates current practices, while also being sufficiently narrow to allow hospitals to determine whether the care was actually delivered prior to submitting the bill. We intend to monitor this aspect of the policy through case review in order to track any changes in hospital practices that may indicate that we need to revise our window definition.

Comment: One commenter argued that the best method to determine whether postacute home health services are related to the inpatient stay would be to match the principal diagnosis codes on the inpatient and home health bills. The commenter believed this would alleviate situations where the patient is discharged from the hospital with a written plan for the provision of home health services, but the services are related to a medical condition other than the condition responsible for the inpatient stay. In addition, the commenter noted that matching principal diagnosis codes would be consistent with current policy for the 3-day window for preadmission services.

Response: We disagree that the determination of whether home health care is related to the acute hospitalization should be based on the presence of identical diagnosis codes on the inpatient and home health bills. This approach would rely on the coding practices of the providers involved. Providers, especially postacute care providers, frequently have the discretion to select from several possible diagnosis codes. A common practice of postacute care providers is to use the V57 diagnosis code category (care involving use of rehabilitation procedures) as principal because those codes best describe the reason for the postacute care. However, this code is seldom used by hospitals for acute care discharges because they are instructed by coding rules to code as principal the condition that required the hospital admission as determined at the time of discharge. In fact, if the hospitals coded discharges with the rehabilitation codes as principal, the discharges would never be included in the postacute care policy because those discharges would never be classified to one of the 10 selected DRGs.

We believe our proposed policy on this issue is preferable. We note that hospitals that code a discharge to home health will be permitted to indicate through a condition code on the inpatient bill that the hospital's discharge plan does not call for home care related to the hospitalization, but that other nonrelated home care is appropriate. This way, the hospital will make a conscious selection that the home care the patient is to receive is not related to the hospitalization, and would be expected to have documentation in the patient's records to that effect.

Comment: In the context of discussing the home health window, MedPAC questioned whether the same day requirement for admission to an excluded hospital or unit or a skilled nursing facility was too limited. The Commission suggested expanding the definition to account for a 24-hour period following discharge.

Response: In describing which discharges to excluded hospitals and units or skilled nursing facilities should be treated as a transfer, the statute states that the patient is admitted to the facility upon discharge from the hospital. We believe that Congress intended that the policy apply to situations when the patient moves from the hospital directly to the excluded facility or the skilled nursing facility. Therefore, unless a patient is being transported from the hospital to the other facility in the middle of the night, the discharge and admission should occur on the same calendar day. We note that a direct transfer that spans midnight and results in a one-day difference in the discharge and admission dates will be considered a transfer for purposes of this policy.

Comment: Many commenters indicated the discharge to postacute care provision will be an administrative burden for hospitals. Because Medicare beneficiaries are free to obtain services without a hospital referral, hospitals are concerned that they will be subject to allegations of fraud and abuse if they discharge a beneficiary to home with no plan of care for home health services and the beneficiary subsequently receives postacute care without the hospital's knowledge. These hospitals believe that they may be forced to hold bills for the 10 DRGS when they discharge a patient to self-care at home so they can follow-up and ensure that the patient did not receive postacute care.

Another commenter is disturbed by our discussion in the proposed rule concerning future actions we may take if we find continued patterns of a hospital billing postacute transfer cases as discharges, including the possibility that hospitals may be investigated for fraudulent or abusive billing practices. The commenter believes that our language was too strong and that we are not allowing a period of transition in which hospitals may make honest billing errors as they adjust to this new policy.

Finally, commenters suggested that we clarify when hospitals are responsible for knowing that a case is transferred for postacute care.

Response: We recognize there may occasionally be cases where a hospital believes it is discharging a patient to home or another setting not included in the postacute transfer definition, and a physician orders postacute care for the patient without notifying the hospital. Although these cases would be considered transfers under this provision, we do not believe that such instances, where they occur truly without knowledge of the hospital, constitute fraudulent actions. As we indicated in the proposed rule, we intend to monitor postacute care cases to evaluate whether such situations occur with unlikely frequency at specific hospitals and we will investigate the circumstances in those instances.

Although we recognize honest mistakes will occur, we do not believe it is inappropriate to put hospitals on notice that we reserve the right to investigate those with aberrant patterns of inaccurate billing on these cases. While it is reasonable to assume there will be a learning curve in terms of hospitals' billing practices as these changes are implemented, we also take seriously our responsibility to protect the Medicare trust fund. Our intention in including a discussion of this issue in the proposed rule was an attempt to avoid any misunderstanding in terms of our commitment to ensure the correct implementation of this provision.

In response to the request for clarification about the hospital's responsibility for knowing when a transfer occurs, the hospital is responsible for coding the bill based on its discharge plan for the patient, or if it finds out subsequently that postacute care occurred, it is responsible for either coding the original bill as a transfer or submitting an adjustment bill. We have consulted with the National Uniform Billing Committee (NUBC) to ensure that the appropriate changes are made on the claims form to enable hospitals to accurately code these cases and to submit corrections to them when additional information affecting the patient's discharge status code becomes available after the bill is submitted.

Comment: One commenter recommended that we establish a hierarchical decision process for determining whether a discharge to home health services qualifies as a transfer. This commenter believed that the overriding consideration should be whether the services are related to the hospital stay. This commenter suggested that any home care ordered in the discharge plan should constitute related home health care, regardless of when it is provided.

Response: Congress directed the Secretary to determine the appropriate time period within which the provision of home health services would trigger a transfer payment. Services provided outside that window, even if related to the hospital stay, would not result in the discharge being considered a transfer. In addition, we believe that a time limit is consistent with the concern that these transfer cases are predominantly situations where care is being shifted from the acute setting to a postacute care setting. If a patient is discharged to home and does not need home health care for several days, there may be little, if any, shift of acute care services to the postacute care setting.

Comment: One commenter stated that we should specify that the written plan of care for home health services should be defined clearly as ''a specific order by the patient's physician in the hospital medical record that directs the hospital to arrange for home health services upon discharge.''

Response: We do not believe that it is necessary to specify the precise definition of what a written plan of care for home health services must entail. We note that we would deem a case to be a transfer if care related to the discharge was provided within 3 days after the date of discharge even if the hospital had no written plan of care.

Comment: A representative of physical therapists expressed concern that the 3-day window for home health services may influence hospitals to wait until after the 3 days to initiate home health services. This commenter is also concerned that our proposal to identify related home health services based on the written plan of care by the hospital at the time of discharge may discourage hospitals from planning for home health, resulting in uncoordinated and delayed postacute care following discharge.

Response: We believe there are sufficient protections against hospitals inappropriately delaying home health care. First, the provision of home health care is ordered by the patient's physician orders. We believe physicians will be reluctant to compromise their patients' treatment by inappropriately delaying home health care. In addition, we will monitor hospitals' discharge patterns to home health for evidence that care is being routinely delayed until the fourth day after discharge and intend to aggressively pursue situations where abuse is evident. If evidence of a pattern of abuse is found, we will address it through appropriate policy changes in the FY 2001 proposed rule.

With respect to the commenter's concern that identifying related home health services based on the hospital's written plan of care may create a disincentive to plan home care, we will also be able to identify those cases where home health services were received within 3 days of discharge and the hospital indicated that the patient was discharged home with no plan for home health services. As we noted above, we recognize there will be a certain percentage of cases where home care is arranged after release from the hospital; however, we would expect such situations to be relatively rare.

Comment: One commenter, representing medical rehabilitation providers, expressed concern that this provision may change hospitals' referral patterns, delaying the initiation of rehabilitation services. The commenter suggested that we collect the following information from prospective payment hospitals to monitor their referral patterns:

- Site of referral for cases in the 10 DRGs, including discharge to home without postacute care.
- Date from onset and length of stay prior to referral, by DRG.
- General medical condition and functional status of the patient if the hospital normally collects functional information.

In addition, HCFA should collect the following information from postacute care providers:

- The DRG assigned to the acute care hospitalization.
- The date from onset and date of referral to the postacute care provider.
- For patients referred for rehabilitation services to a rehabilitation hospital or unit, the functional status of the patient on admission to and at discharge from the rehabilitation provider.

The commenter noted that over 90 percent of rehabilitation providers already use functional assessment tools, therefore, this data collection would not be excessively burdensome.

Response: We appreciate this commenter's concerns regarding any potentially adverse effects of this provision with respect to beneficiaries' health. We already collect most of the hospital data suggested by the commenter (with the exception of patients' functional status and medical condition, though even this could be accessed on a limited basis). Similarly, for postacute providers, the first two items of data are already readily available in our system. As we have described above, we intend to use these data to monitor providers' behavior after implementation of this policy.

Comment: Commenters requested that we require the fiscal intermediaries to

automatically adjust the payments received by the hospital when the hospital codes a case as a discharge and no bill is ever received for postacute care services. In making this request, the commenters referred to the process we described in the proposed rule in which we would compare the discharge status coded on the hospital bills with postacute care bills received to determine whether qualifying postacute care was provided when the hospital billed the case as a discharge.

Response: As noted above, hospitals will be able to submit corrections to their discharge status codes when they determine that previously submitted bills are incorrect. It would be impractical to require the fiscal intermediaries to adjust payments for cases coded as transfers when no matching postacute care bill is identified. Such a requirement raises a potential scenario where a case may be inappropriately adjusted upward because the matching postacute bill has not entered the claims system at the time the bill comparison is made. The prescribed period of time within which a provider may submit a bill for Medicare payment is relatively long and we believe it would be impractical for each intermediary to reprocess already paid bills based solely on the absence of a matching postacute care bill. In addition, we note that there may be occasions when no postacute care bill is submitted even though the patient was discharged to that care. For example, as we discussed above, if a patient is transferred to a skilled nursing facility and receives noncovered care, there will be no bill in the Medicare claims files. We believe it is preferable to require hospitals to submit bill adjustments.

Comment: One commenter was unclear about how postacute care transfers will be identified in the billing process. Specifically, the commenter questioned whether the hospital will indicate a transfer by the discharge status code or whether the identification will occur by matching the acute hospitalization bill against a postacute bill at the fiscal intermediary.

Response: Transfer cases will be identified based on the discharge status code listed on the hospital claim form (the HCFA–1490, also known as the UB–92). As noted above, we have consulted with the NUBC to ensure that the appropriate changes are made on the claims form to enable hospitals to accurately code these cases. The language in the proposed rule concerning a process of matching the date of discharge from the acute hospital stay with the date that postacute care services begin was a description of the process that HCFA will use as a check to verify the accuracy of the discharge codes.

Comment: One commenter asked whether the discharge destination code ''08,'' which is described as ''Discharged/transferred to home under care of a Home IV (intravenous) provider,'' would be used to identify a transfer. This commenter was also concerned about whether code ''05,'' which is described as ''Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution'' would be sufficient to identify transfers to excluded hospitals or units.

Response: Discharge code ''08'' will not trigger a transfer payment because it should not be used in situations where a patient is receiving IV services under the Medicare home health benefit. Rather, code ''06'' should be used to signify all care provided by a home health agency under the Medicare home health benefit.

With respect to discharge code ''05,'' the NUBC is discussing what additional codes need to be added or what current codes may be revised to allow for more specific coding to distinguish transfer situations from nontransfers. Instructions on the discharge codes will be provided to the fiscal intermediaries and, thereafter, to the hospitals before the effective date of the postacute transfer provision (that is, October 1, 1998).

Comment: Several commenters suggested that DRG 483 should not be included as one of the 10 DRGs under this provision. The commenters believed that this DRG is not clinically homogeneous and includes many different conditions with different expected lengths of stay. They also stated that our analysis showed that transfers from this DRG would be paid below costs for almost every day below the mean length of stay. One commenter indicated it appeared this DRG was singled out for specific treatment.

MedPAC commented that the criteria we used to select the 10 DRGs was reasonable, although it indicated that the list is fairly narrow in the types of conditions or procedures represented. Therefore, when we consider an expansion of this list, MedPAC recommended that we include coronary surgery DRGs, such as the coronary bypass DRGs (106, 107, and 109), and the pneumonia DRGs (89, 90, or 91).

Response: As described in the proposed rule and above in this section of the preamble, the 10 DRGs were selected based on the criteria specified in the statute, that is, the DRGs exhibit a high volume and disproportionate percentage of postacute cases. None of the 10 DRGs were predetermined. With respect to DRG 483, a significant percentage of discharges (over 45 percent are transferred to postacute care. This places it in the top 25 DRGs in terms of postacute care utilization. Of those 25 DRGs, it is ranked 9th in terms of the volume of cases receiving postacute care. We believe these factors justify its inclusion.

In addition, contrary to the commenter's statement, our analysis of payments and costs for transfers in this DRG shows that average payments exceed average costs for all but those cases transferred very early in the stay (before the 6th day in a DRG with an average length of stay of 34 days). (See the table for DRG 483 in Appendix D of this final rule.) The marginal costs per day for this DRG are consistent with and are accommodated almost perfectly by the transfer per diem payment methodology.

We appreciate MedPAC's support regarding our selection criteria and will take its recommendations regarding additional DRGs into consideration in our future analysis.

Comment: Some commenters believe that the process we used to select the 10 DRGs did not reflect the intent of Congress. They suggested that, in selecting the 10 DRGs, we should include an evaluation of whether a DRG was prone to inappropriate use of postacute care.

Response: Section 1886(d)(5)(J)(iii)(I) of the Act provides that the affected DRGs are ''* * *10 diagnosis-related groups selected by the Secretary based on a high-volume of discharges classified within such groups and a disproportionate use of post discharge [sic] services * * *.'' This language does not direct the Secretary to select the 10 DRGs based upon their vulnerability to inappropriate use of postacute care. As stated earlier, the postacure care transfer provision adjusts hospital payments to reflect the reduced lengths of stay arising from the shift of care to the postacute care setting.

Comment: One commenter was offended by the rationale stated in the proposed rule for including DRG 264 (Skin Graft and/or Debridement for Skin Ulcer or Cellulitis without complication or comorbidity (CC)) in the list of 10 DRGs. The commenter argued that no medical record coder would intentionally fail to list a CC in order to avoid the transfer payment for a case that groups to DRG 263 (Skin Graft and/or Debridement for Skin Ulcer or Cellulitis With CC). The commenter noted that this would be an illegal,

fraudulent act on the part of the coder and should not be used as a deciding factor in the methodology for selecting the 10 DRGs.

Response: In making our selection of the 10 DRGs, we decided to include paired DRGs if one of them met our criteria. While we do not believe that medical record coders will exclude a CC code in their list of diagnosis codes, the hospital claim is not generally submitted to HCFA by the coder, but rather by a billing office where information included on the claim is frequently subject to additional review. By including DRG 264, we hope to avoid any questions or issues concerning the accurate coding of a particular case involving skin graft and debridement.

Comment: Several commenters stated that the alternative payment methodology for DRGs 209, 210, and 211 described in the proposed rule would not pay the full DRG amount until one day after the geometric mean length of stay for the DRG. This result is contrary to the usual per diem payment methodology where the full DRG payment is received one day before the geometric mean length of stay.

Response: The alternative payment methodology in the proposed rule was described as ''50 percent of the DRG payment for the first day of the stay, and 50 percent of the per diem for the remaining days of the stay.'' This wording imprecisely described our proposed policy. The alternative payment methodology proposed for DRGs 209, 210, and 211 is equal to 50 percent of the DRG payment plus 50 percent of the amount which would be paid under our per diem methodology. Under this formula, on day one of a postacute care transfer, hospitals would receive one-half the DRG payment amount plus the per diem payment for the DRG (one-half the usual transfer payment of double the per diem for day one). For each subsequent day prior to transfer, hospitals receive one-half the per diem up to the full DRG payment, which is reached one day prior to the geometric mean length of stay for the DRG. We note that, although we inaccurately described the methodology, we used the correct formula in calculating the budget neutrality factors and outlier thresholds in the proposed rule.

Comment: One commenter believed that the alternative payment methodology used for DRGs 209, 210, and 211 should be used for all 10 of the DRGs selected under the postacute care transfer provision. The commenter argued that for postacute care transfers, unlike transfers under our current transfer policy, the hospital provides all necessary acute care services to the patient, regardless of length of stay, before transferring the patient to postacute care.

Response: As noted above, we believe care previously provided in the acute care setting increasingly has been shifted to the postacute setting. Therefore, we do not agree with the commenter's belief that these cases are significantly different from those considered transfers under our current definition of transfers; in both situations, the length of stay is reduced and presumably a hospital furnished fewer services and incurs lower costs relative to a typical discharge. Furthermore, as demonstrated in the tables comparing average payments and costs for these DRGs in Appendix D, the seven DRGs that will be paid under the current per diem methodology have a gradual increase in costs as length of stay rises, consistent with the gradual increase in payments under our current per diem methodology. Therefore, we are not expanding the application of the alternative payment methodology beyond the three DRGs identified in the proposed rule.

Comment: MedPAC suggested we may wish to evaluate whether the alternative payment methodology for postacute transfers in DRGs 209, 210, and 211 should be expanded to our policy for transfers between two acute care hospitals.

Response: We have evaluated our transfer payment formula for our current transfer policy in the past and revised it to pay double the per diem amount for the first day of a transfer stay. Because the majority of cases that are transferred from one acute care hospital to another result in the case being assigned to a medical DRG, our analysis indicated that the current per diem payment (with a double payment on the first day) accurately reflects the costs of these cases, as it does for the seven DRGs paid under the per diem methodology under the postacute transfer provision. Although we do not plan further changes in the payment methodology for transfers to another acute care hospital, we will continue to evaluate the potential for further refinements in this policy, particularly in light of the changes introduced in this final rule.

Comment: One commenter requested clarification of how the indirect medical education (IME) and disproportionate share hospital (DSH) adjustments are treated under the transfer payment methodology. This commenter also requested clarification regarding the outlier payment calculation for transfer cases and recommended that the transfer payment rather than the DRG payment serve as the comparative basis for determining whether a transfer case qualifies as an outlier.

Commenters also indicated some confusion as to when full payment would be made under the transfer methodology in situations where the geometric mean length of stay for a DRG is not a whole number, for example, 9.8 days.

Response: The IME and DSH payments are determined in accordance with §§ 412.105(e) and 412.106(a)(2), respectively, by applying the IME and DSH adjustment factors calculated under those sections to the DRG revenue. In the case of a transfer occurring before the average length of stay, the applicable IME or DSH factor would be applied to the DRG revenue determined under the applicable transfer payment methodology.

With respect to outliers for transfer cases, the methodology suggested by the commenter is actually the methodology we use to determine outliers for these cases. In the September 1, 1995 **Federal Register**, we described how the cost outlier threshold is calculated for transfers (60 FR 45804). The outlier threshold for transfer cases reflects the fact that transfer cases receive a reduced payment amount. Specifically, the threshold for transfers paid under the current per diem methodology is equal to the fixed loss outlier threshold for all cases ($11,100 for FY 1999) divided by the geometric mean length of stay for the DRG, multiplied by the length of stay prior to transfer, plus one day. For postacute transfers in DRGs 209, 210, and 211, the outlier threshold is determined by dividing the fixed loss outlier threshold for all cases by the geometric mean length of stay for the DRG, multiplied by the sum of half the geometric mean and half the length of stay for the case, plus one. We note that we are making a conforming change in § 412.80(b), which describes outlier payments for transfers, to incorporate the revisions we are making in the transfer policy.

Finally, in the case of a DRG with a geometric mean length of stay of 9.8 days, full payment would be received on day 9. The following table illustrates this point, using DRGs 209 and 236 with geometric mean lengths of stay of 4.9 and 4.1 days, respectively.

DRG	209	236
Full DRG Payment Amount [1]	$8,400.32	$2,790.60
Per Diem Amount	2,048.86	680.63
Payment for Transfer on Day 1 [2]	6,249.02	1,361.26
Payment for Transfer on Day 2	7,273.45	2,041.89
Payment for Transfer on Day 3	8,297.88	2,722.52
Payment for Transfer on Day 4 [3]	8,400.32	2,790.60

[1] This amount is determined using the other areas national standardized amount from Table 1A in Section VI of the addendum to this final rule. The respective relative DRG weights are taken from Table 5. For DRG 209, the relative weight is 2.1803, and for DRG 236 it is 0.7243. It assumes a wage index of 1.0, and no IME or DSH payments. Any IME or DSH payments would be factored into the transfer amount as described above.

[2] For DRG 209, the payment amount is equal to one-half of the full DRG payment amount ($4,200.16) plus the per diem amount ($2,048.86). For DRG 236, the payment amount is equal to double the per diem amount.

[3] Total payment is limited to the full DRG amount (with the exception of outlier cases), rather the result of an additional per diem amount (or half the per diem).

Comment: A few commenters stated that because average lengths of stay vary by geographic region, the transfer policy punishes those regions with average lengths of stay less than the mean. They recommended that an adjustment factor be developed to recognize this disparity or that regional averages should be used to compute the per diem amount.

Response: We recognize that lengths of stay vary by region and are generally lower in the west, particularly compared to the northeast. In addition, regions with shorter lengths of stay tend to also have lower average costs due to the fewer number of days that patients spend in the hospital. One of the reasons for this variation is the greater reliance on postacute care earlier in the stay in those areas with lower average lengths of stay.

We do not believe it would be appropriate to base the transfer payment methodology on regional average lengths of stay. The national standardized amounts, which apply across all regions, reflect costs and lengths of stay across all regions. If a hospital in one region has a case with certain patient characteristics and a hospital in another region has a case with identical patient characteristics (including the same length of stay), we see no reason to have a rule under which one hospital would receive the full DRG payment but the other hospital would receive a transfer payment.

Comment: One commenter believed that, in lieu of expanding the transfer definition, it would make more sense to recalibrate the 10 DRGs to better reflect the recent reductions in lengths of stay and costs for these categories.

Response: All of the DRGs are recalibrated annually, using the latest available charge data for Medicare beneficiaries. Because of the recalibration process, a reduction in the relative weights of certain DRGs results in an increase in the weights of other DRGs. Therefore, there are no overall reductions in Medicare payments to hospitals. That is, although the hospital will receive a reduced payment through lower weights for the DRGs affected by the shift toward greater utilization of postacute care early in a stay, it will receive greater payment for the DRGs in which the weight is increased because there is no reduction in overall costs. In addition, any reduction in payment for the selected DRGs is shared by all hospitals including those that have not reduced their average length of stay and costs through the increased use of postacute care. We believe that any change in Medicare payment because of the early transfer of acute care patients to postacute care should be targeted at those hospitals that have actually incorporated this practice into their patient care.

Comment: Another commenter noted that, if these cases are to be treated as transfers for payment, they should be treated that way for recalibration as well.

Response: We agree. In the proposed rule, we did not revise the discussion of the recalibration process to specifically mention the postacute transfers, but we did treat these cases as transfers during the recalibration process that resulted in the DRG weights set forth in that rule. For purposes of the DRG recalibration, transfer cases, including the postacute transfer cases, are counted as a fraction of a discharge based on the length of stay, thereby reducing proportionately the contribution of the charges for the case toward the average charges for the DRG. This process effectively inflates the charges of a transfer case to what they would have been had the patient's length of stay been equal to the geometric mean length of stay. If we do not perform this calculation, these cases would receive reduced payment because they are transfers, but be treated as discharges in recalibration, lowering the relative weights for affected DRGs.

Comment: One commenter questioned whether the postacute care transfer provision will have any effect on the payments made by Medicare to the postacute providers.

Response: The only payment implication of this provision is to affect the prospective payment for the acute inpatient hospitalization. Medicare payment to any postacute providers involved in the stay are not affected by this policy.

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 payment adjustment and the criteria for geographic reclassification.

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

- Case-mix index is at least equal to the lower of the median case-mix index for urban hospitals in its census region, excluding hospitals with approved teaching programs, or the median case-mix index for all urban hospitals nationally; and

• Number of discharges is at least 5,000 discharges per year or, if fewer, the median number of discharges for urban hospitals in the census region in which the hospital is located. (The number of discharges criterion for an osteopathic hospital is at least 3,000 discharges per year.)

1. Case-Mix Index

Section 412.96(c)(1) provides that HCFA will establish updated national and regional case-mix index values in each year's annual notice of prospective payment rates for purposes of determining rural referral center status. The methodology we use to determine the proposed national and regional case-mix index values, is set forth in regulations at § 412.96(c)(1)(ii). The proposed national case-mix index value 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 1997 (October 1, 1996 through September 30, 1997) and include bills posted to HCFA's records through December 1997. Therefore, in addition to meeting other criteria, for hospitals with fewer than 275 beds, we proposed that to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 1998, a hospital's case-mix index value for FY 1997 would have to be at least—

• 1.3578; or

• Equal to 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 8, 1998 proposed rule at 63 FR 25593.)

Based on the latest data available (FY 1997 bills received through March 31, 1998), the final national case-mix value is 1.3590 and the median case-mix values by region are set forth in the table below:

Region	Case-mix index value
1. New England (CT, ME, MA, NH, RI, VT)	1.2490
2. Middle Atlantic (PA, NJ, NY)	1.2519
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.3474
4. East North Central (IL, IN, MI, OH, WI)	1.2711
5. East South Central (AL, KY, MS, TN)	1.3042
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.2325
7. West South Central (AR, LA, OK, TX)	1.3326
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.3726
9. Pacific (AK, CA, HI, OR, WA)	1.3427

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 1997 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. However, 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 1996 (that is, October 1, 1995 through September 30, 1996). That is the latest year for which we have complete discharge data available.

Therefore, in addition to meeting other criteria, we proposed that to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 1998, the number of discharges a hospital must have for its cost reporting period that began during FY 1997 would have to be at least—

• 5,000; or

• Equal to the median number of discharges for urban hospitals in the census region in which the hospital is located. (See the table set forth in the May 8, 1998 proposed rule at 63 FR 65594.)

Based on the latest discharge data available for FY 1996, the final median numbers of discharges for urban hospitals by census region areas are as follows:

Region	Number of discharges
1. New England (CT, ME, MA, NH, RI, VT)	6,672
2. Middle Atlantic (PA, NJ, NY)	8,676
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	7,753
4. East North Central (IL, IN, MI, OH, WI)	7,346
5. East South Central (AL, KY, MS, TN)	6,741
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	5,346
7. West South Central (AR, LA, OK, TX)	5,251
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	7,992
9. Pacific (AK, CA, HI, OR, WA)	5,993

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, to qualify for rural referral center status for cost reporting periods beginning on or after October 1, 1998, an osteopathic hospital's number of discharges for its cost reporting period that began during FY 1996 would have to be at least 3,000.

We received no comments on the rural referral center criteria.

C. Payments to Disproportionate Share Hospitals: Conforming Change Regarding Interpretation of Medicaid Patient Days Included in Disproportionate Patient Percentage (§ 412.106)

Effective for discharges beginning on or after May 1, 1986, hospitals that treat a disproportionately large number of low-income patients receive additional payments through the disproportionate share (DSH) adjustment. One means of determining a hospital's DSH payment adjustment for a cost reporting period requires calculation of its disproportionate patient percentage for the period. The disproportionate patient percentage is the sum of a prescribed Medicare fraction and a Medicaid fraction for the hospital's fiscal period. Under clause (I) of section 1886(d)(5)(F)(vi) of the Act and § 412.106(b)(2), the Medicare fraction is determined by dividing the number of the hospital's patient days for patients who were entitled (for such days) to benefits under both Medicare Part A and Supplemental Security Income (SSI) under Title XVI of the Act, by the total number of the hospital's patient days for the patients who were entitled to Medicare Part A. The Medicaid fraction is determined, in accordance with clause (II) of section 1886(d)(5)(F)(vi) of

the Act and § 412.106(b)(4), by dividing the number of the hospital's patient days for patients who (for such days) were eligible for medical assistance under a State Medicaid plan approved under Title XIX of the Act but who were not entitled to Medicare Part A, by the total number of the hospital's patient days for that period.

Initially, HCFA calculated the Medicaid fraction by interpreting section 1886(d)(5)(F)(vi)(II) of the Act to recognize as Medicaid patient days only those days for which the hospital received Medicaid payment for inpatient hospital services. *See* 51 Fed. Reg. 31454, 31460 (1986). The agency's interpretation was declared invalid by four Federal circuit courts of appeals. *See Cabell Huntington Hosp., Inc.* v. *Shalala*, 101 F.3d 984, 990–91 (4th Cir. 1996) (following three other circuits). These courts held that the statute requires, for purposes of calculating the Medicaid fraction, inclusion of each patient day of service for which a patient was eligible on that day for medical assistance under an approved State Medicaid plan. Specifically, the statute requires inclusion of each hospital patient day for a patient eligible for Medicaid on such day, regardless of whether particular items or services were covered or paid under the State Medicaid plan.

On February 27, 1997, the HCFA Administrator issued HCFA Ruling 97–2, which acquiesced in the four adverse appellate court decisions. The Ruling changed the agency's statutory construction to comport with those decisions, in order to facilitate nationwide uniformity in the calculation of the Medicaid fraction. Like the court decisions, the Ruling provides that a hospital's Medicaid patient days include each patient day of service for which a patient was eligible on such day for medical assistance under an approved State Medicaid plan, regardless of whether particular items or services were covered or paid under the State plan. The Ruling also reflects the hospital's burden of furnishing data adequate to prove each claimed Medicaid patient day, and of verifying with the State that a patient was eligible for Medicaid during each day of the inpatient hospital stay.

The Ruling further provides that the agency's new interpretation is effective February 27, 1997 for each cost reporting period that: (1) Begins on or after that effective date; (2) was not settled, as of that date, on the Medicaid patient days issue, by means of an applicable notice of program reimbursement (NPR) (see § 405.1803); or (3) was settled through such an NPR as of the Ruling's effective date and is the subject of a pending administrative appeal or civil action that satisfies all applicable jurisdictional requirements of the Medicare statute and regulations. The Ruling also provides, however, that the change in statutory interpretation effected by the Ruling is not a basis for reopening a hospital cost reporting period (*see* §§ 405.1885-405.1889) that was finalized previously on the same matter at issue.

We proposed to revise § 412.106(b)(4) in order to conform the Medicare regulations to the new statutory construction issued in HCFA Ruling 97–2. These revisions are necessary to ensure that the regulations comport with the four appellate court decisions that declared invalid the agency's prior interpretation and led to the issuance of the HCFA Ruling. The proposed revisions would further facilitate nationwide uniformity in the calculation of the Medicaid fraction.

Since the proposed revisions were intended simply to conform the regulations to HCFA Ruling 97–2 (and hence to the four adverse court decisions), revised § 412.106(b)(4) would reiterate the Ruling's change of interpretation that the Medicaid fraction under section 1886(d)(5)(F)(vi)(II) of the Act includes each hospital patient day for a patient eligible for Medicaid on such day, regardless of whether particular items or services were covered or paid under the State Medicaid Plan. Our proposed revisions to § 412.106(b)(4), like the Ruling, would continue to place on the hospital the burdens of production, proof, and verification as to each claimed Medicaid patient day.

Under our proposal, revised § 412.106(b)(4) would apply to cost reporting periods beginning on or after October 1, 1998. HCFA Ruling 97–2, which includes the same provisions as proposed § 412.106(b)(4), would continue to apply to any cost reporting period beginning before October 1, 1998 provided that, as of February 27, 1997, there is for such period: no submitted cost report; no cost report settled on the Medicaid patient days issue through an applicable NPR; or a cost report settled on that issue, which is also the subject of a jurisdictionally proper administrative appeal or civil action on the issue.

We received no comments in response to this proposal. Therefore, we are incorporating the proposed conforming change in this final rule.

D. Payment for Bad Debts (§ 413.80)

Section 4451 of the Balanced Budget Act of 1997 reduces the payment for enrollee bad debt for hospitals. Specifically, this provision reduces the amount of bad debts otherwise treated as allowable costs, attributable to the deductibles and coinsurance amounts under this title, by 25 percent for cost reporting periods beginning during fiscal year 1998, by 40 percent for cost reporting periods beginning during fiscal year 1999, and by 45 percent for cost reporting periods beginning during a subsequent fiscal year. We proposed to conform the regulations to the statute.

Section 4451 of the Balanced Budget Act of 1997 also provides that in determining such reasonable costs for hospitals, any copayments reduced under the election available for hospital outpatient services under section 1833(t)(5)(B) of the Act will not be treated as a bad debt. This provision will be implemented in the outpatient prospective payment system regulation that implements sections 4521, 4522, and 4523 of the Balanced Budget Act of 1997, to be published later this year.

We received one comment regarding the reduction in Medicare bad debt reimbursement which is discussed below.

Comment: One commenter requested that the regulations and/or cost report forms (HCFA 2552–96) be modified to clarify that hospital-based skilled nursing facility bad debts will continue to be 100 percent reimbursable since freestanding skilled nursing facilities are not subject to the reduction in reimbursement and skilled nursing facilities are not mentioned in the law at section 1861(v)(1)(T). The commenter believed that in the BBA committee reports describing changes in reimbursement for Medicare bad debts, it seemed clear the changes were to apply to all providers, yet the law clearly stated that hospitals are the sole provider type subject to reductions in reimbursement. The commenter also noted that in reviewing the new hospital cost report forms, HCFA 2552–96, the commenter believed that the forms would apply the reduction in reimbursement to hospital-based skilled nursing facilities.

Response: The HCFA 2552–96 hospital cost report forms do not apply the reduction in bad debt reimbursement to hospital-based skilled nursing facilities. Page 36–159, Line 26 and Page 36–164, Line 40 require entering the reduction for ''hospitals only''. Section 4451 of the BBA, and these implementing regulations, apply only to hospitals and any subprovider units settled through the hospital cost report, whether or not they have a separate provider number. Included in this are rehabilitation units, psychiatric

units, and childrens' hospitals, which are considered hospital providers. Cost reports for skilled nursing facilities, home health agencies, outpatient therapy, comprehensive outpatient rehabilitation facilities, community mental health centers, federally qualified health centers, and rural health clinics (after January 1, 1998) are separately settled and bad debts for these providers are not reduced. The bad debt reduction does not apply to ambulatory surgical centers because they are paid on another basis (fee schedule). End stage renal disease bad debts are computed separately and are not reduced.

E. Payment for Direct Costs of Graduate Medical Education to Hospitals and Qualified Nonhospital Providers (§§ 405.2468, 413.85, and 413.86)

1. Statutory Background

Since its inception in 1965, Medicare has provided payment only to hospitals for the costs of graduate medical education (GME) training. The BBA allows for direct GME payment to qualified nonhospital providers to encourage training of future physicians in nonhospital settings.

Under section 1886(k) of the Act, as added by section 4625 of the BBA, the Secretary is now authorized, but not required, to pay qualified nonhospital providers for the direct costs of GME training. The Conference Report also notes that the Conferees believe this authority may help alleviate physician shortages in underserved rural areas. We believe that providing Medicare payment directly to qualified nonhospital providers may facilitate more training and better quality training in nonhospital sites.

Section 1886(k) of the Act states: ''For cost reporting periods beginning on or after October 1, 1997, the Secretary may establish rules for payment to qualified nonhospital providers for their direct costs of medical education, if those costs are incurred in the operation of an approved medical residency training programs described in subsection (h).'' The statute further provides that, to the extent the Secretary exercises this broad discretionary authority, the rules ''shall specify the amounts, form, and manner in which such payments will be made and the portion of such payments that will be made from each of the trust funds under this title.''

a. Payments only to ''qualified nonhospital providers''. The statute confers broad discretion on the Secretary regarding whether and how to pay qualified nonhospital providers for direct GME costs. However, the statute does specify the *entities* whom the Secretary can pay—''qualified nonhospital providers.'' Section 1886(k)(2) of the Act defines ''qualified nonhospital providers'' to include: Federally Qualified Health Centers (FQHCs), as defined in section 1861(aa)(4); Rural Health Centers (RHCs), as defined in section 1861(aa)(2); Medicare+Choice organizations; and such other providers (other than hospitals) as the Secretary determines to be appropriate.

b. Payments only for the ''direct costs'' of training. The statute also specifies *the costs* the Secretary can pay for under section 1886(k) of the Act. Medicare pays hospitals for both the direct and indirect costs of medical education under sections 1886(h) and 1886(d)(5)(B) of the Act respectively, but section 1886(k) of the Act provides for payment to qualified nonhospital providers only for the direct costs of medical education. In addition, section 1886(k) of the Act provides for payment for the direct costs of training medical residents only if those costs are incurred in the operation of an ''approved medical residency training program.'' Accordingly, the statute authorizes Medicare payments to qualified nonhospital providers only for the costs of training medical residents, not for the costs of training other health professionals.

In addition to adding section 1886(k) of the Act, section 4625 of the BBA amends section 1886(h)(3)(B) of the Act to prohibit double payments for direct GME to a hospital and a qualified nonhospital provider. This prohibition on double payments requires that the Secretary reduce a hospital's GME payments (the ''aggregate approved amount'' as defined in section 1886(h)(3)(b) of the Act) to the extent we pay a qualified nonhospital provider for GME under section 1886(k) of the Act.

2. Payment to Hospitals for GME

Under sections 1886(d)(5)(B)(iv) and 1886(h)(4)(E) of the Act, a hospital may include the time a resident spends in nonprovider settings in its indirect medical education (IME) and direct GME full-time equivalent count if it incurs ''all or substantially all'' of the costs of training residents in the nonhospital site. Under §§ 412.105(f) and 413.86(f)(1)(iii), a hospital may count resident training time in nonhospital sites for indirect and direct GME respectively if the resident is involved in patient care and there is a written agreement between the hospital and the nonhospital site that states that the resident's compensation for training time spent outside the hospital setting is to be paid by the hospital.

3. Proposed Policies

Pursuant to section 4625 of the BBA, we proposed to provide Medicare payment to qualified nonhospital providers for the direct costs of GME training, effective for portions of cost reporting periods occurring on or after January 1, 1999. We proposed Medicare would make GME payments to the following ''qualified nonhospital providers''—FQHCs, RHCs, and Medicare+Choice organizations. Under the authority of section 1886(k)(2)(D) of the Act, the Secretary may expand the definition of a ''qualified nonhospital provider'' to include such other providers (other than hospitals) as the Secretary determines to be appropriate. Once we have gained experience providing direct GME payments to FQHCs, RHCs, and Medicare+Choice organizations, we may consider including other types of nonhospital providers in the definition of a ''qualified nonhospital provider.''

Additionally, we proposed that, under certain circumstances, a hospital may continue to receive GME payments for residents who train in the nonhospital setting. In those instances where a hospital is eligible to continue receiving GME payments for residents who train in the nonhospital setting, the nonhospital site could receive payment from the hospital for costs they incur in training medical residents. Thus, our proposed policy would promote the intent of section 4625 of the BBA to provide financial support, either directly from Medicare or through the hospital, to qualified nonhospital providers for the direct costs of training residents in the nonhospital site.

a. ''All or substantially all'' of the costs of training. Similar to our current policy of paying hospitals for training in nonhospital sites, we proposed that a qualified nonhospital provider may receive payment for the direct costs of GME if it incurs ''all or substantially all'' of the training costs. Although we proposed to pay the qualified nonhospital provider only when it incurred ''all or substantially all'' of the costs of training, we solicited comment on possible methods for allocating the GME payments for training in the nonhospital site where neither the hospital nor the qualified nonhospital provider is incurring ''all or substantially all'' of the costs of the training program. Under the proposed system, we would pay either the hospital or the qualified nonhospital provider for the cost of training in the nonhospital site, depending on which

entity incurs ''all or substantially all'' of the costs of training in the nonhospital site. We proposed to revise the definition of ''all or substantially all'' of the costs, which currently applies only to hospitals. Under the proposed redefinition, a hospital or qualified nonhospital provider would incur ''all or substantially all'' of the costs for the training program in the nonhospital setting if it pays for, at a minimum: that portion of the costs of the teaching physicians' salaries and fringe benefits that are related to the time spent in teaching and supervision of residents; and residents' salaries and fringe benefits (including travel and lodging expenses where applicable).

b. Definition of ''direct costs'' of medical education for qualified nonhospital providers. Section 4625 of the BBA provides for payment to qualified nonhospital providers only for the direct costs of training residents. Our proposed definition of ''direct costs'' for qualified nonhospital providers is comparable to the direct costs for hospitals under section 1886(h) of the Act. Under our proposed policy, direct GME costs include costs incurred by the nonhospital site for the education and training of medical residents in approved programs. We proposed to include the following costs in the definition of direct costs:

- residents' salaries and fringe benefits (including related travel and lodging expenses where applicable);
- that portion of costs of the teaching physicians' salaries and fringe benefits that are related to the time spent in teaching and supervision of residents; and
- other related GME overhead costs.

Consistent with our policies on direct GME costs for hospitals, we proposed direct GME costs for qualified nonhospital providers will not include normal operating costs or the marginal increase in costs that the nonhospital site experiences as a result of having an approved medical residency training program. For example, a decrease in productivity and increased intensity in treatment patterns as the result of a training program do not constitute ''direct costs'' of training residents in the nonhospital setting; rather, these are the ''indirect costs'' of such training.

Also consistent with our policies for direct GME payments to hospitals, we proposed to pay qualified nonhospital providers only for training that is related to the delivery of patient care services.

We also proposed that direct GME costs for qualified nonhospital providers, like direct GME costs for hospitals, would include only that portion of costs of the teaching physicians' salaries and fringe benefits associated with time spent in teaching and supervising residents. Specifically, a physician's time spent on teaching of a general nature would constitute a direct GME cost while activities spent in direct patient care which involve residents do not constitute direct costs. In addition, we proposed that direct costs in the qualified nonhospital provider would include that portion of teaching physicians' salaries and fringe benefits associated with time spent developing resident schedules and evaluating or rating the residents. Direct costs may also include the portion of a teaching physician's office costs allocated to GME.

We stated that direct GME costs for qualified nonhospital providers would not include the following: a teaching physician's time spent in the care of individual patients which results in billable services; teaching physicians' activities that are related to the education of other health professionals (i.e., classroom instruction in connection with approved activities other than GME such as provider-operated nursing programs); teaching physicians' time spent on administrative and supervisory services to the qualified nonhospital provider that are unrelated to approved educational activities (i.e. operating costs); and teaching physician activities that involve nonallowable costs such as research and medical school activities that are not related to patient care in the nonhospital setting. Costs associated with the providing teaching services to undergraduate medical students are also not include in direct graduate medical education costs.

GME overhead costs include only those costs that are allocable to direct GME and that are not used in patient care. For example, a portion of administrative and general costs could be appropriately allocated to an RHC's or FQHC's GME cost center. Similarly, a conference room that is dedicated specifically for the training of residents could be appropriately allocated to an RHC or FQHC's GME cost center. By contrast, patient care rooms added to an RHC or an FQHC cannot be appropriately allocated to an RHC's or FQHC's GME cost center.

One of the advantages of the proposed definition of ''direct costs'' is that it is administratively feasible. Our definition of ''direct costs'' for qualified nonhospital providers is comparable to the direct costs that are included in the per resident amount paid to hospitals under section 1886(h) of the Act. At present, there is limited information regarding the actual costs of training residents in nonhospital sites. After we gain experience providing direct GME payments to qualified nonhospital providers and have reviewed the GME costs separately reported by these qualified nonhospital providers, we may revise the definition of ''direct costs.'' We solicited comments on other elements that may constitute direct costs of GME in the qualified nonhospital provider that can be identified, reported, and verified as directly attributable to GME activities through the cost reporting process. We were interested in comments on whether we should include other costs in the definition of ''direct costs'' for qualified nonhospital providers and on the administrative feasibility of identifying the GME portion of those costs.

c. Determining direct costs. One of our major concerns in developing policies for paying qualified nonhospital providers for the direct costs of GME is the administrative feasibility of determining the amount of direct costs incurred by the qualified nonhospital provider. It is our understanding that, currently, hospitals and nonhospital sites often share, to varying degrees, the costs of training residents in the nonhospital site. Because of the difficulty in apportioning costs between the hospital and the nonhospital for the training in the nonhospital site, we believe that it is not administratively feasible to pay both the hospital and the nonhospital site for the cost of training in the nonhospital site. We have been unable to devise a method for accurately apportioning costs between the two entities.

Furthermore, the potential for both the hospital and the qualified nonhospital provider to be paid for the same direct GME expenses poses a significant problem for complying with section 1886(h)(3)(B) of the Act, as amended by the BBA, which specifically prohibits double payments. Under this provision, the Secretary shall reduce the hospital's GME payment (the ''aggregate approved amount'') to the extent we pay the qualified nonhospital provider for GME costs under section 1886(k) of the Act. Consequently, our policy must ensure that Medicare does not pay two entities for the same training time in the nonhospital site.

Given that the hospital's per resident amount can include, but is not necessarily based on the costs of training in the nonhospital site, we were not able to devise an equitable way of reducing the hospital's per resident payment to reflect payments made

under section 1886(k) of the Act. It may not be equitable to subtract the exact amount of payment made to the qualified nonhospital provider from the hospital's per resident payment because the payment made to the nonhospital site may be unrelated to the hospital's per resident amount. We believe that the residents' salaries, teaching physicians' salaries, and overhead costs for the nonhospital setting will constitute a different proportion of the total GME costs in the nonhospital setting as compared with the hospital setting. Rather, it may be more equitable to determine the proportion of costs incurred by each entity and reduce the hospital's per resident payment by the proportion of GME costs incurred by the nonhospital site; however, since specific components of the per resident amount were not identified in the hospital's GME base year (1984), we cannot accurately determine the appropriate amount to reduce the current year hospital per resident payment amount. Moreover, to reduce the hospital's GME payments based solely on the amount paid to the qualified nonhospital provider could result in inequitable payments to the hospital, which has ongoing costs even when the resident is training in the nonhospital site. In fact, it could leave the hospital at risk of receiving no payment for the GME costs it has incurred.

In order to encourage training in nonhospital sites, it is important to develop a policy that, while providing payment to qualified nonhospital providers, would also be equitable to hospitals. We believe that paying only the qualified nonhospital provider for the training costs could result in hospitals choosing not to rotate their residents to the nonhospital site. We have been unable to devise an equitable and accurate method for dividing the GME payment for training in the nonhospital site if neither the hospital, nor the nonhospital site incurs ''all or substantially all'' of the costs. As such, we solicited comment on possible methods for allocating the GME payments for training in the nonhospital site where neither the hospital nor the qualified nonhospital provider agrees who is incurring ''all or substantially all'' of the costs for the training program. We believe that the policies discussed below are equitable to both hospital and qualified nonhospital providers and will achieve Congress' objective of encouraging and supporting training in the nonhospital setting.

Given our concerns about administrative feasibility, the statutory prohibition on double payments, and developing policies that are equitable to hospitals as well as qualified nonhospital providers, we believe the only feasible way to pay for training in nonhospital settings is to pay *either* the hospital or the nonhospital provider. Currently, hospitals may receive payment for the time residents spend in the nonhospital setting if the hospital incurs ''all or substantially all'' of the training costs. We proposed to adopt a similar policy for qualified nonhospital providers; that is, a qualified nonhospital provider may receive payment for the direct costs of GME if it incurs ''all or substantially all'' of the training costs.

d. Payment to FQHC's and RHC's. We proposed to pay FQHC's or RHC's for direct GME costs based on reasonable costs if the FQHC or RHC incurs ''all or substantially all'' of the costs of training the resident in the nonhospital setting. The FQHC or RHC would have to report direct GME costs in a reimbursable cost center on its cost report under the proposal. Conversely, where an FQHC or RHC did not incur ''all or substantially all'' of the costs of training residents in the nonhospital site, the FQHC or RHC would report direct GME costs in a nonreimbursable cost center on the cost report.

We proposed that the FQHC's and RHC's allowable direct GME costs be subject to reasonable cost principles in 42 CFR part 413 and other relevant provisions referenced in part 413. In addition, the FQHC's and RHC's direct GME costs would be subject to the Reasonable Compensation Equivalency limits under §§ 415.60 and 415.70.

Also, Medicare would pay only for its share of the direct costs of training in the qualified nonhospital provider. We proposed that the FQHC's and RHC's Medicare share equal the qualified nonhospital provider's ratio of Medicare visits to total visits. Thus, the amount of Medicare payment would equal the product of the clinic's Medicare allowed reasonable direct GME costs and the clinic's ratio of Medicare visits to total visits.

For FQHC's and RHC's that incur ''all or substantially all'' of the costs for the training program in the nonhospital setting, we proposed that the direct GME costs would not be subject to the existing per visit payment caps for reimbursement under sections 505.1 and 505.2 of the Medicare Rural Health Clinic and Federally Qualified Health Centers Manual. We also proposed that, where payment is available under section 1886(k) of the Act for residents working in either an FQHC or an RHC, the FQHC's and RHC's do not need to include residents as health care staff in the calculation of productivity standards under section 503 of the Manual.

e. Payment to Medicare+Choice organizations. We proposed making direct GME payment to Medicare+Choice organizations which incur ''all or substantially all'' of the costs of training in a nonhospital site. The Medicare+Choice organization would be eligible to receive payment on a reasonable costs basis for residents' salaries and fringe benefits only for the time that the resident spends in the nonhospital setting. In addition, we proposed that the Medicare+Choice organization's allowed costs include only that portion of the teaching physician salaries and fringe benefits that is related to training in the nonhospital setting. We proposed limiting payment to Medicare+Choice organizations to residents' salaries and fringe benefits and supervisory teaching physician compensation which can be allocated to direct GME. We did not propose to pay Medicare+Choice organizations for the costs of overhead that may be associated with a GME program. We solicited suggestions for creating a methodology for allocating and reporting overhead costs for Medicare+Choice organizations and suggestions for mechanisms for the audit and review of the costs for Medicare+Choice organizations.

Similar to our proposed policy for paying FQHCs and RHCs for direct costs of GME, we proposed that the Medicare+Choice organization's reimbursement for residents' salaries and fringe benefits (including related travel and lodging expenses where applicable) would be subject to the reasonable cost principles in 42 CFR part 413 and any other relevant provisions referenced in part 413. In addition, we proposed the Medicare+Choice organization's GME reimbursement would also be subject to the Reasonable Compensation Equivalency limits under §§ 415.60 and 415.70.

We proposed to allow the Medicare+Choice organization to receive direct GME payment only for the direct costs of training in the nonhospital site that are associated with the delivery of patient care services. In determining the amount of direct GME payments to Medicare+Choice organizations, we proposed adjusting for Medicare's share of those education costs. Medicare's share would equal the ratio of the total number of Medicare enrollees in the Medicare+Choice organization to total enrollees in the Medicare+Choice organization.

We proposed that, in order to receive the direct GME payment, the

Medicare+Choice organization must produce a contractual agreement between itself and the nonhospital sites. Medicare+Choice organizations may contract with any nonhospital patient care site, including freestanding clinics, nursing homes, and physicians' offices in connection with approved programs. The contract between the Medicare+Choice organization and the nonhospital site must indicate that, for the time that residents spend in the nonhospital site, the Medicare+Choice organization agrees to pay for the cost of residents' salaries and fringe benefits. In addition, the contract must indicate that the Medicare+Choice organization agrees to pay the portion of the costs of teaching physicians' salaries and fringe benefits that is related to the time spent in teaching and supervision of residents and is unrelated to the volume of services provided by the physician. The contract must stipulate the portion of each teaching physician's time that will be spent training residents in the nonhospital setting. Moreover, the contract must indicate that the Medicare+Choice organization agrees to identify an amount for the cost of the teaching physician's salary based on the time that the resident spends in the nonhospital setting, not based upon a capitated rate for the delivery of physician services.

f. Payment to hospitals. A hospital may include a resident's training time in a nonhospital setting in its FTE counts for direct GME and for IME if the hospital incurs ''all or substantially all'' of the costs for training in the nonhospital setting. We proposed that, in order for a hospital to include residents' training time in a nonhospital setting, the hospital and the nonhospital site must have a written contract which indicates the hospital is assuming financial responsibility for, at a minimum, the cost of residents' salaries and fringe benefits (including travel and lodging expenses where applicable) and the costs for that portion of teaching physicians' salaries and fringe benefits related to the time spent in teaching and supervision of residents.

The contract must indicate that the hospital is assuming financial responsibility for these costs directly or that the hospital agrees to reimburse the nonhospital site for such costs. The contract must also contain an acknowledgment on the part of the qualified nonhospital provider if the nonhospital site is an FQHC or RHC that, since the residents' time is being counted by the hospital, the nonhospital site must report GME costs on the Medicare cost report in a nonreimbursable GME costs center. In addition, in order to determine teaching physician compensation that may be allocated to direct GME, the FQHC and RHC will have to specify the portion of the teaching physicians' time that will be spent training residents in the nonhospital setting. Under § 413.86(f)(1)(iii), hospitals may contract with any nonhospital patient care site such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs. Payment to the hospital for the direct costs of GME training in the nonhospital setting will continue to reflect Medicare's share, which equals the hospital's ratio of Medicare inpatient days to total inpatient days.

5. Trust Funds

Under section 1886(k)(1) of the Act, the rules established by the Secretary for paying qualified nonhospital providers for GME must specify the portion of Medicare payments that will be made from each of the Medicare trust funds. We proposed that GME payments made directly to an FQHC, RHC, or Medicare+Choice organization would be made from the Federal Supplementary Medical Insurance Trust Fund.

6. Proposed Effective Dates

We proposed that the effective date of these provisions for FQHCs, RHCs, Medicare+Choice organizations, and hospitals would be January 1, 1999. Of the provisions affecting hospitals, the policies for IME payments would apply to discharges occurring on or after January 1, 1999. The policies concerning medical education payments to FQHCs, RHCs, and hospitals would apply to portions of cost reporting periods occurring on or after January 1, 1999. We proposed that Medicare+Choice organizations could begin receiving payments for direct GME costs incurred on or after January 1, 1999.

7. Responses to Comments Received on Proposed Policies and Final Rule Provisions

Below we are summarize the comments we received on the proposed policies and provide our responses to those comments.

a. Definition of qualified nonhospital provider. Comment: One commenter stated that HCFA should expand the definition of a qualified nonhospital provider to include preventive medicine residencies. This commenter quoted the Conference Report statement:

> The Conferees also note that preventive medicine residency training occurs most often in nonhospital settings and the Conferees encourage the Secretary to examine carefully the opportunities to provide support to such training programs.

The commenter further noted that a small number of residency programs would benefit if we adopted the suggestion.

Response: Consistent with the direction of the Conference Report, we have examined how to encourage preventive medicine training through the Medicare program. We understand that preventive medicine training consists of one year of clinical training, one year of academic study, and a practicum year. To the extent that the one year of clinical training is provided in patient care sites that qualify to receive medical education payments, Medicare provides payment for training much in the same way we provide payment for all other specialty programs. A hospital can count a preventive medicine resident who receives training in all areas of the hospital complex. The hospital may also count a preventive medicine resident who receives training in a nonhospital site if the resident is involved in direct patient care and there is a written agreement between the hospital and the nonhospital site that the hospital is incurring ''all or substantially all'' of the costs of training the resident in the nonhospital site. FQHCs, RHCs, and Medicare+Choice organizations can receive payment on a reasonable cost basis for costs associated with training preventive medicine residents if the entity incurs ''all or substantially all'' of the costs.

Since the year of academic study does not involve direct patient care, a hospital or qualified nonhospital provider cannot receive Medicare payment for that year of preventive medicine training. A fundamental principle of Medicare payment for education is that the residents must participate in patient care services to patients at the health care site. Although we believe that preventive medicine residents are engaging in activities that will benefit all patients, not just Medicare patients in general, the year of academic study does not constitute patient care services which would qualify for Medicare payment for GME.

We understand the clinical training that preventive medicine residents receive may also occur in patient care sites that do not receive payments from Medicare, such as public health clinics. Even if the clinics were included under the definition of qualified nonhospital provider, Medicare payment to clinics for GME would likely still be very low because it would reflect the share of services provided by the clinic to

Medicare beneficiaries as compared to all services it provides. We do not believe that Medicare beneficiaries make significant use of public health clinics for Medicare covered services since these services are also available through their regular doctor. If we were to provide payments to public health clinics associated with the training of preventive medicine residents, we would also have to resolve technical problems related to providing payments to entities that have never had a relationship with Medicare. As we stated above, where a hospital or qualified nonhospital provider incurs ''all or substantially all'' of the costs of the clinical training in that nonhospital site, Medicare will make payments for GME costs associated with training preventive medicine residents.

Comment: One commenter urged HCFA to consider including nonhospital dental clinics in the definition of qualified nonhospital providers. One commenter urged us to expand the definition of a qualified nonhospital provider to make payment of both direct and indirect GME directly to nursing homes and hospices. One commenter requested clarification as to whether our definition of a qualified nonhospital provider includes community mental health centers. If not, the commenter requested that we consider including community mental health centers in the definition of qualified nonhospital provider.

Response: As we stated in the proposed rule, we believe that it is appropriate to have more experience with providing payments to the qualified nonhospital providers listed in the statute before we expand the definition to include other sites such as those stated by these commenters. We note that even if nonhospital dental clinics were included in the definition of a qualified nonhospital provider, a dental clinic's low Medicare share means the benefit of the provision would be small. Dental clinics are likely to have a low Medicare share because Medicare covers few dental services.

Currently, our definition of qualified nonhospital provider does not include community mental health centers per se, but it may be possible for a community mental health center to meet the criteria for being designated as a rural health clinic under section 1861(aa)(2) of the Act and section 405.2402.

We would note that a hospital or Medicare+Choice organization may receive payment associated with resident rotations through the nonhospital sites suggested by these commenters if the hospital or Medicare+Choice organization incurs ''all or substantially all'' of the costs at the clinic. In this way the clinic will be paid by the hospital for GME costs.

Comment: One commenter argued that Congress specified that a qualified nonhospital provider includes FQHC's, RHC's, and managed care plans to ensure that these organizations were included but that Congress did not intend to limit qualified nonhospital providers to these organizations. The commenter believed that excluding other nonhospital sites from the definition of a qualified nonhospital provider is contrary to Congress' intent.

Response: As we have stated, we will consider other nonhospital sites in the definition of qualified nonhospital providers once we have experience with these policies. We disagree that the proposal to limit the definition of a qualified nonhospital provider at this time to the entities listed in the statute is inconsistent with Congressional intent. The statute defines qualified nonhospital provider to include ''such other providers (other than hospitals) as the Secretary determines to be appropriate.'' Thus, the statute authorizes but does not require the inclusion of other entities.

Comment: One commenter stated that educational consortia are becoming important models for community-based graduate medical and nursing training and suggested that we expand the definition of qualified nonhospital provider to include consortia.

Response: We are interested in learning more about the development of GME programs through educational consortia. Section 4628 of the BBA requires the Secretary to establish a demonstration project under which GME payments will be made to consortia. We will consider changes to our GME payment policies based on our evaluation of any future demonstration projects.

Comment: One commenter urged us to expand the definition of a qualified nonhospital provider to include Osteopathic Postdoctoral Training Institutions (OPTIs), community based health care consortia consisting of one or more colleges accredited by the American Osteopathic Association (AOA), one or more AOA accredited hospitals, and other health care facilities such as nursing homes, ambulatory clinics, community health centers, and managed care organizations. The commenter suggested that payments be made directly to the OPTI based on the number of residents participating in OPTI hospitals or a national average payment. The commenter stated that the OPTI would distribute the payments among the consortia members.

Response: An OPTI includes hospital and nonhospital sites as well as educational institutions and we believe an OPTI is a consortium. As we stated above, we will be studying GME payments to consortia in a demonstration project required by section 4628 of BBA.

b. Definition of direct costs.

Comment: One commenter suggested that direct costs of training in nonhospital sites should include mileage associated with travel between multiple clinic sites. The commenter also stated that direct costs should include the costs of telemedicine, including telephone, fax, videoconference, and the internet because these electronic communication mechanisms enable primary care residents in nonhospital sites to be trained for practice outside of the resource-rich, multispecialty hospital setting.

Response: We agree that travel costs may be an element of direct costs when residents work in multiple nonhospital sites or when residents travel from a hospital training site to remote clinics. We disagree that the cost associated with telecommunication services should be allowable as training costs. Although telecommunication services may be integral to providing services to patients while residents are training in nonhospital sites, these services are not principally designed to be used as GME training tools. Rather, the telecommunication services to which the commenter is referring, like the use of a stethoscope or an examining room, are compensated as operating costs through Medicare's payments for patient care services.

Comment: Several commenters stated that the effect of training on indirect costs is similar in nonhospital clinics and hospitals. One commenter suggested that indirect costs are easily identifiable and should be separately reimbursable in nonhospital settings.

Response: The statute states that the ''Secretary may establish rules for payment to qualified nonhospital providers for the *direct* costs of medical education if those costs are incurred in operation of an approved medical residency training program described in subsection (h).'' The statute clearly limits payment to qualified nonhospital providers under section 1886(k) of the Act for the direct costs of GME.

Comment: One commenter stated that the proposed regulations fail to reflect that FQHCs are eligible for Part B payments for allowable teaching costs even without the new methodology

established pursuant to the new BBA provision. Because FQHCs are governed by cost reimbursement principles that include teaching costs, FQHCs are already allowed to claim all training-related costs, including direct faculty and resident costs. This commenter suggested that FQHCs that participate in teaching programs should be able to recapture higher operating costs caused by lower productivity and increased overhead. According to this commenter, we should consider including the following in direct costs:

—Slowdown in productivity;
—Facilities and space for training;
—Transportation and living costs for residents;
—Availability of lab and radiology equipment and services;
—Administrative overhead;
—Increased intensity in treatment patterns used in training;
—Equipment costs;
—Library (either onsite or electronic access);
—Capital costs for startup of residency program;
—Increased complexity at teaching FQHCs; and
—Increased social complexity of patient case mix.

Response: The costs of resident salaries and fringe benefits and supervising physicians may be allowable costs under § 405.2470. If the RHC or FQHC were to have a written agreement with a hospital where the hospital provides compensation for these costs to the clinic, these costs would become nonreimbursable costs. However, FQHCs and RHCs that have an all-inclusive rate that exceeds the cap under sections 505.1 and 505.2 of the Medicare Rural Health Clinic and Federally Qualified Health Centers Manual would still benefit from the proposed policy in that costs above the cap that would otherwise be nonreimbursable by Medicare can now be compensated as direct GME costs through the agreement with the hospital. That is, if the FQHC or RHC incurs ''all or substantially all'' of the costs and receives payment directly from Medicare, these costs are GME costs that are treated separately in applying the caps on the all-inclusive rate under sections 505.1 and 505.2 of the Medicare Rural Health Clinic and Federally Qualified Health Centers Manual.

An additional benefit in the situation where we pay the FQHC or RHC directly for GME is that residents do not need to be included as health care staff in the calculation of productivity standards under section 503 of the Manual. We further believe that residents should be excluded from productivity standards in situations where the hospital is being paid for training time and GME costs are not reimbursable costs for the FQHC or RHC. We are adopting this policy in this final rule and will modify section 503 of the Manual accordingly. Among the items listed in this comment, we believe that costs which are directly related to the operation of a medical residency training program (facilities and space exclusively dedicated to training, resident travel costs between remote clinic sites) in addition to facility overhead which can be allocated to a medical education cost center constitute allowable direct GME costs for which the FQHC or RHC can receive payment directly from Medicare. We believe the remaining items listed are either indirect costs of training or allowable cost for patient care services under § 405.2468(a) through (e) which can only be reimbursed as non-GME operating costs.

Comment: One commenter was opposed to the application of reasonable compensation equivalents to physicians in FQHCs and RHCs. The commenter stated that the BBA required HCFA to subject RHCs to productivity standards and the per-visit cost limit. According to the commenter, if Congress had intended for the RCE limits to be imposed on RHCs, the BBA would have required such a policy. The commenter stated that, by definition, RHCs and FQHCs are located in areas where it is difficult to attract physicians and that the providers must pay compensation that exceeds the RCE limits to attract qualified physicians. The commenter requested that the limits not be imposed on FQHC and RHC services to individual patients.

Response: For purposes of making indirect GME payments to FQHCs and RHCs, the RCE limits will only apply to the portion of a teaching physician's compensation that is attributable to direct GME. We are not applying the RCE limit to physician compensation that is related to providing services to individual patients. Because we intend to pay for these GME costs on a reasonable cost basis, it is necessary to apply the RCE limits to assure that GME costs will be reasonable.

Comment: One commenter stated that if HCFA intends to compute the fixed cost for nonhospital training of all health professionals from the cost reimbursement data received over the next few years from qualified nonhospital providers, costs associated with training of nonphysician health practitioners should also be reported. This commenter stated that it will be difficult to collect these data at a later date.

Response: FQHCs and RHCs seeking payment from Medicare for direct GME must appropriately classify those costs to a GME cost center on the cost report. These payments are limited to the direct costs the FQHC or RHC incurs for an approved medical residency training program as described under section 1886(h) of the Act. Training of non-physician health professionals are not included in these programs. Therefore, in submitting costs reports, FQHCs and RHCs must clearly distinguish the costs of training residents from the cost of training other health professionals in nonhospital sites. Although FQHCs and RHCs will need to document costs of approved medical residency programs to be allocated to the GME cost center, we do not believe the information benefit associated with obtaining data on training of other health practitioners would justify imposing an additional administrative burden on FQHCs and RHCs to report costs for which they will receive no payment.

c. Revised definition of ''all or substantially all'' of the costs. Comment: A number of commenters felt the proposed redefinition of ''all or substantially all'' of the costs will be counterproductive and result in less training in nonhospital settings. One commenter stated that the current standard of ''or substantially all'' has helped to facilitate resident training in nonhospital sites. This commenter stated that there is strong anecdotal evidence that resident training in ambulatory sites has been increasing and recommended that any changes to existing policies be tested for the likelihood that they promote expanded ambulatory GME.

Response: We disagree with the commenters who suggested that the proposed redefinition of ''all or substantially all'' of the costs of training residents in the nonhospital sites will result in less training in nonhospital settings. First, we do not believe that hospitals themselves will be discouraged from continuing to rotate residents to nonhospital sites. Hospitals must consider accreditation and other program requirements in addition to purely financial considerations. We have reviewed the program requirements for residency education in family practice and internal medicine in the 1997–1998 *GME Directory*. The *Directory* specifies that family practice residents must spend specified amounts of time and see a minimum number of patients in the family practice center in each residency program year. Similarly, the *Directory* specifies that at least 25

percent of the 3 year residency program for internal medicine must be in an ambulatory care setting. Given these requirements for primary care training programs, we do not believe that hospitals will respond to the revised definition of ''all or substantially all'' of the costs by rotating fewer residents to nonhospital sites. Moreover, a hospital that meets the ''all or substantially all'' criterion may count the resident's training time in the nonhospital site for direct GME as well as IME.

Second, we believe that our proposal will encourage more ambulatory sites to participate in training. To the extent our policies would allow qualified nonhospital providers to receive payments directly from Medicare, more qualified nonhospital providers may be willing to become training sites. In addition, the hospital may incur supervisory teaching physician costs that previously might have been borne by the nonhospital site. Therefore, the nonhospital site either will receive revenues for costs that the site itself incurs or will no longer incur those costs.

Comment: Several commenters agreed that it is appropriate to provide GME payment to the entity that incurs ''all or substantially all'' of the costs whether it be the hospital or the qualified nonhospital provider. Many of these commenters, however, believe that ''all or substantially all'' of the costs should be limited to resident salaries and fringe benefits.

Response: We disagree. Section 1886(h)(4)(E) of the Act states that hospitals may include residents in their FTE counts for direct GME if the hospital incurs ''all or substantially all of the costs of the training program in that setting.'' Section 1886(d)(5)(B)(iv) of the Act allows hospitals to count residents for IME effective October 1, 1997 if the hospital ''incurs all or substantially all of the costs for the training program in that setting.'' As we stated previously and in the preamble to the proposed rule (63 FR 25597), we reviewed data on resident costs from recent Medicare hospital cost reports and found that, on average, resident salaries and fringe benefits account for less than half of total direct GME costs. We believe that the revised policy, which requires hospitals to incur a higher percentage of total training costs in the nonhospital setting than are accounted for by resident compensation reflect a better measure of ''all or substantially all'' of the costs than current policy.

Comment: One commenter argued that the rationale for the proposal is insufficient to merit a change in current policy. This commenter stated that our proposal focused only cost data from hospitals and not nonhospital sites. This commenter believed that, because our proposal addressed training in nonhospital sites, it would be more appropriate to analyze resident salaries and fringe benefits as a share of overall training costs at nonhospital sites. The commenter acknowledged that these data are not available at the present time, but believed that resident compensation is likely to be a substantial component of overall training costs in nonhospital sites. The commenter noted that the preamble to the proposed rule indicates that residents' salaries and supervisory costs would likely ''constitute a different proportion of the total GME costs in the nonhospital setting as compared with the hospital setting.'' (63 FR 25597). The commenter added that direct GME payments to hospitals are based on 1984 hospital costs that may not accurately reflect current costs.

Response: Our analysis is based on recent cost report data submitted to us by hospitals. That data shows that resident salaries and fringe benefits are less than half of total resident costs for hospitals. At this time, based on available data as well as a desire to treat hospitals and nonhospital sites equitably, we believe the hospital cost report data is a useful proxy for purposes of applying a standard of ''all or substantially all'' to nonhospital sites. We agree that it would be appropriate to analyze data on the cost of training from nonhospital sites and we will consider revisions to our policies as we obtain cost data from nonhospital sites.

We note that, if resident compensation is, in fact, a larger percentage of total costs in the nonhospital site relative to the hospital, as suggested by this commenter, this would mean that costs other than resident compensation are a smaller proportion of total costs. The hospital would have to assume relatively modest additional costs through arrangements with nonhospital sites to continue counting the residents for indirect and direct GME. We also note that preliminary data by researchers studying costs incurred by a nonhospital site to train residents has shown that resident salary and fringe benefits are a smaller ratio of total costs at the nonhospital site relative to the hospital. If this conclusion is accurate, it would provide additional evidence that our revised definition is a better measure of ''all or substantially all'' of the costs.

Comment: One commenter acknowledged that we revised the definition of ''all or substantially all'' to address a concern that nonhospital sites do not have sufficient resources to support their medical education activities, but argued that the proposed change in policy will not improve the ability of nonhospital sites to support training and may compromise existing and developing relationships between hospital and nonhospital GME sites. This commenter stated that the relationship between the hospital and nonhospital site should be voluntary and that it is up to the parties to define the appropriate parameters of their relationships, including how costs beyond the resident stipend and benefits should be accommodated.

Response: As we stated earlier, we do not believe that this revised policy will compromise existing training relationships between hospitals and nonhospital sites. We agree with the commenter that arrangements between hospitals and nonhospital sites for training should be voluntary and the entities should be responsible for negotiating the parameters of their relationship. If a hospital and nonhospital site cannot agree on an arrangement regarding costs, the hospital may pursue an agreement with another nonhospital site for training. Similarly, if a nonhospital site cannot reach agreement with a hospital, it does not have to allow its facility to be used as a training site and can pursue a training arrangement with another hospital.

Comment: One commenter asked why a nonhospital site would claim costs, and report an offset to those costs, if the hospital incurs the GME costs for training in the nonhospital site.

Response: In response to this comment, in this final rule we are modifying the requirements for both hospitals and qualified nonhospital providers. As stated previously, hospitals are required to furnish a written agreement between the hospital and the nonhospital site that indicates that the hospital is incurring the cost of the resident's compensation in the nonhospital site and that the hospital is providing reasonable compensation for teaching activities to the nonhospital site. The agreement must also indicate the amounts being furnished to the nonhospital site for teaching activities. If the resident is working at an FQHC or RHC and there is a written agreement that allows the hospital to count the resident for indirect and direct GME, the FQHC or RHC must report its direct GME costs in a nonreimbursable cost center. The FQHC or RHC is not required to offset from those GME costs revenues received from the hospital.

We are requiring the FQHC or RHC to report its direct GME costs in a nonreimbursable cost center because these costs will no longer be allowable costs under § 405.2468(a) through (e). As stated earlier, direct GME costs will not be subject to the cap on the all-inclusive rate under section 503 of the RHC and FQHC Manual. The reporting of direct GME costs in a separate cost center on the FQHC and RHC cost report will also allow us to receive data on the costs of training in nonhospital sites.

Comment: Some commenters argued that our proposal would impose undue administrative burden on hospitals and nonhospital sites by requiring them to report all of the GME costs they incur. One commenter stated that HCFA should retain the current definition of ''all or substantially all'' of the costs because it is logical, straightforward, and appropriate. This commenter asserted that it is difficult to isolate and quantify costs other than resident salaries and fringe benefits are incurred in nonhospital sites. According to this commenter, resident salaries and fringe benefits are easy to identify and their administration and recordkeeping can be monitored uniformly across the GME community. The commenter suggested that in assuming responsibility for resident compensation, the teaching hospital assumes responsibility for assuring that all residents are provided appropriate educational environments, supervision, and support for their training.

Another commenter argued that the proposed redefinition of ''all or substantially all'' of the costs does not reflect certain services or costs (e.g. house staff credentialing and related functions) just as the per resident amounts do not reflect services or costs that are included in the proposal (e.g. resident travel and lodging). These commenters suggested that resident salaries and fringe benefits should suffice as a proxy that appropriate educational services at an appropriate cost are being delivered by the hospital for the nonhospital training. Another commenter stated that it is a managed care organization that pays the resident salaries and fringe benefits and that this should be sufficient for receiving GME payment in the nonhospital site. According to these commenters, the entity that incurs the costs of the resident compensation should be considered to be incurring ''all or substantially all'' of the costs and be eligible to count the resident for direct and indirect GME.

Response: We do not believe that we are establishing a burdensome regulatory structure with tremendous documentation requirements. For hospitals seeking to count the time of residents training in the nonhospital site, we are requiring a written agreement between the hospital and the nonhospital site stating that the hospital will incur ''all or substantially all'' of the costs. The written agreement must indicate that the hospital is incurring the cost of the resident salaries and providing compensation for supervisory teaching physician costs. The agreement must also specify the amounts paid to the nonhospital site. These agreements and amounts paid by the hospital to the nonhospital site may be the product of negotiation between the hospital and nonhospital site. The hospital does not have to report the nonhospital site's GME costs. We anticipate that in the course of any negotiation between the hospital and nonhospital site, the nonhospital site may need to identify its training costs. However, this is a matter between the hospital and nonhospital.

If a hospital seeks to count the time of residents training in FQHC's and RHC's, the FQHC or RHC must identify its training costs in a nonreimbursable GME cost center. FQHC's and RHC's must separately report GME costs in order to distinguish these costs from other patient care costs that are paid for by Medicare on the basis of reasonable costs through the all inclusive rate. Under this final rule, we are not requiring FQHC's and RHC's to report the offset to those costs for payments received from the hospital. Requiring FQHC's and RHC's to report costs without offsetting revenues received from the hospital will allow us to obtain gross cost data on the costs of training in nonhospital sites.

RHC's and FQHC's must identify teaching physician costs and allocate overhead to the direct GME cost center, in addition to the current cost reporting requirements for these entities. These entities are currently paid on the basis of costs, and we do not believe the additional cost reporting requirements will be substantial.

We disagree with the comment that resident compensation should suffice as a proxy that appropriate educational services, at an appropriate cost, are being delivered and should be the sole criterion for determining which entity receives payment. Our concern in developing this policy is not whether we are paying for appropriate educational services but whether the entities that incur training costs are appropriately paid. Regardless of which entity incurs the cost of the resident's compensation, Medicare should only pay for appropriate educational services. Other regulations independent of the ''all or substantially all'' criterion ensure that Medicare pays for accredited educational programs.

Comment: One commenter stated that teaching physicians in nonhospital sites may be remunerated through a variety of different arrangements, including ''in kind'' compensation for continuing education or through voluntary contributions. According to this commenter, the proposed policies would require hospitals and nonhospital sites to identify financial transactions which may not exist. The commenter further stated that there is no established methodology for defining or quantifying supervisory costs. The commenter noted that even if the costs could be identified, the costs would vary depending upon specialty and the year of residency training, which would require a sophisticated accounting infrastructure. The commenter also asserted that community-based physicians would be discouraged from training residents because of the administrative burden of documenting the precise number of hours they spend teaching or supervising residents.

Response: We recognize that there could be a variety of financial arrangements between hospitals and nonhospital sites with regard to training. The hospital and the nonhospital site can take into account those types of arrangements in negotiating an agreement.

Although there will be some additional cost reporting requirements imposed on FQHC's and RHC's that receive payment for direct GME through the hospital or directly from Medicare, there are established cost reporting principles for identifying these costs in providers. Medicare+Choice organizations, in addition to producing a written agreement with nonhospital sites, will have to report GME costs when they incur ''all or substantially all'' of the costs. We are developing a modest one page cost statement that will allow the Medicare+Choice organizations to claim direct GME costs that are eligible for payment. If an FQHC or RHC incurs ''all or substantially all'' of the costs of the program, and is therefore eligible to be paid directly for GME, we do not believe the burden of documenting supervisory physician time spent in GME activities will be substantial. Our expectation is that physicians will need to estimate the number of hours they will spend in GME and non-GME activities during the course of the year and verify the estimates with a limited time study. This is similar to the documentation that was required of hospitals to allocate teaching physician costs between Part A

and Part B and between operating costs and direct medical education.

Comment: Several commenters suggested that we initiate demonstration projects addressing payment for GME in nonhospital sites. One commenter suggested that we analyze our proposed revision to ''all or substantially all'' of the costs through a demonstration project before implementing the changes on a nationwide basis. Such a demonstration project would indicate whether the proposed change would encourage or discourage training in nonhospital sites. Another commenter suggested that our proposed policy may adversely affect many GME programs and should be tested prior to being implemented on a national basis.

Response: Congress established a provision in the BBA authorizing the Secretary to provide payment to nonhospital sites and we do not believe a demonstration project is necessary. Furthermore, since this policy is more stringent than existing regulations, we are doubtful that hospitals would participate voluntarily in a demonstration project.

Comment: One commenter objected to the revision of the ''all or substantially all'' criteria and stated that the proposed policy would constrain the ability of teaching hospitals and Medicare+Choice organizations to develop reasonable rotations in hospitals and managed care plans. The commenter suggested an alternative under which a Medicare+Choice organization could submit a short application that would contain agreements between hospitals and Medicare+Choice organization addressing, among other things, the amount of time residents would spend at each site.

Under this approach, we would pay the qualified nonhospital provider based on the product of a per resident amount, the number of FTE residents, and the Medicare share. Each resident would be counted as a partial FTE based for the hospital and for the qualified nonhospital provider based on the percentage of time worked at each site. A Medicare+Choice organization would be paid its FTE percentage times a portion of the hospital per resident payment amount or a national average per resident amount. This commenter argued that this approach would meet the Congressional objective of allowing residents to receive training in hospitals and Medicare+Choice organizations while prohibiting double payment without establishing a cumbersome new set of cost reporting requirements.

Response: We considered the approach suggested by this commenter but we believe it would not facilitate training in qualified nonhospital providers. FQHC's, RHC's, and Medicare+Choice organizations generally provide a low percentage of total services to Medicare beneficiaries. The commenter's approach would to some extent substitute the Medicare share of the qualified nonhospital provider for the Medicare share of the hospital, and we believe this would result in lower Medicare payments overall for training in nonhospital sites. Also, we believe this approach would be inequitable to hospitals in that they would lose both the direct and indirect medical education payments for the proportion of time residents spend in the qualified nonhospital provider even though they have ongoing training costs while the residents train in the nonhospital site.

We believe that it is reasonable to pay the hospital or qualified nonhospital provider which incurs ''all or substantially all'' of the costs. Furthermore, the revised definition reflects a better measure of ''all or substantially all'' of the costs and will result in appropriate payment to hospitals for training in qualified nonhospital providers and other nonhospital sites.

As we stated in the May 8 proposed rule (63 FR 25597), we also have concerns that it would not be equitable to eliminate the hospital's payment entirely for the time resident's spend in nonhospital sites because the hospital may continue to incur some of the costs associated with training residents in nonhospital sites. We believe that the policies we are adopting are equitable to both hospital and nonhospital sites and will achieve Congress' objective of encouraging training in nonhospital sites.

Comment: One commenter stated that there might be important differences in the accounting and administrative systems of various categories of qualified nonhospital providers that might present some difficulties in identifying the cost data necessary to accurately complete cost reporting forms. Other commenters stated that hospitals will have difficulty obtaining the necessary data from the nonhospital sites to complete the agreements or that the revised definition of ''all or substantially all'' would impose undue administrative burden. Another commenter stated that the revised definition of ''all or substantially all'' creates a major problem in identifying the portion of time office physicians spend in teaching and supervising residents and is another administrative burden placed on physicians.

Response: As stated before, we do not believe we are imposing undue administrative burden. Direct GME costs for FQHC's and RHC's will have to be separately identified and reported. Although this will require the development of a mechanism for FQHC's and RHC's to allocate overhead and supervisory physician costs to the GME costs center, we do not believe that our policy will create significant administrative difficulties for FQHC's and RHC's, which already prepare cost reports for Medicare. As stated previously, we do not believe this process will generate a substantial burden on supervising physicians in FQHC's and RHC's beyond a written agreement between the clinic and the physician regarding the amount of time the physician expects to spend in GME activities and a time study verifying the allocation.

The submission of a cost statement for GME will be a new responsibility for Medicare+Choice organizations which do not have experience with reporting costs. However, as stated above, we are developing a one page cost statement of GME expenses to limit the administrative burden on Medicare+Choice organizations.

With regard to the concern expressed about creating a burdensome set of new cost reporting requirements, we reiterate that a condition of payment to the hospital for training in the nonhospital site is the production of the written agreement between the hospital and the nonhospital site. We are not requiring hospitals to submit cost data to Medicare as a precondition to counting the resident for indirect and direct GME.

Comment: One commenter noted that some arrangements between hospitals and nonhospital settings for the training of residents predate the GME base year. This commenter stated that hospitals did not compensate nonhospital sites for supervisory teaching physician costs and it would not be fair to shift these costs to teaching hospitals. The commenter also stated that teaching hospitals have already entered into written agreements with nonhospital sites under the existing rules. According to the commenter, the proposed rule would necessitate renegotiation of thousands of agreements, imposing tremendous transaction costs upon the academic medical community. The commenter noted that if the agreements are not renegotiated prior to the effective date, the hospital will be unable to count the residents for direct and indirect GME, and this will have a lasting effect because of the 3 year averaging rules. Another commenter stated that there are many complex

contractual arrangements between hospital based programs and nonhospital sites regarding the placement, training and patient service utilization of residents, and any change in Medicare GME payment policy could have significant and unknown impacts on these current training structures.

Response: The GME provisions of this final rule will be effective January 1, 1999. All other provisions of this final rule are effective October 1, 1998. By making a later effective date for the GME provisions, hospitals and nonhospital sites will have 5 months following publication of this final rule to negotiate agreements that will allow hospitals to continue counting residents training in nonhospital sites for indirect and direct GME. These agreements are related solely to financial arrangements for training in nonhospital sites. We do not believe that the agreements regarding these financial transactions will necessitate changes in the placement and training of residents.

In response to the comment that it is unfair to shift costs to the hospital, we believe it is appropriate to include supervisory costs in the nonhospital site as part of ''all or substantially all'' of the costs that hospitals must incur to count the resident. Currently, the hospital is able to count the resident even though its costs for that resident may be lower during the time the resident trains outside the hospital. At the same time, the nonhospital site may have incurred costs for which it received no compensation. We believe that requiring the hospital to incur the costs associated with training in the nonhospital site is equitable to both the hospital and nonhospital site and is consistent with the statutory requirement that the hospital must incur ''all or substantially all'' of the costs.

Comment: One commenter argued that we should not use reasonable costs as the basis for making payment to qualified nonhospital providers. This commenter stated that Medicare+Choice organizations do not submit cost reports and it would be extraordinarily expensive and cumbersome to report accounting costs. Several commenters also objected to our proposal to the extent we would allow overhead costs for FQHCs, RHCs, and hospitals but not Medicare+Choice organizations. These commenters believed that the policy cannot be justified on the basis that Medicare+Choice organizations do not submit cost reports. One commenter suggested that HCFA use predetermined payment amounts that do not require the subsequent submission of cost reports. The commenter noted that the proposed rule itself notes that direct GME payments are based on average per resident costs from 1984 that might bear little or no relation to accounting costs in 1998. Another commenter suggested that Medicare+Choice organizations should be paid an overhead factor for direct GME costs based on square footage of the clinic and a number of other factors. Alternatively, this commenter suggested use of an average overhead factor based on the number of residents trained until actual overhead expenses for Medicare+Choice organizations can be identified.

Response: Medicare+Choice organizations will typically contract with clinics for the provision of services to beneficiaries. In these situations, we can make payment directly to the Medicare+Choice organization if the plan produces a written agreement with the clinics where training occurs that the plan will incur ''all or substantially all'' of the costs associated with training in the nonhospital site. We are requiring a written agreement between the Medicare+Choice organization and the nonhospital sites. We believe that the primary components of GME costs are resident compensation and supervisory teaching physician costs and that facility overhead costs which can be allocated to direct GME are a smaller component of direct GME costs. Nevertheless, we agree that we should not limit allowable direct GME costs for Medicare+Choice organizations to resident compensation and supervisory physician costs. If the Medicare+Choice organization can document other direct GME costs that directly relate to a training program, we will allow these costs. We note that, at this time, it is not feasible to develop an average overhead factor which can be paid to Medicare+Choice organizations that incur ''all or substantially all'' of the costs of a training program in a nonhospital site. This is because our data systems on hospital GME costs do not distinguish between supervisory teaching physician costs and overhead costs attributable to direct GME.

In response to the comment that we use square footage or other mechanisms as a basis for allocating overhead to GME costs for Medicare+Choice organizations, we are concerned about developing a sophisticated cost allocation process for determining Medicare+Choice allowable direct GME costs since Medicare+Choice organizations do not submit cost reports. However, we are revising our proposal to require the written agreement to state that the Medicare+Choice organization will incur the costs of residents' salaries and fringe benefits and provide reasonable compensation for the remaining costs of the training program in the nonhospital site. Based on the statement of costs, the Medicare+Choice organization will report its costs to HCFA and we will provide payment based on the lower of the Medicare+Choice organization's cost per resident or a national average of the hospital per resident amounts.

Comment: Several commenters were concerned that if neither the hospital or nonhospital site incurs ''all or substantially all'' of the costs, neither setting would receive payment even though each entity incurs a portion of the training costs. One commenter suggested that there will be difficulty allocating costs under our proposed definition of ''incurring costs'' and stated that we should encourage affiliations and provide simpler and clearer guidance for institutions.

Response: Under this final rule, an entity must incur ''all or substantially all'' of the costs to receive payments for the time the resident spends in the nonhospital site. Since we do not conduct cost-finding to determine who bears ''all or substantially all'' of the graduate medical education costs, we are generally dependent on hospital and non-hospital provider agreements to determine who bears them. As stated earlier in this final rule as well as in the proposed rule, we do not believe it would be administratively feasible to apportion payments appropriate to the hospital and nonhospital site in situations where neither the hospital or nonhospital site agree on who incurs ''all or substantially all'' of the costs. We must also consider the statutory prohibition on double payments in these situations. Furthermore, although it may be appropriate to provide payment for GME costs where the nonhospital site incurs only a portion of the training costs, we do not believe it would be equitable to allow a nonhospital site to be paid where it was incurring only a portion of the costs but only allow payment to a hospital when it incurs ''all or substantially all'' of the costs.

In response to the commenter who suggested that we should encourage ''affiliations,'' we believe the revised definition of ''all or substantially all'' of the costs provides incentives for hospitals and nonhospital sites to reach agreement with regard to financial arrangements for training in nonhospital sites to avoid the situation where neither entity receives payment for GME.

Comment: One commenter asked whether hospitals would be eligible to receive payments in situations where the teaching faculty volunteers their

services and neither the hospital or nonhospital entity incurs costs for supervisory teaching physicians, but the hospital incurs the costs of resident salaries and fringe benefits (including travel and lodging expenses where applicable). The commenter asked whether the contract should state that there are no teaching physician costs incurred and the remainder of the costs represent ''all or substantially all'' of the costs. Another commenter stated that the ''all or substantially all'' definition creates special problems where community physicians voluntarily serve in a teaching capacity without compensation. The commenter stated that the implication of the proposed policy is that some portion of the community physician's earnings must be included in the calculation and asked that we either delete the proposed change or specify that voluntary supervision of training residents does not need to be included in the definition of ''all or substantially all'' of the costs.

Response: We have received anecdotal information that some supervisory teaching physicians participate in teaching activities without compensation in nonhospital clinics. Although there may be situations where a supervising physician is participating in teaching, we do not believe that lack of explicit compensation for teaching activities means that physicians are necessarily volunteering their time. Rather, we believe that the physician's compensation in the clinic encompasses both teaching and nonteaching activities. Nevertheless, for 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.

Comment: One commenter stated that a hospital was permitted to include, within in its GME base period costs, teaching physician costs related to the hospital by common ownership or control under § 413.17. Citing the GME consistency principle at § 412.113(b)(3), this commenter requested that we clarify that the same policy applies in the context of GME payment to nonhospital sites. That is, the regulation should include specific language which states that costs incurred by an organization related to the hospital under § 413.17 will be recognized as if incurred by the hospital in applying the expanded definition of ''all or substantially all'' of the costs.

Response: The consistency principle under § 412.113(b)(3) required consistent treatment of medical education costs during the transition to the inpatient hospital PPS during the 1980s. This rule was intended to prevent medical education costs from being included in hospital payments for operating costs and also being paid on a reasonable costs basis to hospitals as GME during the early years of the PPS. We do not see a relationship between the consistency rule and our proposed policies with regard to payment for GME training in nonhospital sites.

With regard to the costs of related parties under § 413.17, our policy was not to include costs associated with training in nonhospital clinics in the per resident amount even though certain direct GME costs of related parties could have been allowable. We also do not believe that § 413.17 has applicability to our proposed policy. We are requiring a written agreement between hospitals and nonhospital sites for purposes of this final rule, even where the hospital and nonhospital site are related organizations under § 413.17. In practice, since we are requiring an agreement between hospitals and nonhospital sites that are under common ownership or control, the agreements should be a formality.

Comment: One commenter stated that the necessary statutory and regulatory incentives do not exist for teaching hospitals to provide compensation to nonhospital sites for their GME costs.

Response: We disagree. The proposed rule requires a written agreement between the hospital and nonhospital site that the hospital will provide compensation to the nonhospital site for certain types of GME costs. Without this agreement, the hospital will be unable to count the resident for indirect and direct GME. As stated earlier, the agreements must also indicate the amounts the hospital will actually pay to the nonhospital site for GME training.

Comment: One commenter stated the definition of ''all or substantially all'' of the costs should not include residents' travel and lodging costs. This commenter stated that there is no rationale for this change and that the criteria imposes significant reporting burdens with no offsetting benefits. The commenter also stated that the phrase ''where applicable'' is vague and requires additional definition language (related to distance, means of travel) if entities are to understand their reporting obligations.

Response: Our intent in adding the phrase ''including residents travel and lodging costs, where applicable'' was to provide for the inclusion of direct GME costs that may be more prevalent in a nonhospital setting than in the hospital setting. The phrase ''where applicable'' means that depending on the specific arrangement in some cases, residents will be responsible for paying their own travel and lodging costs while serving at the nonhospital site. In other cases, it is possible that the site will pay for the residents to travel to the site and for lodging while at the site. This is basically a fringe benefit paid by the site for the resident. Therefore, in situations where travel and lodging is an expense of the nonhospital site while the resident is training there, the written agreement must indicate that the hospital will incur these costs. In determining whether the hospital has incurred ''all or substantially all'' of the costs of the program, the hospital must include this ''unique'' fringe benefit if it was paid for by the nonhospital site.

Comment: One commenter stated that the proposed regulations effectively deny payments to FQHC's unless they incur ''all or substantially all'' of the costs of the program. The commenter stated that since the FQHC does not typically pay the residents' salaries, the proposed rule does not significantly increase the ability of the FQHC to recover GME costs. This commenter stated that it is eminently possible to devise a method under which hospitals that utilize qualified nonhospital providers would report costs showing allowable FQHC costs. In these situations, costs would be apportioned to the proper cost center.

Response: We disagree. The FQHC can recover its GME costs either directly from Medicare if it incurs ''all or substantially all'' of the costs, or from the hospital through the written agreement. Without a written agreement that specifies the amounts the hospital will pay the nonhospital site for training in the nonhospital site, the hospital will be unable to count the resident for indirect and direct GME.

d. Medicare share. Comment: One commenter stated that the limitation of direct GME payments to FQHC's based on Medicare's share at the FQHC will seriously constrain participation because only 8 percent of FQHC patients are Medicare patients. The commenter quoted the Conference Report which states that ''the Conferees believe this authority may help alleviate physician shortages in rural areas.'' According to this commenter, the combination of requiring the FQHC to incur ''all or substantially all'' of the costs in order to receive payment and the limitation to Medicare share does little to provide sufficient resources to allow FQHC's to train physicians in underserved rural areas. The commenter believed the limitation of payments based on Medicare's share is not

required by the BBA provision authorizing GME to qualified nonhospital providers and is contrary to the intent of the law.

Response: It is a fundamental and longstanding principle that, to the extent Medicare pays for certain types of costs, the Medicare program should pay only its fair share. This principle applies not only in the context of Medicare payment for medical education, but also to Medicare payment in general.

Comment: One commenter stated that Medicare enrollees use 3.5 times the number of outpatient services as non-enrollees. The commenter suggested that it would be more equitable to base Medicare's share for Medicare+Choice organizations on the ratio of outpatient expenses for Medicare enrollees to total enrollees. As an alternative, this commenter suggested using Medicare visits to total visits to calculate Medicare share, consistent with the calculation in the inpatient setting of Medicare inpatient days to total inpatient days.

Response: We believe that either of the proposals suggested by this commenter would impose significant additional reporting responsibilities on Medicare+Choice organizations which receive payment from Medicare for direct GME. Basing the Medicare share calculation on the ratio of outpatient expenses attributable to Medicare beneficiaries to total expenses would require Medicare+Choice organizations to provide a sophisticated report of expenses not unlike the Medicare cost report. In situations where the Medicare+Choice organization is contracting for services provided in a clinic, this would require the Medicare+Choice organization to document costs which are not even its own. We considered using the ratio of Medicare enrollee to total enrollee visits in the Medicare share calculation, but have concerns that this approach would also be burdensome in that it would require Medicare+Choice organizations to furnish utilization data for clinics or physician offices that they do not own or control.

e. *National average per resident amounts. Comment*: One commenter argued that national average per resident amounts are not appropriate for the nonhospital setting. According to the commenter, residency training differs from other types of services because it involves complicated transactions with nongovernmental entities such as medical schools that may sponsor a hospital's programs and compensate physicians directly, and accreditation bodies that may require a certain content and curriculum in training programs.

Response: We did not propose the use of national average per resident amounts in the nonhospital setting but will consider whether a national average per resident amount is appropriate after we have experience with the provision and have reliable data on the costs of training in the nonhospital setting.

f. Technical errors concerning GME policy published in the May 12, 1998 final rule.

In the May 12, 1998 final rule for the FY 1998 inpatient hospital prospective payment system, we set forth certain policies on GME. The portion of the May 12, 1998 final rule concerning counting residents for direct medical education (beginning at (63 FR 26327)) contained the following technical errors:

- *Merged Hospitals*—On page 26329, third column, we stated that the FTE cap of merged hospitals would be the aggregation of the FTE cap for each hospital participating in the merger. We stated that § 413.86 would be modified to reflect this policy, but we did not modify the regulations text. We do not believe a change to the regulations text is necessary.
- *Application of the FTE Cap*—There is a discrepancy between the methodologies described in the August 29, 1997 final rule with comment period (62 FR 46005) and the May 12, 1998 final rule (63 FR 26330) for application of the FTE cap in situations where a hospital has more residents than the cap. The methodology described in the May 12, 1998 final rule is incorrect. The correct methodology is described in the August 29, 1997 final rule with comment period.
- *New Medical Residency Training Program*—On page 26332, in the first column, we stated, ''for these reasons, we believe it is appropriate to consider a medical residency training program to be newly established if the program received initial accreditation or began training residents on or after January 1, 1995.'' We are clarifying that, for hospitals that trained residents prior to January 1, 1995, we will adjust the FTE caps for programs were accredited or began training residents on or after January 1, 1995 and prior to August 5, 1997.
- *Application of the FTE Cap to an Affiliated Group*—On page 26341, in the third column, we stated, ''If the combined FTE counts for the individual hospitals do not exceed the aggregate cap, we will pay each hospital based on its FTE cap as adjusted per agreements.'' That sentence should have read as follows: ''If the combined FTE counts for the individual hospitals exceed the aggregate cap, we will pay each hospital based on its FTE cap as adjusted per agreements.''

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

A. Cap on the Capital Indirect Medical Education Adjustment Ratio (§ 417.322)

Under section 1886(g) of the Act, the Secretary has broad discretion in implementing the capital prospective payment system. Section 412.322 of the regulations specifies the formula for the capital indirect medical education (IME) adjustment factor. The capital IME adjustment is intended to pay the Medicare capital prospective payment system share of the indirect costs of medical education to teaching hospitals. The formula was incorporated in the August 30, 1991 final rule for the capital prospective payment system (56 FR 43380), and uses the ratio of interns and residents to average daily census (defined as total inpatient days divided by the number of days in the cost reporting period). Section 1886(d)(5)(B) of the Act requires the use of the ratio of residents-to-beds to calculate the IME adjustment for the operating prospective payment system. However, pursuant to our authority under section 1886(g) of the Act, we adopted the resident to average daily census ratio for the capital prospective payment system because we believed it was a more appropriate method for measuring teaching intensity, and because we believed it was less subject to manipulation.

The IME adjustment factor increases by approximately 2.8 percentage points for each 0.10 increase in the hospital's ratio of residents to average daily census. The IME adjustment for inpatient capital-related costs for hospitals paid under the prospective payment system takes the form of [e raised to the power (.2822 x ratio of interns and residents to average daily census) − 1] where e is the natural antilog of 1, based on the total cost regression results. In order to determine the Federal rate portion of the hospital's payment, the IME adjustment factor is multiplied by the standard Federal rate, the DRG weight, the geographic adjustment factor, and any other relevant payment adjustments such as the DSH adjustment or the large urban add-on. The formula is as follows: (Standard Federal Rate) x (DRG weight) x (GAF) x (Large Urban Add-on, if applicable) x (COLA adjustment for hospitals located in Alaska and Hawaii) x (1 + Disproportionate Share Adjustment Factor + IME Adjustment Factor, if applicable).

In the May 8, 1998 proposed rule (63 FR 25600) we indicated that it had come to our attention that because of the application of the capital IME adjustment, one hospital would receive a capital IME payment greater than its total hospital costs. We also stated that of the approximately 1,200 teaching hospitals in the United States, based on December 1997 data, 8 hospitals had a resident to average daily census ratio of more than 1.5. A resident to average daily census ratio of 1.5 results in a capital IME adjustment factor of 0.53, which increases the Federal rate portion of the hospital's capital payment by 53 percent.

To address this unintended effect of the capital IME methodology, we proposed capping the capital IME ratio at 1.5. A ratio greater than 1.5 means a hospital has, on average, considerably more residents than inpatients. Capping the ratio at 1.5 would allow for one resident per patient on the inpatient side plus some outpatient training, and would keep capital IME payments more consistent with the costs incurred. Because the operating IME ratio is based on the number of beds, it has only slightly exceeded 1.0 in two cases. This change would ensure that the capital IME adjustment is more in line with hospital costs.

We received no comments on our proposed change. We have decided to implement this policy as proposed. Effective October 1, 1998, the capital IME ratio will be capped at 1.5.

B. Payment Methodology for Mergers Involving New Hospitals (§ 412.331)

The August 30, 1991 final rule (56 FR 43418), which implemented the capital prospective payment system, established special payment provisions for new hospitals. Under § 412.324(b), a new hospital is paid 85 percent of its allowable Medicare capital-related costs through its first cost reporting period ending at least 2 years after the hospital accepts its first patient. The first cost reporting period beginning at least 1 year after the hospital accepts its first patient is the hospital's base year for purposes of determining its hospital-specific rate. Section 412.302(b) defines a new hospital's old capital costs as allowable capital-related costs for land and depreciable assets that were put in use for patient care on or before the last day of the hospital's base year cost reporting period. Beginning with the third year, the hospital is paid under the fully prospective or hold-harmless payment methodology, as appropriate. If the hospital is paid under the hold-harmless payment methodology, the hospital's hold-harmless payments for its old capital costs can continue for up to 8 years.

In the August 30, 1991 final rule, we defined a new hospital as one that had operated (under previous or present ownership) for less than 2 years and did not have a 12-month cost reporting period that ended on or before December 31, 1990. In the September 1, 1992 final rule (57 FR 39789), as a result of situations brought to our attention after publication of the original prospective payment system final rule, we clarified that the new hospital exemption would not apply in situations where the facility was not truly a new hospital.

In the May 8, 1998 proposed rule (63 FR 25600), we indicated that questions had arisen regarding application of our rules for payment of new hospitals in merger situations. We stated that consistent with our previously stated policy, we were proposing to further clarify the new hospital payment provisions. We proposed that, if during the period it is eligible for payment as a new hospital (as defined at § 412.300(b) and § 412.328(b)), a new hospital merges with one or more existing hospitals, and the merger meets the existing capital-related reasonable cost rules regarding the criteria for recognizing a merger at § 413.134 and the new hospital is the surviving corporation (as defined in § 413.134(l)(2)), we would treat as old capital only those assets of the existing hospital that met the definition of old capital (as defined in § 412.302(b)) prior to the merger, for purposes of determining payments after the merger.

Any assets of the existing hospital that were considered new capital prior to the merger would still be considered new capital after the merger. However, the merger cannot be used to convert the existing hospital's new capital into old capital. After the merger, the discharges of each campus of the merged entity would maintain their pre-merger payment methodology until the end of the 2-year period that the new hospital campus is eligible for reasonable cost reimbursement as defined at § 412.324(b). That is, the discharges at the new hospital would be paid based on 85 percent of its allowable Medicare hospital capital-related costs, while discharges from the existing hospital would continue to be paid under that hospital's methodology, that is, fully prospective or hold-harmless. At the end of this period, the intermediary would calculate a hospital specific rate for the ''new'' campus of the merged hospital. Finally, the calculation methodology for hospital mergers at new § 412.331(a)(1) and (2) would be performed and a combined hospital-specific rate would be determined and a payment methodology selected for the merged hospital as a whole.

The calculation at § 412.331(a)(1) and (2) uses each hospital's base year old capital costs. Any new capital of the previously existing hospital would not be used in the determination. If the merged entity qualifies for the hold-harmless payment methodology, only the capital which meets the definition of old capital at § 412.302(b) would be eligible for hold-harmless payments.

We received one comment on our proposal.

Comment: One hospital association commented on the policy that only the assets of the existing hospital that met the definition of old capital prior to the merger would be treated as old capital after the merger, even if all of the capital had been acquired and put into use during the new hospital's base year. They also stated that the proposal changes the regulatory definition of a new hospital's old capital, revises its payment methodology determination, and creates special payment rules for new hospitals that merge with existing hospitals. The commenter also states that a hospital in a situation similar to that described in our example was told that after a merger between a new hospital and an existing hospital, all assets acquired by the new hospital in the base year would become old capital costs. The commenter suggests that if HCFA will not reconsider the proposed change, at least it should not be applied retroactively.

Response: As indicated in the proposed rule, we addressed this issue because questions have arisen regarding application of our rules for payment for new hospitals in merger situations. Accordingly, we proposed to clarify the application of our rules in merger situations. Before the proposed rule, we had not specifically addressed in the **Federal Register** the issue of mergers between an ''existing'' hospital and a ''new'' hospital, but our clarification is consistent with existing rules; the clarification does not reflect new policy or a change in policy that can only be applied prospectively.

The commenter is correct that with regard to the capital of the existing hospital that merges with a new hospital, our proposal would treat as old capital only capital that qualified as old capital prior to the merger. Any capital that was new capital of the existing hospital prior to the merger would remain new capital after the merger. The new hospital will be paid 85 percent of its allowable Medicare inpatient hospital capital-related costs through its

cost reporting period ending at least two years after the hospital accepts its first patient. In our September 1, 1992 final rule (57 FR 39789), we clarified that the new hospital exemption under the capital prospective payment system would not apply to a facility that opened as an acute care hospital if that hospital had previously operated under current or prior ownership and had a historic asset base. We also clarified that even a hospital that replaced its entire facility (with or without a change of ownership) would not qualify for a new hospital exemption and that a previously existing PPS-excluded hospital (paid under section 1886(b) of the Act) that became an acute care hospital (paid under section 1886(d)) of the Act would not qualify as a new hospital. With this current proposal we are clarifying our rules as they apply to a new hospital which merges with an existing hospital.

When a new hospital merges with an existing hospital that has already had the benefit of reasonable cost reimbursement prior to the inception of capital PPS, on October 1, 1991, we believe it would be inappropriate for all of the capital assets of a previously existing hospital to be eligible for payment as old capital simply because it merged with a new hospital. As with the other situations that we clarified in 1992, this current clarification of the regulation at § 412.331(a)(3) is consistent with the principle that the new hospital exemption should only be available to those hospitals that had not received reasonable cost payments in the past and needed special payment protection during their initial period of operation. Our policy seeks to ensure that when a new hospital acquires the assets of an existing hospital through a merger, any assets of the existing hospital that were previously considered new capital prior to the merger are not transformed to old capital, as a result of the merger. The new hospital will still be paid 85 percent of its allowable Medicare capital-related costs for all other assets it acquires through the end of its base period.

The commenter fails to note that our current payment rules at § 412.331(a)(3) for merger situations already provide that only the existing capital-related costs related to the assets of each merged or consolidated hospital as of December 31, 1990 are recognized as old capital costs during the transition period. If the merged hospital is paid under the hold-harmless methodology after merger or consolidation, only that original base year old capital is eligible for hold-harmless payments. These rules mean that in cases of a merger between two existing hospitals, only the capital assets which were recognized as old capital prior to December 31, 1990 are eligible for payment as old capital after the merger. We are clarifying that this principle would also apply to the situation of merger between an existing hospital and a new hospital. The regulation that defines a new hospital's old capital was not intended to apply to capital acquired through merger with an existing hospital subject to capital PPS.

Finally, the commenter is mistaken that HCFA has previously ruled that the new capital assets of an existing hospital could be paid as old capital after a merger with a new hospital. In fact, our policy is consistent with our regulation at § 412.331(a)(3) cited above, in that only the existing capital-related costs related to the assets of each merged or consolidated hospital as of December 31, 1990 are recognized as old capital costs during the transition period.

We are implementing this clarification as proposed. For an example of how our policy works, see the May 8, 1998 proposed rule (63 FR 25601).

C. Special Exceptions Process

As described in § 412.348(g) of the regulations, an additional payment may be made for up to 10 years beyond the end of the capital PPS transition period for eligible hospitals that meet: (1) a project need requirement, (2) a project size requirement, and, (3) in the case of certain urban hospitals, an excess capacity test. The regulation establishing this special exceptions provision, and describing the criteria by which eligible hospitals qualify, was published on September 1, 1994 (59 FR 45385). At that time we described the purpose of 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.''

The special exceptions process is available to certain classes of hospitals that meet the eligibility criteria described at § 412.348(g)(1). The eligible classes of hospitals are sole community hospitals; urban hospitals with at least 100 beds that either have a disproportionate share percentage of 20.2 percent or 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.

Eligible hospitals must satisfy a project need requirement as described at § 412.348(g)(2) and a project size requirement as described at § 412.348(g)(5). For hospitals in States with Certificate of Need (CON) requirements, the project need requirement is satisfied by obtaining 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 during the period beginning on or after its first cost reporting period beginning on or after October 1, 1991 to the end of its last cost reporting period beginning before October 1, 2001, and the project meets certain cost thresholds specified in the regulations.

The minimum payment level for qualifying hospitals is 70 percent of allowable capital-related costs. A qualifying hospital may receive payments for up to ten years from the year which it completes a qualifying project. Finally, the regulations at § 412.348(g)(8) describe the cumulative payment comparison and offsetting amounts which are used to determine a qualifying hospital's exception payment.

A few hospitals have expressed concern with the required completion date of October 1, 2001, and other qualifying criteria for the special exceptions. 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, because hospitals are eligible to receive special exceptions payments for up to ten years from the year in which they complete their project. If a project is completed by September 30, 2001, then exceptions payments could continue up to October 30, 2011. We intended to limit cost-based exceptions payments to the period not more than ten years beyond the end of the transition to fully prospective payment for capital. When we adopted the criteria for the special exceptions process, we selected the project completion date with the goal of not extending this transition unnecessarily. In addition, we believed that eligible hospitals will not have had the opportunity to reserve prior year capital PPS payments for financing projects begun in the early years of PPS.

In order for us to analyze the impact of potential changes in the special exceptions policies, we are soliciting the following information on major capital construction projects as defined at § 412.348(g)(5) that will be put to use for patient care on or after October 1, 1996:

(1) Name, address, phone number and provider number of hospital;

(2) Cost of capital project;

(3) Date of CON approval, if required;

(4) Start date of project; and

(5) Anticipated completion date.

Please forward this information by September 30, 1998 to the Division of Acute Care, Attention: Cassandra Black at the following address: HCFA, C4–01–26, 7500 Security Blvd., Baltimore, Md. 21244–1850. We will analyze the data to determine whether any changes in the special exceptions policies are necessary. Any changes, if necessary, would be included in next year's FY 2000 proposed rule for hospital PPS.

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

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

1. Updated Caps

Section 1886(b)(3) of the Act as amended by section 4414 of the BBA established caps on the target amounts for 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. For purposes of calculating the caps, the statute requires the Secretary to first calculate the 75th percentile of the target amounts for each class of hospital (psychiatric, rehabilitation, or long-term care) for cost reporting periods ending during FY 1996. The resulting amounts are updated by the market basket percentage to the applicable fiscal year.

A discussion of how the caps on the target amounts were calculated for cost reporting periods beginning during FY 1998 can be found in the August 29, 1997, final rule with comment period (62 FR 46018). On March 6, 1998, we published a correction notice correcting the caps for FY 1998 (63 FR 11148).

In the May 8 proposed rule for FY 1999, we published proposed caps for cost reporting periods beginning during FY 1999 (63 FR 25601); however, the caps that we published inadvertently reflected updates to the amounts published on August 29, 1997, rather than the corrected amounts published on March 6, 1998 (see May 13, 1998 correction notice, 63 FR 26565). Thus, as corrected, the proposed caps for FY 1999 were as follows:

(1) Psychiatric hospitals and units: $10,797

(2) Rehabilitation hospitals and units: $19,582

(3) Long-term care hospitals: $38,630

These proposed caps reflected an update of 2.5 percent, the projected market basket percentage increase at the time we developed the proposed rule.

The final projection of the market basket percentage for excluded hospitals and units for FY 1999, based on the most recent data available, is 2.4 percent. Accordingly, the final caps on the target amounts for existing hospitals for cost reporting periods beginning during FY 1999 are as follows:

(1) Psychiatric hospitals and units: $10,787

(2) Rehabilitation hospitals and units: $19,562

(3) Long-term care hospitals: $38,593

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

Section 1886(b)(7) of the Act establishes a new statutory 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 which first receives payments on or after October 1, 1997, the amount of payment will be determined as follows. For each of the first two cost reporting periods, the amount of payment is 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 and adjusted for differences in area wage levels.

In the August 29, 1997 final rule with comment period, we published the figures for 110 percent of the national median of target amounts for each class of hospital (62 FR 46020). In the May 12, 1998 final rule for FY 1998, we revised the figure for long-term care hospitals to $21,494 (63 FR 26347).

The table below lists 110 percent of the wage neutral national median target amounts for each class of excluded hospitals for cost reporting periods beginning during FY 1999. These figures reflect updates to the final FY 1998 figures by the projected market basket increase of 2.4 percent. For a new provider, the labor-related share of the target amount should be multiplied by the appropriate geographic area wage index and added to the nonlabor-related share in order to determine the limit on payment under the statutory payment methodology for new providers.

Total	Labor-related share	Nonlabor-related share
(1) Psychiatric	$6,214	$2,472
(2) Rehabilitation	12,219	4,858
(3) Long-Term Care ..	15,749	6,261

3. Classification of Hospitals and Units (§ 413.40(c))

In the May 8 proposed rule, we stated that, after publication of the August 29, 1997 final rule with comment period, some excluded facilities had suggested that if they are currently excluded as one class of hospital or unit but also qualify for exclusion as another class of hospital, they should be permitted to choose which classification applies for purposes of applying the cap on target amounts. For example, some hospitals that participate in Medicare as psychiatric hospitals (defined under section 1861(f) of the Act, and the special conditions of participation in 42 CFR part 482 subpart E) have noted that they have average lengths of stay greater than 25 days. Those hospitals have asked to be ''reclassified'' as long-term care hospitals and given the benefit of the higher cap on target amounts applicable to that hospital class.

In the proposed rule, we indicated that we had considered these hospitals' suggestions but, for reasons explained in that document, believed it would not be appropriate to adopt them. Accordingly, in the May 8 proposed rule, we proposed to revise § 413.40(c)(4)(iii) to specify that, for purposes of that paragraph, the classification of a hospital that was excluded from the prospective payment system for its cost reporting period ending in FY 1996 would be determined by its classification (that is, the basis on which it was excluded) in FY 1996. If a hospital or unit was not excluded for a cost reporting period ending in FY 1996, but could be excluded on more than one basis (for example, as either a rehabilitation or long-term care hospital) in a given cost reporting period, it would be assigned to the classification group with the lowest limit.

Comment: One commenter agreed that psychiatric hospitals should not be allowed the higher cap on target amounts that is applicable to long-term care hospitals, even if they also have average lengths of inpatient stay greater than 25 days. The commenter pointed out that psychiatric hospitals participate in Medicare under a provision of the law (section 1861(f) of the Act) that is separate from the provision applicable

to other excluded hospitals (section 1861(e) of the Act), and that the exclusion criteria for psychiatric hospitals differ from those for other hospitals. The commenter stated that because of these differences, a psychiatric hospital could not qualify for exclusion as another type of hospital or be eligible for the cap that applies to another type of hospital. The commenter suggested that it is unnecessary to specify that a psychiatric hospital cannot qualify for the cap on target amounts applicable to long-term care or other types of excluded hospitals.

Response: If a hospital qualifies under more than one of the exclusion criteria pursuant to section 1886(d)(1)(B) of the Act, we would apply the lowest applicable cap to the hospital. For example, where a hospital qualifies as both a rehabilitation and long-term care hospital, we will apply the lower rehabilitation hospital cap to the hospital. Since this rule applies to all PPS-excluded hospitals, whether a psychiatric hospital can qualify as another type of hospital or not, the policy of applying the lowest cap is still needed.

Comment: One commenter pointed out that some non-psychiatric (section 1861(e) of the Act) hospitals might be able to qualify for exclusion either as rehabilitation or as long-term care hospitals. The commenter stated that in many cases such facilities are excluded as long-term care hospitals. Therefore, the commenter recommended that any hospital in this category be given the benefit of the long-term care hospital cap.

Response: We understand that some hospitals may simultaneously be able to qualify for exclusion on more than one basis. If a hospital is excluded from PPS as a certain type of hospital, we believe the hospital should be subject to the cap applicable for that class of hospital, even if it qualifies for exclusion on another basis. Thus, if a hospital qualifies for exclusion on more than one basis, then it is subject to all applicable caps, which in turn means the hospital's target amount cannot exceed the lowest of the applicable caps. We believe this policy not only is appropriate, but also provides greater incentives for efficient and cost-effective operation.

Comment: Two commenters stated that if a hospital is classified as one type of hospital in any period to which the limits apply, and does not simultaneously qualify for exclusion on any other basis, the law (section 1886(b)(3) of the Act) does not authorize application of any cap other than the one applicable to the exclusion category to which the hospital is assigned. One commenter stated that this is the case even if the basis for the hospital's exclusion in a given cost reporting period is different than the basis for its exclusion for the cost reporting period ending during FY 1996 (for example, a hospital may have been excluded as a rehabilitation hospital during that period and later qualified for exclusion as a long-term care hospital).

Response: We agree with the commenter that, if the basis for a hospital's exclusion for a given cost reporting period is different than the basis for the hospital's exclusion for the cost reporting period ending during FY 1996, the earlier basis of exclusion should not control which cap applies. We are revising § 413.40(c)(4)(iv) accordingly. Thus, in applying the caps to excluded hospitals (or units), we will consider only the current basis (or bases) for exclusion. As stated above, if a hospital qualifies for more than one type of exclusion, its target amount may not exceed the lowest of the applicable caps.

We note that, for the reasons explained in the proposed rule, we continue to be concerned that hospitals and units may seek changes in their basis of exclusion solely to take advantage of a higher cap, and that the resulting changes could compromise the effectiveness of the caps. We will monitor this situation carefully and may seek further legislative changes to the extent necessary to preserve the effectiveness of the caps.

Comment: One commenter recommended that the regulations be revised to state that where two hospitals who are subject to different caps on TEFRA limits merge, the TEFRA cap that applies is the cap of the surviving hospital.

Response: If two hospitals merge, the cap that applies depends on the status of the surviving entity. However, we do not believe that the regulations as described above, can be interpreted in any other way. Therefore, we do not agree that the regulations need to be revised to specifically address this situation.

Comment: One commenter suggested that if a new hospital subject to the limits revised under § 413.40(f)(2)(ii) changes the basis on which it is excluded from the PPS (for example, from being a rehabilitation hospital to a long-term care hospital), the cap applied for purposes of the comparison should be the cap applicable to the hospital's ''current'' exclusion category, not the hospital's previous exclusion category.

Response: We agree that the cap applied should be based on the exclusion category for which the hospital currently qualifies. In light of the changes made in response to comments described above, we do not believe the regulations need to be further revised.

4. Exceptions

The August 29, 1997 final rule with comment period (62 FR 46018) specified that a hospital that has a target amount that is capped at the 75th percentile, would not be granted an adjustment payment to the target amount (also referred to as an exception payment) as governed by § 413.40(g)(3) 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, in the May 8, 1998 proposed rule, we proposed to clarify that, to the extent we grant an exception in accordance with § 413.40(g)(3) to a hospital not affected by the cap, the amount of the exception would be limited to the cap on the hospital's target amount. By establishing caps on TEFRA target amounts, Congress has limited payments to individual hospitals based on amounts that reflect the cost experience of other hospitals. Therefore, in determining the extent of any adjustment paid to a hospital as an exception under our regulations at § 413.40(g)(3), we believe it is consistent with Congressional intent to limit the extent of the adjustment to the hospital's cap on its target amount.

We proposed to revise § 413.40(g)(1) in order to set forth the limitation on the adjustment payments.

Comment: One commenter stated that the proposed rule conflicts with section 1886(b)(4)(A)(i) of the Act, which requires HCFA to provide for adjustments to providers who exceed their TEFRA ceiling. The commenter also believed that our proposed provision limiting the TEFRA exception to the TEFRA cap is inconsistent with HCFA's past TEFRA adjustment processing practices. The commenter also stated that the proposed rule would adversely affect beneficiaries by limiting the scope and extent of services that hospitals in high wage areas are financially able to deliver. For these reasons, the commenter requested that HCFA modify the proposed rule to permit the granting of exceptions to the TEFRA cap.

Response: Section 1886(b)(4)(A)(i) of the Act provides that the Secretary

''shall provide'' for exceptions and adjustments ''where events beyond the hospital's control or extraordinary circumstances, including changes in the case mix of such hospital, create a distortion in the increase in costs for a cost reporting period.'' Prior to the enactment of Public Law 105–33, the payment for each excluded hospital was limited by a hospital-specific target amount, which was updated each year. The exceptions and adjustments provision provided for payments above the hospital's target amount if the hospital experienced ''a distortion in the increase in costs'' for a given period. Thus, a hospital could receive an exception based on its cost experience.

The BBA enacted a system of caps which significantly changed the TEFRA payment system. Under the new system of TEFRA caps, a hospital's payments are not based solely on its own cost experience; instead, a hospital is now subject to a cap based on the cost experience of other hospitals.

We believe our policies harmonize the exceptions provision and the cap provision. Under our policies, a hospital whose target amount is below the cap may receive an exception up to the cap. Thus, consistent with the mandate of section 1886(b)(4) of the Act, we continue to provide for exceptions, contrary to the assertion of the commenter. However, by establishing caps on TEFRA target amounts, Congress has limited payments to individual hospitals based on amounts that reflect the cost experience of other hospitals. Therefore, in determining the extent of any adjustment paid to a hospital as an exception under our regulations, we believe it is consistent with Congressional intent to limit the extent of the adjustment to the hospital's cap on its target amount. If a hospital's otherwise applicable target amount is above the cap, it cannot receive an exception based solely on a comparison of its current year costs or patient mix to base year costs or patient mix.

VII. MedPAC Recommendations

As required by law, we have reviewed the March 1998 report submitted by MedPAC to Congress and gave its recommendations careful consideration in conjunction with the proposals set forth in the 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 and response in the discussion below. Recommendations concerning the update factors for inpatient operating costs and for hospitals and hospital distinct-part units excluded from the prospective payment system are discussed in Appendix C, of this final rule.

Potential Effects of Target Amount Caps

Recommendation: The wage-related portion of the excluded hospital target amount caps should be adjusted by the appropriate hospital wage index to account for geographic differences in wages. (For more information see Volume 1, chapter 7, page 71 of the March 1998 report.)

Response in the Proposed Rule: As MedPAC indicated in its recommendation, legislation would be required to adjust the target amount caps in such a substantial manner as to adjust for differences in area labor costs.

Comment: Several commenters believed that the caps on the target amounts should be wage adjusted in order to recognize the different labor markets. They believe to do otherwise would be unfair and inequitable and may cause hospitals to cut back on services they provide to their Medicare beneficiaries.

Response: We previously addressed this issue in the final rule published in the **Federal Register** on May 12, 1998 (63 FR 26345). Our decision, as expressed in our response in that final rule, remains unchanged.

VIII. Other Required Information

Requests for Data From the Public

In order to respond promptly to public requests for data related to the prospective payment system, we have set up a process under which commenters can gain access to the raw data on an expedited basis. Generally, the data are available in computer tape format or cartridges; however, some files are available on diskette, and on the Internet at HTTP://WWW.HCFA.GOV/STATS/PUBFILES.HTML. In our May 8 proposed rule, we published a list of data files that are available for purchase (63 FR 25603).

List of Subjects

42 CFR Part 405

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

42 CFR Part 412

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

42 CFR Part 413

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

42 CFR Chapter IV is amended as set forth below:

A. Part 405 is amended as follows:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

1. The authority citation for part 405 is revised to read as follows:

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

Subpart X—Rural Health Clinic and Federally Qualified Health Center Services

2. In § 405.2468, a new paragraph (f) is added to read as follows:

§ 405.2468 Allowable costs

* * * * *

(f) *Graduate medical education.* (1) Effective for that portion of cost reporting periods occurring on or after January 1, 1999, if an RHC or an FQHC incurs ''all or substantially all'' of the costs for the training program in the nonhospital setting as defined in § 413.86(b) of this chapter, the RHC or FQHC may receive direct graduate medical education payment for those residents.

(2) Direct graduate medical education costs are not included as allowable cost under § 405.2466(b)(1)(i); and therefore, are not subject to the limit on the all-inclusive rate for allowable costs.

(3) Allowable graduate medical education costs must be reported on the RHC's or the FQHC's cost report under a separate cost center.

(4) Allowable graduate medical education costs are non-reimbursable if payment for these costs are received from a hospital or a Medicare+Choice organization.

(5) Allowable direct graduate medical education costs under paragraphs (f)(6) and (f)(7)(i) of this section, are subject to reasonable cost principles under part 413 and the reasonable compensation equivalency limits in §§ 415.60 and 415.70 of this chapter.

(6) The allowable direct graduate medical education costs are those costs

incurred by the nonhospital site for the educational activities associated with patient care services of an approved program, subject to the redistribution and community support principles in § 413.85(c).

(i) The following costs are allowable direct graduate medical education costs to the extent that they are reasonable—

(A) The costs of the residents' salaries and fringe benefits (including travel and lodging expenses where applicable).

(B) The portion of teaching physicians' salaries and fringe benefits that are related to the time spent teaching and supervising residents.

(C) Facility overhead costs that are allocated to direct graduate medical education.

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

(A) Costs associated with training, but not related to patient care services.

(B) Normal operating and capital-related costs.

(C) The marginal increase in patient care costs that the RHC or FQHC experiences as a result of having an approved program.

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

(7) Payment is equal to the product of—

(i) The RHC's or the FQHC's allowable direct graduate medical education costs; and

(ii) Medicare's share, which is equal to the ratio of Medicare visits to the total number of visits (as defined in § 405.2463).

(8) Direct graduate medical education payments to RHCs and FQHCs made under this section are made from the Federal Supplementary Medical Insurance Trust Fund.

B. Part 412 is amended as set forth below:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

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

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1895hh).

Subpart A—General Provisions

2. Section 412.4 is revised to read as follows:

§ 412.4 Discharges and transfers.

(a) *Discharges.* Subject to the provisions of paragraphs (b) and (c) of this section, a hospital inpatient is considered discharged from a hospital paid under the prospective payment system when—

(1) The patient is formally released from the hospital; or

(2) The patient dies in the hospital.

(b) *Transfer—Basic rule.* A discharge of a hospital inpatient is considered to be a transfer for purposes of payment under this part if the discharge is made under any of the following circumstances:

(1) From a hospital to the care of another hospital that is—

(i) Paid under the prospective payment system; or

(ii) Excluded from being paid under the prospective payment system because of participation in an approved Statewide cost control program as described in subpart C of part 403 of this chapter.

(2) From one inpatient area or unit of a hospital to another inpatient area or unit of the hospital that is paid under the prospective payment system.

(c) *Transfers—Special 10 DRG rule.* For discharges occurring on or after October 1, 1998, a discharge of a hospital inpatient is considered to be a transfer for purposes of this part when the patient's discharge is assigned, as described in § 412.60(c), to one of the qualifying diagnosis-related groups (DRGs) listed in paragraph (d) of this section and the discharge is made under any of the following circumstances—

(1) To a hospital or distinct part hospital unit excluded from the prospective payment system under subpart B of this part.

(2) To a skilled nursing facility.

(3) To home under a written plan of care for the provision of home health services from a home health agency and those services begin within 3 days after the date of discharge.

(d) *Qualifying DRGs.* The qualifying DRGs for purposes of paragraph (c) of this section are DRGs 14, 113, 209, 210, 211, 236, 263, 264, 429, and 483.

(e) *Payment for discharges.* The hospital discharging an inpatient (under paragraph (a) of this section) is paid in full, in accordance with § 412.2(b).

(f) *Payment for transfers.* (1) *General rule.* Except as provided in paragraph (f)(2) or (f)(3) of this section, a hospital that transfers an inpatient under the circumstances described in paragraph (b) or (c) of this section, is paid a graduated per diem rate for each day of the patient's stay in that hospital, not to exceed the amount that would have been paid under subparts D and M of this part if the patient had been discharged to another setting. The per diem rate is determined by dividing the appropriate prospective payment rate (as determined under subparts D and M of this part) by the geometric mean length of stay for the specific DRG to which the case is assigned. Payment is graduated by paying twice the per diem amount for the first day of the stay, and the per diem amount for each subsequent day, up to the full DRG payment.

(2) *Special rule for DRGs 209, 210, and 211.* A hospital that transfers an inpatient under the circumstances described in paragraph (c) of this section and the transfer is assigned to DRGs 209, 210 or 211 is paid as follows:

(i) 50 percent of the appropriate prospective payment rate (as determined under subparts D and M of this part) for the first day of the stay; and

(ii) 50 percent of the amount calculated under paragraph (f)(1) of this section for each day of the stay, up to the full DRG payment.

(3) *Transfer assigned to DRG 385.* If a transfer is classified into DRG 385 (Neonates, died or transferred) the transferring hospital is paid in accordance with § 412.2(e).

(4) *Outliers.* Effective with discharges occurring on or after October 1, 1984, a transferring hospital may qualify for an additional payment for extraordinarily high-cost cases that meet the criteria for cost outliers as described in subpart F of this part.

Subpart F—Payment for Outlier Cases

3. In § 412.80, paragraph (b) is revised to read as follows:

§ 412.80 General provisions

* * * * *

(b) *Outlier cases in transferring hospitals.* HCFA provides cost outlier payments to a transferring hospital for cases paid in accordance with § 412.4(f), if the hospital's charges for covered services furnished to the beneficiary, adjusted to costs by applying cost-to-charge ratios as described in § 412.84(h), exceed the DRG payment for the case plus a fixed dollar amount (adjusted for geographic variation in costs) as specified by HCFA, divided by the geometric mean length of stay for the DRG, and multiplied by an applicable factor determined as follows:

(1) For transfer cases paid in accordance with § 412.4(f)(1), the applicable factor is equal to the length of stay plus 1 day.

(2) For transfer cases paid in accordance with § 412.4(f)(2), the applicable factor is equal to 0.5 plus the product of the length of stay plus 1 day multiplied by 0.5.

* * * * *

Subpart G—Special Treatment of Certain Facilities Under the Prospective Payment System for Inpatient Operating Costs

§ 412.105 [Amended]

4. In § 412.105(f)(1)(ii)(C), the reference to ''413.86(f)(1)(iii)'' is revised to read ''413.86(f)(4).''

5. In § 412.106, paragraph (b)(4) is revised to read as follows:

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

* * * * *

(b) * * *

(4) *Second computation.* The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:

(i) A patient is deemed eligible for Medicaid on a given day if the patient is eligible for medical assistance under an approved State Medicaid plan on such day, regardless of whether particular items or services were covered or paid under the State plan.

(ii) The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

* * * * *

Subpart M—Prospective Payment System for Inpatient Hospital Capital Costs

6. In § 412.322, paragraph (a)(3) is revised to read as follows:

§ 412.322 Indirect medical education adjustment factor.

(a) * * *

(3) The measurement of teaching activity is the ratio of the hospital's full-time equivalent residents to average daily census. This ratio cannot exceed 1.5.

* * * * *

7. In § 412.331, paragraphs (a) and (b) are redesignated as paragraphs (b) and (c) respectively, a new paragraph (a) is added and the first sentence of the introductory text of newly redesignated paragraph (b) is revised to read as follows:

§ 412.331 Determining hospital-specific rates in cases of hospital merger, consolidation, or dissolution.

(a) *New hospital merger or consolidation.* If, after a new hospital accepts its first patient but before the end of its base year, it merges with one or more existing hospitals, and two or more separately located hospital campuses are maintained, the hospital-specific rate and payment determination for the merged entity are determined as follows—

(1) *Post-merger base year payment methodology.* The new campus is paid based on reasonable costs until the end of its base year. The existing campus remains on its previous payment methodology until the end of the new campus' base year. Effective with the first cost reporting period beginning after the the end of the new campus' base year, the intermediary determines a hospital-specific rate applicable to the new campus in accordance with § 412.328, and then determines a revised hospital-specific rate for the merged entity in accordance with paragraph (a)(2) of this section.

(2) *Revised hospital-specific rate.* Using each hospital's base period data, the intermediary determines a combined average discharge-weighted hospital-specific rate.

(3) *Post-base year payment determination.* To determine the applicable payment methodology under § 412.336 and for payment purposes under § 412.340 or § 412.344, the discharge-weighted hospital-specific rate determined by the intermediary is compared to the Federal rate. The revised payment methodology is effective on the first day of the cost reporting period beginning after the end of the new campus' base year.

(b) *Existing hospital merger or consolidation.* If, after the base year, two or more hospitals merge or consolidate into one hospital as provided for under § 413.134(k) of this chapter and the provisions of paragraph (a) of this section do not apply, the intermediary determines a revised hospital-specific rate applicable to the combined facility under § 412.328, which is effective beginning with the date of merger or consolidation. * * *

* * * * *

C. Part 413 is amended as set forth below:

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

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

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i) and (n), 1861(v), 1871, 1881, 1883, and 1866 of the Social Security Act (42 U.S.C. 1302, 1395f(b), 1395g, 1395l, 1395l(a), (i) and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww).

Subpart C—Limits on Cost Reimbursement

2. In § 413.40, paragraph (c)(4)(iv) is redesignated as paragraph (c)(4)(v), a new paragraph (c)(4)(iv) is added, and paragraph (g)(1) is revised to read as follows:

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

* * * * *

(c) * * *

(4) * * *

(iv) For purposes of the limits on target amounts established under paragraph (c)(4)(iii) of this section, each hospital or unit that qualifies for exclusion as a member of only one class of excluded facility (psychiatric hospital or unit, rehabilitation hospital or unit, or long-term care hospital) will be subject to the limit applicable to that class. If a hospital or unit qualifies to be classified in more than one way under the exclusion criteria in subpart B of part 412 of this chapter, the hospital's or unit's target amount may not exceed the lowest applicable limit.

* * * * *

(g) *Adjustments*—(1) *General rule.* HCFA may adjust the amount of the operating costs considered in establishing the rate-of-increase ceiling for one or more cost reporting periods, including both periods subject to the ceiling and the hospital's base period, under the circumstances specified in paragraphs (g)(2), (g)(3), and (g)(4) of this section. When an adjustment is requested by the hospital, HCFA makes an adjustment only to the extent that the hospital's operating costs are reasonable, attributable to the circumstances specified separately identified by the hospital, and verified by the intermediary. HCFA may grant an adjustment requested by the hospital only if the hospital's operating costs exceed the rate-of-increase ceiling imposed under this section. In the case of a psychiatric hospital or unit,

rehabilitation hospital or unit, or long-term care hospital, the amount of payment made to a hospital after an adjustment under paragraph (g)(3) of this section may not exceed the applicable limit based on 75th percentile of the target amounts for hospitals of the same class as described in § 413.40(c)(4)(iii).

* * * * *

Subpart F—Specific Categories of Costs

3. In § 413.80, paragraph (h) is redesignated as paragraph (i), and a new paragraph (h) is added to read as follows:

§ 413.80 Bad debts, charity, and courtesy allowances.

* * * * *

(h) *Limitations on bad debts.* In determining reasonable costs for hospitals, the amount of bad debts otherwise treated as allowable costs (as defined in paragraph (e) of this section) is reduced—

(1) For cost reporting periods beginning during fiscal year 1998, by 25 percent;

(2) For cost reporting periods beginning during fiscal year 1999, by 40 percent; and

(3) For cost reporting periods beginning during a subsequent fiscal year, by 45 percent.

* * * * *

4. In § 413.85, a new paragraph (h) is added to read as follows:

§ 413.85 Cost of educational activities.

* * * * *

(h) *Medicare+Choice organizations.* (1) Effective January 1, 1999, Medicare+Choice organizations may receive direct graduate medical education payments for the time that residents spend in nonhospital provider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs.

(2) Medicare+Choice organizations may receive direct graduate medical education payments if all of the following conditions are met:

(i) The resident spends his or her time in patient care activities.

(ii) The Medicare+Choice organization incurs ''all or substantially all'' of the costs for the training program in the nonhospital setting as defined in § 413.86(b).

(iii) There is a written agreement between the Medicare+Choice organization and the nonhospital site that indicates the Medicare+Choice organization will incur the costs of the resident's salary and fringe benefits and provide reasonable compensation to the nonhospital site for teaching activities.

(3) A Medicare+Choice organization's allowable direct graduate medical education costs, subject to the redistribution and community support principles in § 413.85(c), consist of—

(i) Residents' salaries and fringe benefits (including travel and lodging where applicable); and

(ii) Reasonable compensation to the nonhospital site for teaching activities related to the training of medical residents.

(4) The direct graduate medical education payment is equal to the product of—

(i) The lower of—

(A) The Medicare+Choice organization's allowable direct graduate medical education costs per resident as defined in paragraph (h)(3) of this section; or

(B) The national average per resident amount; and

(ii) Medicare's share, which is equal to the ratio of the number of Medicare beneficiaries enrolled to the total number of individuals enrolled in the Medicare+Choice organization.

(5) Direct graduate medical education payments made to Medicare+Choice organizations under this section are made from the Federal Supplementary Medical Insurance Trust Fund.

5. In § 413.86, the introductory text of paragraph (b) is republished, a new definition in alphabetical order is added to paragraph (b), paragraphs (i) and (j) are redesignated as paragraphs (j)and (k) respectively, paragraph (f)(2) is redesignated as new paragraph (i), paragraphs (f)(2)(i) through (vii) are redesignated as paragraphs (i)(1) through (7) respectively, the introductory text of paragraph (f)(1) is redesignated as the introductory text of paragraph (f), paragraphs (f)(1)(i) through (iii) are redesignated as paragraphs (f)(1) through (3) respectively, paragraphs (f)(1)(iii)(A) and (B) are redesignated as (f)(3)(i) and (ii) respectively, new paragraphs (f)(2) and (f)(3) introductory text are revised, and a new paragraph (f)(4) is added to read as follows:

§ 413.86 Direct graduate medical education payments.

* * * * *

(b) *Definitions.* For purposes of this section, the following definitions apply:

* * * * *

All or substantially all of the costs for the training program in the nonhospital setting means 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 graduate medical education.

* * * * *

(f) * * *

(2) No individual may be counted as more than one FTE. Except as provided in paragraphs (f)(3) and (4) of this section, if a resident spends time in more than one hospital or, in a nonprovider setting, the resident counts as partial FTE based on the proportion of time worked at the hospital to the total time worked. A part-time resident counts as a partial FTE based on the proportion of allowable time worked compared to the total time necessary to fill a full-time internship or residency slot.

(3) On or after July, 1, 1987 and for portions of cost reporting periods occurring before January 1, 1999, the time residents spend in nonprovider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs is not excluded in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met—

* * * * *

(4) For portions of cost reporting periods occurring on or after January 1, 1999, the time residents spend in nonprovider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs may be included in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met—

(i) The resident spends his or her time in patient care activities.

(ii) The written agreement between the hospital and the nonhospital site must indicate that the hospital will incur the cost of the resident's salary and fringe benefits while the resident is training in the nonhospital site and the hospital is providing reasonable compensation to the nonhospital site for supervisory teaching activities. The agreement must indicate the compensation the hospital is providing to the nonhospital site for supervisory teaching activities.

* * * * *

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

Dated: July 23, 1998.

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

Dated: July 27, 1998.

Donna E. Shalala,

Secretary.

[Editorial Note: The following addendum and appendixes will not appear in the Code of Federal Regulations.]

Addendum—Schedule of Standardized Amounts Effective With Discharges Occurring On or After October 1, 1998, Payment Amounts for Blood Clotting Factor Effective for Discharges Occurring On or After October 1, 1998, and Update Factors and Rate-of-Increase Percentages Effective With Cost Reporting Periods Beginning On or After October 1, 1998

I. Summary and Background

In this addendum, we set forth the amounts and factors for determining prospective payment rates for Medicare inpatient operating costs and Medicare inpatient capital-related costs. In addition, we set forth the updated add-on payment amounts for blood clotting factors. We also set forth rate-of-increase percentages for updating the target amounts for hospitals and hospital units excluded from the prospective payment system.

For discharges occurring on or after October 1, 1998, except for sole community hospitals, Medicare-dependent, small rural hospitals, and hospitals located in Puerto Rico, each hospital's payment per discharge under the prospective payment system will be based on 100 percent of the Federal national rate.

Sole community hospitals are paid based on whichever of the following rates yield the greatest aggregate payment: the Federal national rate, the updated hospital-specific rate based on FY 1982 cost per discharge, or the updated hospital-specific rate based on FY 1987 cost per discharge. Medicare-dependent, small rural hospitals are paid based on the Federal national rate or, if higher, the Federal national rate plus 50 percent of the difference between the Federal national rate and the updated hospital-specific rate based on FY 1982 or FY 1987 cost per discharge, whichever is higher. For hospitals in Puerto Rico, the payment per discharge is based on the sum of 50 percent of a Puerto Rico rate and 50 percent of a national rate.

As discussed below in section II, we are making changes in the determination of the prospective payment rates for Medicare inpatient operating costs. The changes, to be applied prospectively, affect the calculation of the Federal rates. In section III, we are updating the payments per unit for blood clotting factor provided to hospital inpatients who have hemophilia. In section IV of this addendum, we discuss our changes for determining the prospective payment rates for Medicare inpatient capital-related costs. Section V of this addendum sets forth our changes for determining the rate-of-increase limits for hospitals excluded from the prospective payment system. The tables to which we refer in the preamble to this final rule are presented at the end of this addendum in section VI.

II. Changes to Prospective Payment Rates For Inpatient Operating Costs for FY 1999

The basic methodology for determining prospective payment rates for inpatient operating costs is set forth at § 412.63 for hospitals located outside of Puerto Rico. The basic methodology for determining the prospective payment rates for inpatient operating costs for hospitals located in Puerto Rico is set forth at §§ 412.210 and 412.212. Below, we discuss the factors used for determining the prospective payment rates. The Federal and Puerto Rico rate changes will be effective with discharges occurring on or after October 1, 1998. As required by section 1886(d)(4)(C) of the Act, we must also adjust the DRG classifications and weighting factors for discharges in FY 1999.

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

- Updates of 0.5 percent for all areas (that is, the market basket percentage increase of 2.4 percent minus 1.9 percentage points);
- An adjustment to ensure budget neutrality as provided for in sections 1886(d)(4)(C)(iii) and (d)(3)(E) of the Act by applying new budget neutrality adjustment factors to the large urban and other standardized amounts;
- An adjustment to ensure budget neutrality as provided for in section 1886(d)(8)(D) of the Act by removing the FY 1998 budget neutrality factor and applying a revised factor; and
- An adjustment to apply the revised outlier offset by removing the FY 1998 outlier offset and applying a new offset.

The standardized amounts set forth in Tables 1E and 1F of section VI of this addendum, which apply to ''temporary relief'' hospitals (see 62 FR 46001 for a discussion of these hospitals), reflect updates of 0.8 percent for all areas but otherwise reflect the same adjustments as the national standardized amounts. As described in § 412.107, these hospitals receive an update that is 0.3 percentage points more than the update factor applicable to all other prospective payment hospitals for FY 1999.

A. Calculation of Adjusted Standardized Amounts

1. Standardization of Base-Year Costs or Target Amounts

Section 1886(d)(2)(A) of the Act required the establishment of base-year cost data containing allowable operating costs per discharge of inpatient hospital services for each hospital. The preamble to the September 1, 1983 interim final rule (48 FR 39763) contains a detailed explanation of how base-year cost data were established in the initial development of standardized amounts for the prospective payment system and how they are used in computing the Federal rates.

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

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

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

2. Computing Large Urban and Other Area Averages

Sections 1886(d)(2)(D) and (3) of the Act require the Secretary to compute two average standardized amounts for discharges occurring in a fiscal year: one for hospitals located in large urban areas and one for hospitals located in other areas. In addition, under sections 1886(d)(9)(B)(iii) and (C)(i) of the Act, the average standardized amount per discharge must be determined for hospitals located in urban and other areas in Puerto Rico. Hospitals in Puerto Rico are paid a blend of 50 percent of the applicable Puerto Rico standardized amount and 50 percent of a national standardized payment amount.

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

Based on 1997 population estimates published by the Bureau of the Census, 61 areas meet the criteria to be defined as large urban areas for FY 1999. These areas are identified by a footnote in Table 4A. We note that on June 23, 1998, the Office of Management and Budget announced the designation of the Missoula, Montana MSA. We have incorporated this change in this final rule.

3. Updating the Average Standardized Amounts

Under section 1886(d)(3)(A) of the Act, we update the area average standardized amounts each year. In accordance with section 1886(d)(3)(A)(iv) of the Act, we are updating the large urban and the other areas average standardized amounts for FY 1999 using the applicable percentage increases specified in section 1886(b)(3)(B)(i) of the Act. Section 1886(b)(3)(B)(i)(XIV) of the Act specifies that, for hospitals in all areas, the update factor for the standardized amounts for FY 1999 is equal to the market basket percentage increase minus 1.9 percentage points. The ''temporary relief'' provision under section 4401 of Public Law 105–33 provides for an update equal to the market basket percentage increase minus 1.6 percentage points for hospitals that are not Medicare-dependent, small rural hospitals, that receive no IME or DSH payments, that are located in a state in which aggregate Medicare operating payments for such hospitals were less than their aggregate allowable Medicare operating costs for their cost reporting periods beginning during FY 1995, and whose Medicare operating payments are less than their allowable Medicare operating costs for their cost reporting period beginning during FY 1999.

The percentage change in the market basket reflects the average change in the price of goods and services purchased by hospitals to furnish inpatient care. The most recent forecast of the hospital market basket increase for FY 1999 is 2.4 percent. Thus, for FY 1999, the update to the average standardized amounts equals 0.5 percent (0.8 percent for those hospitals qualifying under the ''temporary relief'' provision of Public Law 105–33).

As in the past, we are adjusting the FY 1998 standardized amounts to remove the effects of the FY 1998 geographic reclassifications and outlier payments before applying the FY 1999 updates. That is, we are increasing the standardized amounts to restore the reductions that were made for the effects of geographic reclassification and outliers. We then apply the new offsets to the standardized amounts for outliers and geographic reclassifications for FY 1999.

Although the update factor for FY 1999 is set by law, we are required by section 1886(e)(4)(A) of the Act to report to Congress on our final recommendation of update factors for FY 1999 for both prospective payment hospitals and hospitals excluded from the prospective payment system. We have included our final recommendations in Appendix C to this final rule.

4. Other Adjustments to the Average Standardized Amounts

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

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

To comply with the requirement of section 1886(d)(4)(C)(iii) of the Act that DRG reclassification and recalibration of the relative weights be budget neutral, and the requirement in section 1886(d)(3)(E) of the Act that the updated wage index be budget neutral, and the requirement in section 4410 of Public law 105–33 that application of the floor on the wage index be budget neutral, we used historical discharge data to simulate payments and compared aggregate payments using the FY 1998 relative weights and wage index to aggregate payments using the FY 1999 relative weights and wage index. The same methodology was used for the FY 1998 budget neutrality adjustment. (See the discussion in the September 1, 1992 final rule (57 FR 39832).) Based on this comparison, we computed a budget neutrality adjustment factor equal to 0.999006. We adjust the Puerto Rico-specific standardized amounts for the effect of DRG reclassification and recalibration. We computed a budget neutrality adjustment factor for Puerto Rico-specific standardized amounts equal to 0.998912. These budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the FY 1998 budget neutrality adjustments. We do not remove the prior budget neutrality adjustment because estimated aggregate payments after the changes in the DRG relative weights and wage index should equal estimated aggregate payments prior to the changes. If we removed the prior year adjustment, we would not satisfy this condition.

In addition, we will continue to apply the same FY 1999 adjustment factor to the hospital-specific rates that are effective for cost reporting periods beginning on or after October 1, 1998, in

order to ensure that we meet the statutory requirement that aggregate payments neither increase nor decrease as a result of the implementation of the FY 1999 DRG weights and updated wage index. (See the discussion in the September 4, 1990 final rule (55 FR 36073).)

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

Under section 1886(d)(8)(D) of the Act, the Secretary is required to adjust the standardized amounts so as to ensure that total aggregate payments under the prospective payment system after implementation of the provisions of sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act are equal to the aggregate prospective payments that would have been made absent these provisions. To calculate this budget neutrality factor, we used historical discharge data to simulate payments, and compared total prospective payments (including IME and DSH payments) prior to any reclassifications to total prospective payments after reclassifications. In the proposed rule, we applied an adjustment factor of 0.994019 to ensure that the effects of reclassification are budget neutral. The final budget neutrality adjustment factor is 0.993433.

The adjustment factor is applied to the standardized amounts after removing the effects of the FY 1998 budget neutrality adjustment factor. We note that the proposed FY 1999 adjustment reflected wage index and standardized amount reclassifications approved by the MGCRB or the Administrator as of February 27, 1998. The effects of any additional reclassification changes resulting from appeals and reviews of the MGCRB decisions for FY 1999 or from a hospital's request for the withdrawal of a reclassification request are reflected in the final budget neutrality adjustment that is required under section 1886(d)(8)(D) of the Act and that is published in this final rule.

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

i. FY 1999 Outlier Thresholds. For FY 1998, the fixed loss cost outlier threshold is equal to the prospective payment for the DRG plus the IME and DSH payments plus $11,050 ($10,080 for hospitals that have not yet entered the prospective payment system for capital-related costs). The marginal cost factor for cost outliers (the percent of costs paid after costs for the case exceed the threshold) is 80 percent. We applied an outlier adjustment to the FY 1998 standardized amounts of 0.948840 for the large urban and other areas rates and 0.9382 for the capital Federal rate.

We proposed to establish a fixed loss cost outlier threshold for FY 1999 equal to the prospective payment rate for the DRG plus the IME and DSH payments plus $11,350 ($10,355 for hospitals that have not yet entered the prospective payment system for capital-related costs). In addition, we proposed to maintain the marginal cost factor for cost outliers at 80 percent. In setting the final FY 1999 outlier thresholds, we used updated data and a revised cost inflation factor. In this final rule, we are establishing a fixed loss cost outlier threshold for FY 1999 equal to the prospective payment rate for the DRG plus IME and DSH payments plus $11,100 ($10,129 for hospitals that have not yet entered the prospective payment system for capital-related costs). In addition, we are maintaining the marginal cost factor for cost outliers at 80 percent. In FY 1994, we began using a cost inflation factor rather than a charge inflation factor to update billed charges for purposes of estimating outlier payments. This refinement was made to improve our estimation methodology. For FY 1998, we used a cost inflation factor of minus 2.005 percent (a cost per case decrease of 2.005 percent). In the proposed rule, based on data then available, we used a cost inflation factor of minus 1.831 percent to set outlier thresholds for FY 1999. Based on the most recent data available, we are using a cost inflation factor of minus 1.724 percent to set the final FY 1999 outlier thresholds.

ii. Other changes concerning outliers. In accordance with section 1886(d)(5)(A)(iv) of the Act, we calculated outlier thresholds so that outlier payments are projected to equal 5.1 percent of total payments based on DRG prospective payment rates. In accordance with section 1886(d)(3)(E), we reduced the FY 1999 standardized amounts by the same percentage to account for the projected proportion of payments paid to outliers.

As stated in the September 1, 1993 final rule (58 FR 46348), we establish outlier thresholds that are applicable to both inpatient operating costs and inpatient capital-related costs. When we modeled the combined operating and capital outlier payments, we found that using a common set of thresholds resulted in a higher percentage of outlier payments for capital-related costs than for operating costs. We project that the thresholds for FY 1999 will result in outlier payments equal to 5.1 percent of operating DRG payments and 6.1 percent of capital payments based on the Federal rate.

The proposed outlier adjustment factors applied to the standardized amounts for FY 1999 were as follows:

	Operating standard-ized amounts	Capital federal rate
National	0.948819	0.9378
Puerto Rico	0.972962	0.9626

The final outlier adjustment factors applied to the standardized amounts for FY 1999 are as follows:

	Operating standard-ized amounts	Capital federal rate
National	0.948740	0.9392
Puerto Rico	0.972959	0.9634

As in the proposed rule, we apply the outlier adjustment factors after removing the effects of the FY 1998 outlier adjustment factors on the standardized amounts.

Table 8A in section VI of this addendum contains the updated Statewide average operating cost-to-charge ratios for urban hospitals and for rural hospitals to be used in calculating cost outlier payments for those hospitals for which the intermediary is unable to compute a reasonable hospital-specific cost-to-charge ratio. These Statewide

average ratios would replace the ratios published in the August 29, 1997 final rule with comment period (62 FR 46113), effective October 1, 1998. Table 8B contains comparable Statewide average capital cost-to-charge ratios. These average ratios would be used to calculate cost outlier payments for those hospitals for which the intermediary computes operating cost-to-charge ratios lower than 0.217484 or greater than 1.27282 and capital cost-to-charge ratios lower than 0.01313 or greater than 0.17490. This range represents 3.0 standard deviations (plus or minus) from the mean of the log distribution of cost-to-charge ratios for all hospitals. We note that the cost-to-charge ratios in Tables 8A and 8B will be used during FY 1999 when hospital-specific cost-to-charge ratios based on the latest settled cost report are either not available or outside the three standard deviations range.

iii. FY 1997 and FY 1998 outlier payments. In the August 29, 1997 final rule with comment period (62 FR 46041), we stated that, based on available data, we estimated that actual FY 1997 outlier payments would be approximately 4.8 percent of actual total DRG payments. This was computed by simulating payments using actual FY 1996 bill data available at the time. That is, the estimate of actual outlier payments did not reflect actual FY 1997 bills but instead reflected the application of FY 1997 rates and policies to available FY 1996 bills. Our current estimate, using available FY 1997 bills, is that actual outlier payments for FY 1997 were approximately 5.5 percent of actual total DRG payments. We note that the MedPAR file for FY 1997 discharges continues to be updated.

We currently estimate that actual outlier payments for FY 1998 will be approximately 5.4 percent of actual total DRG payments, slightly higher than the 5.1 percent we projected in setting outlier policies for FY 1998. This estimate is based on simulations using the March 1998 update of the provider-specific file and the March 1998 update of the FY 1997 MedPAR file (discharge data for FY 1997 bills). We used these data to calculate an estimate of the actual outlier percentage for FY 1998 by applying FY 1998 rates and policies to available FY 1997 bills.

We received one comment on outliers, which commended us for improving our outlier estimation methodology.

5. FY 1999 Standardized Amounts

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

B. Adjustments for Area Wage Levels and Cost of Living

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

1. Adjustment for Area Wage Levels

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

2. Adjustment for Cost of Living in Alaska and Hawaii

Section 1886(d)(5)(H) of the Act authorizes an adjustment to take into account the unique circumstances of hospitals in Alaska and Hawaii. Higher labor-related costs for these two States are taken into account in the adjustment for area wages described above. For FY 1999, we are adjusting the payments for hospitals in Alaska and Hawaii by multiplying the nonlabor portion of the standardized amounts by the appropriate adjustment factor contained in the table below.

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

Alaska—All areas	1.25
Hawaii:	.....
County of Honolulu	1.225
County of Hawaii	1.15
County of Kauai	1.225
County of Maui	1.225
County of Kalawao	1.225

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

C. DRG Relative Weights

As discussed in section II of the preamble, we have developed a classification system for all hospital discharges, assigning them into DRGs, and have developed relative weights for each DRG that reflect the resource utilization of cases in each DRG relative to Medicare cases in other DRGs. Table 5 of section VI of this addendum contains the relative weights that we will use for discharges occurring in FY 1999. These factors have been recalibrated as explained in section II.C of the preamble.

D. Calculation of Prospective Payment Rates for FY 1999 General Formula for Calculation of Prospective Payment Rates for FY 1999

Prospective payment rate for all hospitals located outside of Puerto Rico except sole community hospitals and Medicare-dependent, small rural hospitals = Federal rate.

Prospective payment rate for sole community hospitals = Whichever of the following rates yields the greatest aggregate payment: 100 percent of the Federal rate, 100 percent of the updated FY 1982 hospital-specific rate, or 100 percent of the updated FY 1987 hospital-specific rate.

Prospective payment rate for Medicare-dependent, small rural hospitals = 100 percent of the Federal rate plus, if the greater of the updated FY 1982 hospital-specific rate or the updated FY 1987 hospital-specific rate is higher than the Federal rate, 50 percent of the difference between the applicable hospital-specific rate and the Federal rate.

Prospective payment rate for Puerto Rico = 50 percent of the Puerto Rico rate + 50 percent of a discharge-weighted average of the national large urban standardized amount and the national other standardized amount.

1. Federal Rate

For discharges occurring on or after October 1, 1998 and before October 1,

1999, except for sole community hospitals, Medicare-dependent, small rural hospitals, and hospitals in Puerto Rico, the hospital's payment is based exclusively on the Federal national rate.

The payment amount is determined as follows:

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

Step 2—Multiply the labor-related portion of the standardized amount by the applicable wage index (see Tables 4A, 4B, and 4C in section VI of this addendum).

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

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

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

2. Hospital-Specific Rate (Applicable Only to Sole Community Hospitals and Medicare-Dependent, Small Rural Hospitals)

Sections 1886(d)(5)(D)(i) and (b)(3)(C) of the Act provide that sole community hospitals are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal rate, the updated hospital-specific rate based on FY 1982 cost per discharge, or the updated hospital-specific rate based on FY 1987 cost per discharge.

Sections 1886(d)(5)(G) and (b)(3)(D) of the Act provide that Medicare-dependent, small rural hospitals are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal rate or the Federal rate plus 50 percent of the difference between the Federal rate and the greater of the updated hospital-specific rate based on FY 1982 and FY 1987 cost per discharge.

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

a. Updating the FY 1982 and FY 1987 hospital-specific rates for FY 1999. We are increasing the hospital-specific rates by 0.5 percent (the hospital market basket percentage increase of 2.4 percent minus 1.9 percentage points) for sole community hospitals and Medicare-dependent, small rural hospitals located in all areas for FY 1999. Section 1886(b)(3)(C)(iv) of the Act provides that the update factor applicable to the hospital-specific rates for sole community hospitals equals the update factor provided under section 1886(b)(3)(B)(iv) of the Act, which, for FY 1999, is the market basket rate of increase minus 1.9 percentage points. Section 1886(b)(3)(D) of the Act provides that the update factor applicable to the hospital-specific rates for Medicare-dependent, small rural hospitals equals the update factor provided under section 1886(b)(3)(B)(iv) of the Act, which, for FY 1999, is the market basket rate of increase minus 1.9 percentage points.

b. Calculation of hospital-specific rate. For sole community hospitals and Medicare-dependent, small rural hospitals, the applicable FY 1999 hospital-specific rate would be calculated by increasing the hospital's hospital-specific rate for the preceding fiscal year by the applicable update factor (0.5 percent), which is the same as the update for all prospective payment hospitals except ''temporary relief'' hospitals. In addition, the hospital-specific rate would be adjusted by the budget neutrality adjustment factor (that is, 0.999006) as discussed in section II.A.4.a of this Addendum. This resulting rate would be used in determining under which rate a sole community hospital or Medicare-dependent, small rural hospital is paid for its discharges beginning on or after October 1, 1998, based on the formula set forth above.

3. General Formula for Calculation of Prospective Payment Rates for Hospitals Located in Puerto Rico Beginning on or After October 1, 1998 and Before October 1, 1999

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

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

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

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

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

Step 5—Multiply the amount from Step 4 by the appropriate DRG relative weight (see Table 5 in section VI of this addendum).

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

Step 1—Multiply the labor-related portion of the national average standardized amount (see Table 1C or 1F of section VI of the addendum) by the appropriate national wage index (see Tables 4A and 4B in section VI of this addendum).

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

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

Step 4—Multiply the amount from Step 3 by the appropriate DRG relative weight (see Table 5 in section VI of this addendum).

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

III. Changes to the Payment Rates for Blood Clotting Factor for Hemophilia Inpatients

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

We are calculating the add-on payment for FY 1999 using the same methodology we described in the August 29, 1997 and May 12, 1998 final rules. That is, we are establishing a price per unit of clotting factor based on the average wholesale price (AWP). To identify the AWP, we are using the most recent data available from First Databank. The add-on payment amount for each clotting factor, as described by HCFA's Common Procedure Coding System (HCPCS), is based on the median AWP of the several products available in that category of factor, discounted by 15 percent.

Based on this methodology, the prices per unit of factor for FY 1999 are as follows:

J7190 Factor VIII (antihemophilic factor, human)	0.78
J7192 Factor VIII (antihemophilic factor, recombinant)	1.00
J7194 Factor IX (complex)	0.38
J7196 Other hemophilia clotting factors (e.g., anti-inhibitors)	1.10
Q0160 Factor IX (antihemophilic factor, purified, nonrecombinant)	0.93
Q0161 Factor IX (antihemophilic factor, purified, recombinant)	1.00

These prices for blood clotting factor administered to inpatients who have hemophilia will be effective for discharges beginning on or after October 1, 1998 through September 30, 1999. Payment will be made for blood clotting factor only if there is an ICD–9–CM diagnosis code for hemophilia included on the bill.

IV. Changes to Payment Rates for Inpatient Capital-Related Costs for FY 1999

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

The basic methodology for determining Federal capital prospective rates is set forth at §§ 412.308 through 412.352. Below we discuss the factors that we used to determine the Federal rate and the hospital-specific rates for FY 1999. The rates will be effective for discharges occurring on or after October 1, 1998.

For FY 1992, we computed the standard Federal payment rate for capital-related costs under the prospective payment system by updating the FY 1989 Medicare inpatient capital cost per case by an actuarial estimate of the increase in Medicare inpatient capital costs per case. Each year after FY 1992 we update the standard Federal rate, as provided in § 412.308(c)(1), to account for capital input price increases and other factors. Also, § 412.308(c)(2) provides that the Federal rate is adjusted annually by a factor equal to the estimated proportion of outlier payments under the Federal rate to total capital payments under the Federal rate. In addition, § 412.308(c)(3) requires that the Federal rate be reduced by an adjustment factor equal to the estimated proportion of payments for exceptions under § 412.348. Furthermore, § 412.308(c)(4)(ii) requires that the Federal rate be adjusted so that the annual DRG reclassification and the recalibration of DRG weights and changes in the geographic adjustment factor are budget neutral. For FYs 1992 through 1995, § 412.352 required that the Federal rate also be adjusted by a budget neutrality factor so that aggregate payments for inpatient hospital capital costs were projected to equal 90 percent of the payments that would have been made for capital-related costs on a reasonable cost basis during the fiscal year. That provision expired in FY 1996. Section 412.308(b)(2) describes the 7.4 percent reduction to the rate made in FY 1994, and § 412.308(b)(3) describes the 0.28 percent reduction to the rate made in FY 1996 as a result of the revised policy of paying for transfers. In the FY 1998 final rule with comment period (62 FR 45966) we implemented section 4402 of the BBA, which required that for discharges occurring on or after October 1, 1997 and before October 1, 2002, the unadjusted standard Federal rate is reduced by 17.78 percent. A small part of that reduction will be restored effective October 1, 2002.

For each hospital, the hospital-specific rate was calculated by dividing the hospital's Medicare inpatient capital-related costs for a specified base year by its Medicare discharges (adjusted for transfers), and dividing the result by the hospital's case mix index (also adjusted for transfers). The resulting case-mix adjusted average cost per discharge was then updated to FY 1992 based on the national average increase in Medicare's inpatient capital cost per discharge and adjusted by the exceptions payment adjustment factor and the budget neutrality adjustment factor to yield the FY 1992 hospital-specific rate. Since FY 1992, the hospital-specific rate has been updated annually for inflation and for changes in the exceptions payment adjustment factor. For FYs 1992 through 1995, the hospital-specific rate was also adjusted by a budget neutrality adjustment factor. In the FY 1998 final rule with comment period (62 FR 46012) we implemented section 4402 of the BBA, which required that for discharges occurring on or after October 1, 1997 and before October 1, 2002, the unadjusted hospital-specific rate is reduced by 17.78 percent. A small part of that reduction will also be restored effective October 1, 2002.

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

In accordance with section 1886(d)(9)(A) of the Act, under the prospective payment system for inpatient operating costs, hospitals located in Puerto Rico are paid for operating costs under a special payment formula. Prior to FY 1998, hospitals in Puerto Rico were paid a blended rate that consisted of 75 percent of the applicable standardized amount specific to Puerto Rico hospitals and 25 percent of the applicable national average standardized amount. However, effective October 1, 1997, as a result of section 4406 of the BBA, operating payments to hospitals in Puerto Rico are based on a blend of 50 percent of the applicable standardized amount specific to Puerto Rico hospitals and 50 percent of the applicable national average standardized amount. In conjunction with this change to the operating blend percentage, effective with discharges on or after October 1, 1997, we compute capital payments to hospitals in Puerto Rico based on a blend of 50 percent of the Puerto Rico rate and 50 percent of the Federal rate. Section 412.374 provides for the use of this blended payment system for payments to Puerto Rico hospitals under the prospective payment system for inpatient capital-related costs. Accordingly, for capital-related costs we compute a separate payment rate specific to Puerto Rico hospitals using the same methodology used to compute the national Federal rate for capital.

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

For FY 1998, the Federal rate was $371.51. In the proposed rule, we stated that the proposed FY 1999 Federal rate was $377.25. In this final rule, we are establishing a FY 1999 Federal rate of $378.05.

In the discussion that follows, we explain the factors that were used to determine the FY 1999 Federal rate. In particular, we explain why the FY 1999 Federal rate has increased 1.76 percent compared to the FY 1998 Federal rate. Even though we estimate that Medicare hospital inpatient discharges will decline by approximately 2.25 percent between FY 1998 and FY 1999, we also estimate that aggregate capital payments

will increase by 2.78 percent during this same period. This aggregate increase is primarily due to the change in the federal rate blend percentage from 70 percent to 80 percent, the 1.76 percent increase in the rate, and a projected increase in case mix.

The major factor contributing to the increase in the capital Federal rate for FY 1999 relative to FY 1998 is that the FY 1999 exceptions reduction factor is 1.28 percent higher than the factor for FY 1998. The exceptions reduction factor equals 1 minus the projected percentage of exceptions payments. We estimate that the projected percentage of exceptions payments for FY 1999 will be lower than the projected percentage for FY 1998; accordingly, the FY 1999 rate reflects less of a reduction to account for exceptions than the FY 1998 rate.

Total payments to hospitals under the prospective payment system are relatively unaffected by changes in the capital prospective payments. Since capital payments constitute about 10 percent of hospital payments, a 1 percent change in the capital Federal rate yields only about 0.1 percent change in actual payments to hospitals. Aggregate payments under the capital prospective payment transition system are estimated to increase in FY 1999 compared to FY 1998.

1. Standard Federal Rate Update

a. Description of the update framework. Under section 412.308(c)(1), the standard Federal rate is updated on the basis of an analytical framework that takes into account changes in a capital input price index (CIPI) and other factors. The update framework consists of a CIPI and several policy adjustment factors. Specifically, we have adjusted the projected CIPI rate of increase as appropriate each year for case-mix index related changes, for intensity, and for errors in previous CIPI forecasts. The proposed rule reflected an update factor of 0.2 percent, based on data available at that time. Under the update framework the final update factor for FY 1999 is 0.1 percent. This update factor is based on a projected 0.7 percent increase in the CIPI, policy adjustment factors of −0.2, and a forecast error correction of −0.4 percent. We explain the basis for the FY 1999 CIPI projection in section D of this addendum. Here we describe the policy adjustments that have been applied.

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

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

- The average resource use of Medicare patients changes (''real'' case-mix change);
- Changes in hospital coding of patient records result in higher weight DRG assignments (''coding effects''); and
- The annual DRG reclassification and recalibration changes may not be budget neutral (''reclassification effect'').

We define real case-mix change as actual changes in the mix (and resource requirements) of Medicare patients as opposed to changes in coding behavior that result in assignment of cases to higher-weighted DRGs but do not reflect higher resource requirements. In the update framework for the prospective payment system for operating costs, we adjust the update upwards to allow for real case-mix change, but remove the effects of coding changes on the case-mix index. We also remove the effect on total payments of prior changes to the DRG classifications and relative weights, in order to retain budget neutrality for all case-mix index-related changes other than patient severity. (For example, we adjusted for the effects of the FY 1992 DRG reclassification and recalibration as part of our FY 1994 update recommendation.) The operating adjustment consists of a reduction for total observed case-mix change, an increase for the portion of case-mix change that we determine is due to real case-mix change rather than coding modifications, and an adjustment for the effect of prior DRG reclassification and recalibration changes. We have adopted this case-mix index adjustment in the capital update framework as well.

For FY 1999, we are projecting a 1.0 percent increase in the case-mix index. We estimate that real case-mix increase will equal 0.8 percent in FY 1999. Therefore, the net adjustment for case-mix change in FY 1999 is—0.2 percentage points.

We estimate that DRG reclassification and recalibration result in a 0.0 percent change in the case mix when compared with the case-mix index that would have resulted if we had not made the reclassification and recalibration changes to the DRGs.

The capital update framework contains an adjustment for forecast error. The input price index forecast is based on historical trends and relationships ascertainable at the time the update factor is established for the upcoming year. In any given year there may be unanticipated price fluctuations that may result in differences between the actual increase in prices faced by hospitals and the forecast used in calculating the update factors. In setting a prospective payment rate under the framework, we make an adjustment for forecast error only if our estimate of the capital input price index rate of increase for any year is off by 0.25 percentage points or more. There is a 2-year lag between the forecast and the measurement of the forecast error. We estimate a forecast error of −0.4 percentage points in the update for FY 1997. That is, current data indicate that the FY 1997 CIPI used in calculating the FY 1997 update factor overstated price increases by 0.4 percent. Therefore we are making a −0.4 percent adjustment for forecast error in the update for FY 1999.

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

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

For FY 1999, we have developed a Medicare-specific intensity measure based on a 5-year average using FY 1993–1997 data. In determining case-mix constant intensity, we found that observed case-mix increase was 0.9 percent in FY 1993, 0.8 percent in FY 1994, 1.7 percent in FY 1995, 1.6 percent in FY 1996, and 0.3 percent in FY 1997. For FY 1995 and FY 1996, we estimate that real case-mix increase was 1.0 to 1.4 percent each year. The estimate for those years is supported by past studies of case-mix change by the RAND Corporation. The most recent study was ''Has DRG Creep Crept Up? Decomposing the Case Mix Index Change Between 1987 and 1988'' by G. M. Carter, J. P. Newhouse, and D. A. Relles, R–4098–HCFA/ProPAC (1991). The study suggested that real case-mix change was not dependent on total change, but was usually a fairly steady 1.0 to 1.5 percent per year. We use 1.4 percent as the upper bound because the RAND study did not take into account that hospitals may have induced doctors to document medical records more completely in order to improve payment. Following that study, we consider up to 1.4 percent of observed case-mix change as real for FY 1992 through FY 1997. Based on this analysis, we believe that all of the observed case-mix increase for FY 1993, FY 1994 and FY 1997 is real.

We calculate case-mix constant intensity as the change in total charges per admission, adjusted for price level changes (the CPI hospital component), and changes in real case-mix. Given estimates of real case mix of 0.9 percent for FY 1993, 0.8 percent for FY 1994, 1.0 percent for FY 1995, and 1.0 percent for FY 1996, and 0.3 percent for FY 1997, we estimate that case-mix constant intensity declined by an average 1.5 percent during FYs 1993 through 1997, for a cumulative decrease of 7.3 percent. If we assume that real case-mix increase was 0.9 percent for FY 1993, 0.8 percent for FY 1994, 1.4 percent for FY 1995, 1.4 percent for FY 1996 and 0.3 percent for FY 1997, we estimate that case-mix constant intensity declined by an average 1.6 percent during FYs 1993 through 1997, for a cumulative decrease of 7.7 percent. Since we estimate that intensity has declined during that period, we are making a 0.0 percent intensity adjustment for FY 1999.

In summary, the FY 1999 final update under our framework is 0.1 percent. This update factor is based on a projected 0.7 percent increase in the CIPI, policy adjustment factors of −0.2, and a forecast error correction of −0.4 percent.

b. Comparison of HCFA and MedPAC update recommendations. As discussed in the proposed rule, MedPAC recommended a 0.0 to 0.7 percent update to the standard Federal rate and we recommended a 0.2 percent update. (See the May 8, 1998 proposed rule for a discussion of the differences between the MedPAC and HCFA update frameworks (63 FR 25615)). In this final rule, as discussed in the previous section, we are implementing a 0.1 percent update to the capital Federal rate.

Comment: MedPAC noted our update recommendation of 0.2 percent was within the range of the 0.0 percent to 0.7 percent update which they had recommended. They also restated a comment from their March report, that although the operating and capital payment rates are determined separately, they are related to the costs generated by providing hospital services to the same Medicare patients, and distinguishing between them for payment purposes is arbitrary and does not foster efficient hospital decision-making about resource allocation. Since the transition to fully prospective payment for capital will end on September 30, 2001, the objective of combining the two payment systems should be kept in mind.

Response: Several years ago ProPAC made a similar comment recommending the adoption of a single update framework for adjusting operating and capital prospective payment rates when the transition to full Federal rate capital payments is complete. In the September 1, 1995 prospective payment system final rule (60 FR 45816) we responded that our long term goal was to develop a single update framework and that we would begin development of a unified framework. We stated that in the meantime we would maintain as much consistency as possible with the current operating framework in order to facilitate the eventual development of a unified framework. We believe that because of the similarities in the operating and capital update frameworks, they could be combined without too much difficulty. We maintain our goal of combining the update frameworks at the end of the capital transition period and may examine combining the payment systems post transition.

2. Outlier Payment Adjustment Factor

Section 412.312(c) establishes a unified outlier methodology for inpatient operating and inpatient capital-related costs. A single set of thresholds is used to identify outlier cases for both inpatient operating and inpatient capital-related payments. Outlier payments are made only on the portion of the Federal rate that is used to calculate the hospital's inpatient capital-related payments (for example, 80 percent for cost reporting periods beginning in FY 1999 for hospitals paid under the fully prospective methodology). Section 412.308(c)(2) provides that the standard Federal rate for inpatient capital-related costs be reduced by an adjustment factor equal to the estimated proportion of outlier payments under the Federal rate to total inpatient capital-related payments under the Federal rate. The outlier thresholds are set so that operating outlier payments are projected to be 5.1 percent of total operating DRG payments. The inpatient capital-related outlier reduction factor reflects the inpatient capital-related outlier payments that would be made if all hospitals were paid 100 percent of the Federal rate. For purposes of calculating the outlier thresholds and the outlier reduction factor, we model payments as if all hospitals were paid 100 percent of the Federal rate because, as explained above, outlier payments are made only on the portion of the Federal rate that is included in the hospital's inpatient capital-related payments.

In the August 29, 1997 final rule with comment period, we estimated that outlier payments for capital in FY 1998 would equal 6.18 percent of inpatient capital-related payments based on the Federal rate. Accordingly, we applied an outlier adjustment factor of 0.9382 to the Federal rate. For FY 1999, we estimate that outlier payments for capital will equal 6.08 percent of inpatient capital-related payments based on the Federal rate. We are, therefore, establishing an outlier adjustment factor of 0.9392 to the Federal rate. Thus, estimated capital outlier payments for FY 1999 represent a smaller percentage of total capital standard payments than in FY 1998.

The outlier reduction factors are not built permanently into the rates; that is, they are not applied cumulatively in determining the Federal rate. Therefore, the net change in the outlier adjustment to the Federal rate for FY 1999 is 1.0011 (0.9392/0.9382). Thus, the outlier adjustment increases the FY 1999 Federal rate by 0.11 percent (1.0011–1) compared with the FY 1998 outlier adjustment.

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

Section 412.308(c)(4)(ii) requires that the Federal rate be adjusted so that

aggregate payments for the fiscal year based on the Federal rate after any changes resulting from the annual DRG reclassification and recalibration and changes in the GAF are projected to equal aggregate payments that would have been made on the basis of the Federal rate without such changes. We use the actuarial model, described in Appendix B, to estimate the aggregate payments that would have been made on the basis of the Federal rate without changes in the DRG classifications and weights and in the GAF. We also use the model to estimate aggregate payments that would be made on the basis of the Federal rate as a result of those changes. We then use these figures to compute the adjustment required to maintain budget neutrality for changes in DRG weights and in the GAF.

For FY 1998, we calculated a GAF/DRG budget neutrality factor of 0.9989. In the proposed rule for FY 1999, we proposed a GAF/DRG budget neutrality factor of 1.0032. In this final rule, based on calculations using updated data, we are applying a factor of 1.0027. The GAF/DRG budget neutrality factors are built permanently into the rates; that is, they are applied cumulatively in determining the Federal rate. This follows from the requirement that estimated aggregate payments each year be no more than they would have been in the absence of the annual DRG reclassification and recalibration and changes in the GAF. The incremental change in the adjustment from FY 1998 to FY 1999 is 1.0027. The cumulative change in the rate due to this adjustment is 1.0028 (the product of the incremental factors for FY 1993, FY 1994, FY 1995, FY 1996, FY 1997, FY 1998, and FY 1999: 0.9980 x 1.0053 x 0.9998 x 0.9994 x 0.9987 x 0.9989 x 1.0027 = 1.0028).

This factor accounts for DRG reclassifications and recalibration and for changes in the GAF. It also incorporates the effects on the GAF of FY 1999 geographic reclassification decisions made by the MGCRB compared to FY 1998 decisions. However, it does not account for changes in payments due to changes in the disproportionate share and indirect medical education adjustment factors or in the large urban add-on.

4. Exceptions Payment Adjustment Factor

Section 412.308(c)(3) requires that the standard Federal rate for inpatient capital-related costs be reduced by an adjustment factor equal to the estimated proportion of additional payments for exceptions under § 412.348 relative to total payments under the hospital-specific rate and Federal rate. We use an actuarial model described in Appendix B to determine the exceptions payment adjustment factor.

For FY 1998, we estimated that exceptions payments would equal 3.41 percent of aggregate payments based on the Federal rate and the hospital-specific rate. Therefore, we applied an exceptions reduction factor of 0.9659 (1—0.0341) in determining the Federal rate. In the May 8, 1998 proposed rule, we estimated that exceptions payments for FY 1999 would equal 2.39 percent of aggregate payments based on the Federal rate and the hospital-specific rate. Therefore, we proposed an exceptions payment reduction factor of 0.9761 to the Federal rate for FY 1999. For this final rule, based on updated data, we estimate that exceptions payments for FY 1999 will equal 2.17 percent of aggregate payments based on the Federal rate and the hospital-specific rate. We are, therefore, applying an exceptions payment reduction factor of 0.9783 (1—0.0217) to the Federal rate for FY 1999. The final exceptions reduction factor for FY 1999 is 1.28 percent higher than the factor for FY 1998 and .23 percent higher than the factor in the FY 1999 proposed rule.

The exceptions reduction factors are not built permanently into the rates; that is, the factors are not applied cumulatively in determining the Federal rate. Therefore, the net adjustment to the FY 1999 Federal rate is 0.9783/0.9659, or 1.0128.

5. Standard Capital Federal Rate for FY 1999

For FY 1998, the capital Federal rate was $371.51. With the changes we proposed to the factors used to establish the Federal rate, we proposed that the FY 1999 Federal rate would be $377.25. In this final rule, we are establishing a FY 1999 Federal rate of $378.05. The Federal rate for FY 1999 was calculated as follows:

- The FY 1999 update factor is 1.0010, that is, the update is 0.10 percent.
- The FY 1999 budget neutrality adjustment factor that is applied to the standard Federal payment rate for changes in the DRG relative weights and in the GAF is 1.0027.
- The FY 1999 outlier adjustment factor is 0.9392.
- The FY 1999 exceptions payments adjustment factor is 0.9783.

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

We are providing a chart that shows how each of the factors and adjustments for FY 1999 affected the computation of the FY 1999 Federal rate in comparison to the FY 1998 Federal rate. The FY 1999 update factor has the effect of increasing the Federal rate by 0.10 percent compared to the rate in FY 1998, while the final geographic and DRG budget neutrality factor has the effect of increasing the Federal rate by 0.27 percent. The FY 1999 outlier adjustment factor has the effect of increasing the Federal rate by 0.11 percent compared to FY 1998. The FY 1999 exceptions reduction factor has the effect of increasing the Federal rate by 1.27 percent compared to the exceptions reduction factor for FY 1998. The combined effect of all the changes is to increase the Federal rate by 1.76 percent compared to the Federal rate for FY 1998.

COMPARISON OF FACTORS AND ADJUSTMENTS—FY 1998 FEDERAL RATE AND FY 1999 FEDERAL RATE

	FY 98	FY 99	Change	Percent change
Update factor [1]	1.0090	1.0010	1.0010	0.10
GAF/DRG Adjustment Factor [1]	0.9989	1.0027	1.0027	0.27
Outlier Adjustment Factor [2]	0.9382	0.9392	1.0011	0.11
Exceptions Adjustment Factor [2]	0.9659	0.9783	1.0128	1.28
Federal Rate	$371.51	$378.05	1.0176	1.76

[1] The update factor and the GAF/DRG budget neutrality factors are built permanently into the rates. Thus, for example, the incremental change from FY 1998 to FY 1999 resulting from the application of the GAF/DRG budget neutrality factor for FY 1999 is 1.0027.

[2] The outlier reduction factor and the exceptions reduction factor are not built permanently into the rates; that is, these factors are not applied cumulatively in determining the rates. Thus, for example, the net change resulting from the application of the FY 1999 outlier reduction factor is 0.9392/0.9382, or 1.0011.

We are also providing a chart that shows how the final FY 1999 Federal rate differs from the proposed FY 1999 Federal rate.

COMPARISON OF FACTORS AND ADJUSTMENTS—FY 1999 PROPOSED FEDERAL RATE AND FY 1999 FINAL FEDERAL RATE

	Proposed FY 99	Final FY 99	Change	Percent change
Update factor	1.0020	1.0010	0.9990	−0.10
GAF/DRG Adjustment Factor	1.0032	1.0027	0.9995	−0.05
Outlier Adjustment Factor	0.9378	0.9392	1.0015	0.15
Exceptions Adjustment Factor	0.9761	0.9783	1.0023	0.23
Federal Rate	$377.25	$378.05	1.0021	0.21

6. Special Rate for Puerto Rico Hospitals

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

Since we implemented a separate GAF for Puerto Rico, we applied separate budget neutrality adjustments for the national GAF and for the Puerto Rico GAF. We applied the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. Separate adjustments were unnecessary for FY 1998 since the Puerto Rico specific GAF was implemented that year. For FY 1999 the Puerto Rico GAF budget neutrality factor is 0.9988, while the DRG adjustment is 1.0034, for a combined cumulative adjustment of 1.0022. (For a more detailed explanation of this change see Appendix B.)

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

For FY 1998, before application of the GAF, the special rate for Puerto Rico hospitals was $177.57. With the changes we proposed to the factors used to determine the rate, the proposed FY 1999 special rate for Puerto Rico was $180.73. In this final rule, the FY 1999 capital rate for Puerto Rico is $181.10.

B. Determination of Hospital-Specific Rate Update

Section 412.328(e) of the regulations provides that the hospital-specific rate for FY 1999 be determined by adjusting the FY 1998 hospital-specific rate by the following factors:

1. Hospital-Specific Rate Update Factor

The hospital-specific rate is updated in accordance with the update factor for the standard Federal rate determined under § 412.308(c)(1). For FY 1999, we are updating the hospital-specific rate by a factor of 1.0010.

2. Exceptions Payment Adjustment Factor

For FYs 1992 through FY 2001, the updated hospital-specific rate is multiplied by an adjustment factor to account for estimated exceptions payments for capital-related costs under § 412.348, determined as a proportion of the total amount of payments under the hospital-specific rate and the Federal rate. For FY 1999, we estimated in the proposed rule that exceptions payments would be 2.39 percent of aggregate payments based on the Federal rate and the hospital-specific rate. Therefore, we proposed that the updated hospital-specific rate be adjusted by a factor of 0.9761. In this final rule, we estimate that exceptions payments will be 2.17 percent of aggregate payments based on the Federal rate and the hospital-specific rate. Accordingly, for FY 1999, we are applying an exceptions reduction factor of 0.9783 to the hospital-specific rate. The exceptions reduction factors are not built permanently into the rates; that is, the factors are not applied cumulatively in determining the hospital-specific rate. The net adjustment to the FY 1999 hospital-specific rate is 0.9783/0.9659, or 1.0128.

3. Net Change to Hospital-Specific Rate

We are providing a chart to show the net change to the hospital-specific rate. The chart shows the factors for FY 1998 and FY 1999 and the net adjustment for each factor. It also shows that the cumulative net adjustment from FY 1998 to FY 1999 is 1.0138, which represents a increase of 1.38 percent to the hospital-specific rate. For each hospital, the FY 1999 hospital-specific rate is determined by multiplying the FY 1998 hospital-specific rate by the cumulative net adjustment of 1.0138.

FY 1999 UPDATE AND ADJUSTMENTS TO HOSPITAL-SPECIFIC RATES

	FY 98	FY 99	Net adjustment	Percent change
Update Factor	1.0090	1.0010	1.0010	0.10
Exceptions Payment Adjustment Factor	0.9659	0.9783	1.0128	1.28

FY 1999 UPDATE AND ADJUSTMENTS TO HOSPITAL-SPECIFIC RATES—Continued

	FY 98	FY 99	Net adjustment	Percent change
Cumulative Adjustments	0.9746	0.9880	1.0138	1.38

Note: The update factor for the hospital-specific rate is applied cumulatively in determining the rates. Thus, the incremental increase in the update factor from FY 1998 to FY 1999 is 1.0020. In contrast, the exceptions payment adjustment factor is not applied cumulatively. Thus, for example, the incremental increase in the exceptions reduction factor from FY 1998 to FY 1999 is 0.9783/0.9659, or 1.0128.

C. Calculation of Inpatient Capital-Related Prospective Payments for FY 1999

During the capital prospective payment system transition period, a hospital is paid for the inpatient capital-related costs under one of two payment methodologies—the fully prospective payment methodology or the hold-harmless methodology. The payment methodology applicable to a particular hospital is determined when a hospital comes under the prospective payment system for capital-related costs by comparing its hospital-specific rate to the Federal rate applicable to the hospital's first cost reporting period under the prospective payment system. The applicable Federal rate was determined by making adjustments as follows:

- For outliers by dividing the standard Federal rate by the outlier reduction factor for that fiscal year; and,
- For the payment adjustment factors applicable to the hospital (that is, the hospital's GAF, the disproportionate share adjustment factor, and the indirect medical education adjustment factor, when appropriate).

If the hospital-specific rate is above the applicable Federal rate, the hospital is paid under the hold-harmless methodology. If the hospital-specific rate is below the applicable Federal rate, the hospital is paid under the fully prospective methodology.

For purposes of calculating payments for each discharge under both the hold-harmless payment methodology and the fully prospective payment methodology, the standard Federal rate is adjusted as follows: (Standard Federal Rate) x (DRG weight) x (GAF) x (Large Urban Add-on, if applicable) x (COLA adjustment for hospitals located in Alaska and Hawaii) x (1 + Disproportionate Share Adjustment Factor + IME Adjustment Factor, if applicable). The result is the adjusted Federal rate.

Payments under the hold-harmless methodology are determined under one of two formulas. A hold-harmless hospital is paid the higher of the following:

- 100 percent of the adjusted Federal rate for each discharge; or
- An old capital payment equal to 85 percent (100 percent for sole community hospitals) of the hospital's allowable Medicare inpatient old capital costs per discharge for the cost reporting period plus a new capital payment based on a percentage of the adjusted Federal rate for each discharge. The percentage of the adjusted Federal rate equals the ratio of the hospital's allowable Medicare new capital costs to its total Medicare inpatient capital-related costs in the cost reporting period.

Once a hospital receives payment based on 100 percent of the adjusted Federal rate in a cost reporting period beginning on or after October 1, 1994 (or the first cost reporting period after obligated capital that is recognized as old capital under § 412.302(c) is put in use for patient care, if later), the hospital continues to receive capital prospective payment system payments on that basis for the remainder of the transition period.

Payment for each discharge under the fully prospective methodology is the sum of the following:

- The hospital-specific rate multiplied by the DRG relative weight for the discharge and by the applicable hospital-specific transition blend percentage for the cost reporting period; and
- The adjusted Federal rate multiplied by the Federal transition blend percentage.

The blend percentages for cost reporting periods beginning in FY 1999 are 80 percent of the adjusted Federal rate and 20 percent of the hospital-specific rate.

Hospitals may also receive outlier payments for those cases that qualify under the thresholds established for each fiscal year. Section 412.312(c) provides for a single set of thresholds to identify outlier cases for both inpatient operating and inpatient capital-related payments. Outlier payments are made only on that portion of the Federal rate that is used to calculate the hospital's inpatient capital-related payments. For fully prospective hospitals, that portion is 80 percent of the Federal rate for discharges occurring in cost reporting periods beginning during FY 1999. Thus, a fully prospective hospital will receive 80 percent of the capital-related outlier payment calculated for the case for discharges occurring in cost reporting periods beginning in FY 1999. For hold-harmless hospitals paid 85 percent of their reasonable costs for old inpatient capital, the portion of the Federal rate that is included in the hospital's outlier payments is based on the hospital's ratio of Medicare inpatient costs for new capital to total Medicare inpatient capital costs. For hold-harmless hospitals that are paid 100 percent of the Federal rate, 100 percent of the Federal rate is included in the hospital's outlier payments.

The outlier thresholds for FY 1999 are in section II.A.4.c of this Addendum. For FY 1999, a case qualifies as a cost outlier if the cost for the case (after standardization for the indirect teaching adjustment and disproportionate share adjustment) is greater than the prospective payment rate for the DRG plus $11,100.

During the capital prospective payment system transition period, a hospital may also receive an additional payment under an exceptions process if its total inpatient capital-related payments are less than a minimum percentage of its allowable Medicare inpatient capital-related costs. The minimum payment level is established by class of hospital under § 412.348. The minimum payment levels for portions of cost reporting periods beginning in FY 1999 are:

- Sole community hospitals (located in either an urban or rural area), 90 percent;
- Urban hospitals with at least 100 beds and a disproportionate share patient percentage of at least 20.2 percent; and
- Urban hospitals with at least 100 beds that qualify for disproportionate share payments under § 412.106(c)(2), 80 percent; and
- All other hospitals, 70 percent.

Under § 412.348(d), the amount of the exceptions payment is determined by comparing the cumulative payments made to the hospital under the capital prospective payment system to the cumulative minimum payment levels applicable to the hospital for each cost reporting period subject to that system.

Any amount by which the hospital's cumulative payments exceed its cumulative minimum payment is deducted from the additional payment that would otherwise be payable for a cost reporting period.

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

D. Capital Input Price Index

1. Background

Like the prospective payment hospital operating input price index, the Capital Input Price Index (CIPI) is a fixed-weight price index that measures the price changes associated with costs during a given year. The CIPI differs from the operating input price index in one important aspect—the CIPI reflects the vintage nature of capital, which is the acquisition and use of capital over time. Capital expenses in any given year are determined by the stock of capital in that year (that is, capital that remains on hand from all current and prior capital acquisitions). An index measuring capital price changes needs to reflect this vintage nature of capital. Therefore, the CIPI was developed to capture the vintage nature of capital by using a weighted-average of past capital purchase prices up to and including the current year.

Using Medicare cost reports, AHA data, and Securities Data Corporation data, a vintage-weighted price index was developed to measure price increases associated with capital expenses. We periodically update the base year for the operating and capital input prices to reflect the changing composition of inputs for operating and capital expenses. Currently, the CIPI is based to FY 1992 and was last rebased in 1997. The most recent explanation of the CIPI was discussed in the final rule with comment period for FY 1998 published in the August 29, 1997 **Federal Register** (62 FR 46050). The following **Federal Register** documents also describe development and revisions of the methodology involved with the construction of the CIPI: September 1, 1992 (57 FR 40016), May 26, 1993 (58 FR 30448), September 1, 1993 (58 FR 46490), May 27, 1994 (59 FR 27876), September 1, 1994 (59 FR 45517), June 2, 1995 (60 FR 29229), and September 1, 1995 (60 FR 45815), May 31, 1996 (61 FR 27466), August 30, 1996 (61 FR 46196), and June 2, 1997 (62 FR 29953), August 29, 1997 (67 FR 46050), and May 8, 1998 (63 FR 25619).

2. Forecast of the CIPI for Federal Fiscal Year 1999

DRI forecasts a 0.7 percent increase in the CIPI for FY 1999. This is the outcome of a projected 1.9 percent increase in vintage-weighted depreciation prices (building and fixed equipment, and movable equipment) and a 2.9 percent increase in other capital expense prices in FY 1999, partially offset by a 3.0 percent decline in vintage-weighted interest rates in FY 1999. The weighted average of these three factors produces the 0.7 percent increase for the CIPI as a whole.

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

A. Rate-of-Increase Percentages for Excluded Hospitals and Hospital Units

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

Each hospital's target amount is adjusted annually, at the beginning of its cost reporting period, by an applicable update factor. Section 1886(b)(3)(B) of the Act provides that for cost reporting periods beginning on or after October 1, 1998 and before October 1, 1999, the update factor is the market basket less a percentage point between 0 and 2.5 depending on the hospital's or unit's costs in relation to the ceiling. For hospitals with costs exceeding the ceiling by 10 percent or more, the update factor is the market basket increase. For hospitals with costs exceeding the ceiling by less than 10 percent, the update factor is the greater of 0 percent or the market basket minus .25 percent for each percentage point by which costs are less than 10 percent over the ceiling. For hospitals with costs equal to or less than the ceiling but greater than 66.7 percent of the ceiling, the update factor is the greater of 0 percent or the market basket minus 2.5 percent. For hospitals with costs that do not exceed 66.7 percent of the ceiling, the update factor is 0.

The most recent forecast of the market basket increase for FY 1999 for hospitals and hospital units excluded from the prospective payment system is 2.4 percent; therefore, the update to a hospital's target amount for its cost reporting period beginning in FY 1999 would be between 0 and 2.4 percent.

In addition, section 1886(b)(3)(H) of the Act provides that for cost reporting periods beginning on or after October 1, 1998 and before October 1, 1999, the target amount for psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals may not exceed an updated cap that is based on the 75th percentile of target amounts for hospitals in the same class for cost reporting periods ending during FY 1996. The FY 1998 75th percentile target amounts were $10,534 for psychiatric hospitals and units, $19,104 for rehabilitation hospital and units, and $37,688 for long-term care hospitals. As discussed in detail in section VII. of the preamble, for purposes of calculating the caps, the statute requires the Secretary to first calculate the 75th percentile of the target amounts for each class of hospital (psychiatric, rehabilitation, or long-term care) for cost reporting periods ending during FY 1996. The resulting amounts are updated by the market basket percentage to the applicable fiscal year.

B. Wage Index Exceptions for Excluded Hospitals and Units

In the August 30, 1991 final rule (56 FR 43232), we set forth our policy for target amount adjustments for

significant wage increases. Effective with cost reporting periods beginning on or after April 1, 1990, significant increases in wages since the base period are recognized as a basis for an adjustment in the target amount under § 413.40(g).

To qualify for an adjustment, the excluded hospital or hospital unit must be located in a labor market area for which the average hourly wage increased significantly more than the national average hourly wage between the hospital's base period and the period subject to the ceiling. We use the hospital wage index for prospective payment hospitals to determine the rate of increase in the average hourly wage in the labor market area. For a hospital to qualify for an adjustment, the wage index value for the cost reporting period subject to the ceiling must be at least 8 percent higher than the wage index based on wage survey data collected for the base year cost reporting period. If survey data are not available for one (or both) of the cost reporting periods used in the comparison, the wage index based on the latest available survey data collected before that cost reporting period will be used. For example, to make the comparison between a 1983 base period and a hospital's cost reporting period beginning in FY 1996, we would use the rate of increase between the wage index based on 1982 wage data and the wage index based on the FY 1995 data, since the FY 1995 data are the most recent data currently available. Further, the comparison is made without regard to geographic reclassifications made by the MGCRB under sections 1886(d) (8) and (10) of the Act. Therefore, the comparison is made based on the wage index value of the labor market area in which the hospital is actually located.

We determine the amount of the adjustment for wage increases by considering three factors for the time between the base period and the period for which an adjustment is requested: The rate of increase in the hospital's average hourly wage; the rate of increase in the average hourly wage in the labor market area in which the hospital is located; and, the rate of increase in the national average hourly wage for hospital workers. The adjustment is limited to the amount by which the lower of the hospital's or the labor market area's rate of increase in average hourly wages significantly exceeds the national increase (that is, exceeds the national rate of increase by more than 8 percent). For purposes of computing the adjustment, the relative rate of increase in the average hourly wage for the labor market area is assumed to have been the same over each of the intervening years between the wage surveys.

To determine the rate of increase in the national average hourly wage, we use the average hourly earnings (AHE) for hospital workers produced by the Bureau of Labor Statistics.

The average hourly earnings for hospital workers show the following increases:

1992=4.8 percent
1993=3.6 percent
1994=2.7 percent
1995=3.3 percent
1996=3.1 percent
1997=2.0 percent
1998=2.6 percent
1999=2.7 percent

We note that this section merely provides updated information with respect to areas that would qualify for the wage index adjustment under § 413.30(g). This information was calculated in accordance with established policy and does not reflect any change in that policy. The geographic areas in which the percentage difference in wage indexes was sufficient to qualify for a wage index adjustment are listed in Table 10 of section VI of the addendum to this final rule.

VI. Tables

This section contains the tables referred to throughout the preamble to this final rule and in this Addendum. For purposes of this final rule, and to avoid confusion, we have retained the designations of Tables 1 through 5 that were first used in the September 1, 1983 initial prospective payment final rule (48 FR 39844). Tables 1A, 1C, 1D, 1E, 1F, 3C, 4A, 4B, 4C, 4D, 4E, 4F, 5, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 7A, 7B, 8A, 8B, and 10 are presented below. The tables presented below are as follows:

Table 1A—National Adjusted Operating Standardized Amounts, Labor/Nonlabor
Table 1C—Adjusted Operating Standardized Amounts for Puerto Rico, Labor/Nonlabor
Table 1D—Capital Standard Federal Payment Rate
Table 1E—National Adjusted Operating Standardized Amounts for ''Temporary Relief'' Hospitals, Labor/Nonlabor
Table 1F—Adjusted Operating Standardized Amounts for ''Temporary Relief'' Hospitals in Puerto Rico, Labor/Nonlabor
Table 3C—Hospital Case Mix Indexes for Discharges Occurring in Federal Fiscal Year 1997 and Hospital Average Hourly Wage for Federal Fiscal Year 1999 Wage Index
Table 4A—Wage Index and Capital Geographic Adjustment Factor (GAF) for Urban Areas
Table 4B—Wage Index and Capital Geographic Adjustment Factor (GAF) for Rural Areas
Table 4C—Wage Index and Capital Geographic Adjustment Factor (GAF) for Hospitals That Are Reclassified
Table 4D—Average Hourly Wage for Urban Areas
Table 4E—Average Hourly Wage for Rural Areas
Table 4F—Puerto Rico Wage Index and Capital Geographic Adjustment Factor (GAF)
Table 5—List of Diagnosis Related Groups (DRGs), Relative Weighting Factors, Geometric Mean Length of Stay, and Arithmetic Mean Length of Stay Points Used in the Prospective Payment System
Table 6A—New Diagnosis Codes
Table 6B—New Procedure Codes
Table 6C—Invalid Diagnosis Codes
Table 6D—Invalid Procedure Codes
Table 6E—Revised Diagnosis Code Titles
Table 6F—Additions to the CC Exclusions List
Table 6G—Deletions to the CC Exclusions List
Table 7A—Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 97 MEDPAR Update 03/98 GROUPER V15.0
Table 7B—Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 97 MEDPAR Update 03/98 GROUPER V16.0
Table 8A—Statewide Average Operating Cost-to-Charge Ratios for Urban and Rural Hospitals (Case Weighted) July 1998
Table 8B—Statewide Average Capital Cost-to-Charge Ratios (Case Weighted) July 1998
Table 10—Percentage Difference on Wage Indexes for Areas that Qualify for a Wage Index Exception for Excluded Hospitals and Units

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

Large urban areas		Other areas	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
2,783.42	1,313.41	2,739.36	1,113.47

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

	Large urban areas		Other areas	
	Labor	Nonlabor	Labor	Nonlabor
National	2,760.01	1,121.87	2,760.01	1,121.87
Puerto Rico	1,327.81	534.48	1,306.79	526.01

TABLE 1D.—CAPITAL STANDARD FEDERAL PAYMENT RATE

	Rate
National	378.05
Puerto Rico	181.10

TABLE 1E.—NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS FOR ''TEMPORARY RELIEF'' HOSPITALS, LABOR/NONLABOR

Large urban areas		Other areas	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
2,791.73	1,134.76	2,747.54	1,116.79

TABLE 1F.—ADJUSTED OPERATING STANDARDIZED AMOUNTS FOR ''TEMPORARY RELIEF'' HOSPITALS IN PUERTO RICO, LABOR/NONLABOR

	Large urban areas		Other areas	
	Labor	Nonlabor	Labor	Nonlabor
National	2,768.25	1,125.22	2,768.25	1,125.22
Puerto Rico	1,331.77	536.08	1,310.69	527.58

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TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1997 PAGE 1 OF 15
:HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 1999 WAGE INDEX

PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE
010001	01.4644	15.97	010097	00.9172	14.87	030006	01.5703	18.22	040003	01.0870	13.97	040109	01.1364	14.57
010004	01.0062	13.79	010098	01.1900	13.02	030007	01.3026	17.95	040004	01.6722	17.69	040114	01.8754	17.98
010005	01.1743	15.89	010099	01.1062	09.13	030008	02.2398	14.19	040005	01.0447	13.38	040116	01.2647	16.72
010006	01.4642	16.19	010100	01.3320	16.02	030009	01.2633	17.83	040007	01.8705	18.99	040118	01.3516	15.27
010007	01.1318	14.09	010101	01.0378	14.69	030010	01.4364	20.05	040008	01.0263	13.20	040119	01.1630	15.54
010008	01.0827	13.76	010102	00.9500	12.71	030011	01.4750	19.48	040010	01.3275	16.83	040124	01.0535	16.23
010009	01.1474	17.51	010103	01.8120	17.64	030012	01.2354	18.04	040011	00.9598	11.65	040126	00.9550	13.26
010010	01.0878	15.40	010104	01.6882	18.66	030013	01.2956	20.90	040014	01.2132	18.12	040132	.	08.82
010011	01.6445	20.28	010108	01.2182	16.69	030014	01.5288	18.96	040015	01.1666	14.80	040134	02.7084	.
010012	01.2725	17.45	010109	01.1256	13.41	030016	01.1894	19.00	040016	01.6791	16.66	040135	01.0265	.
010015	01.1428	14.04	010110	01.0261	14.97	030017	01.4737	19.72	040017	01.2715	14.80	050002	01.5282	27.86
010016	01.2550	17.40	010112	01.2003	14.59	030018	01.8088	20.61	040018	01.2587	18.08	050006	01.5656	20.69
010018	00.9614	17.72	010113	01.6522	16.50	030019	01.2683	23.65	040019	01.1390	15.05	050007	01.5311	27.11
010019	01.2463	15.00	010114	01.3203	16.49	030022	01.4136	18.78	040020	01.5411	15.42	050008	01.4432	24.64
010021	01.2508	15.83	010115	00.8712	08.92	030023	01.4836	20.04	040021	01.2039	16.15	050009	01.6471	24.26
010022	01.0060	18.25	010117	00.8624	.	030024	01.6993	20.87	040022	01.5331	23.41	050013	01.8468	23.25
010023	01.6883	16.06	010118	01.3042	28.66	030025	01.0608	14.97	040024	01.0025	13.38	050014	01.1894	23.57
010024	01.4242	15.62	010119	00.8398	19.19	030027	01.0266	17.17	040025	00.8996	12.48	050015	01.3820	24.35
010025	01.3877	14.53	010120	01.0108	15.75	030030	01.7140	19.00	040026	01.5676	17.88	050016	01.1889	18.74
010027	00.8180	36.37	010121	01.3481	13.03	030033	01.2741	15.67	040027	01.2933	13.77	050017	02.1023	24.47
010029	01.6129	17.24	010123	01.2905	16.28	030034	01.0791	17.44	040028	01.0446	14.24	050018	01.2575	17.02
010031	01.2819	17.36	010124	01.2883	16.44	030035	01.2329	17.93	040029	01.3006	17.64	050021	01.4143	24.41
010032	00.9803	13.81	010125	01.0747	15.15	030036	01.2648	20.35	040030	00.8325	12.20	050022	01.5833	23.22
010033	01.9692	18.82	010126	01.2176	18.91	030037	02.0603	20.18	040032	00.9689	11.81	050024	01.3656	20.68
010034	01.1086	14.54	010127	01.3586	18.07	030038	01.6294	20.57	040035	00.9841	10.12	050025	01.8247	21.99
010035	01.1830	17.08	010128	00.9738	12.76	030040	01.1553	14.74	040036	01.5137	17.85	050026	01.5427	28.62
010036	01.1886	17.99	010129	01.0577	12.94	030041	00.9538	14.31	040037	01.1061	12.40	050028	01.3853	15.51
010038	01.3055	19.03	010130	00.9978	15.85	030043	01.2211	17.92	040039	01.2408	13.39	050029	01.4911	21.76
010039	01.7091	17.67	010131	01.3868	17.25	030044	00.9712	16.04	040040	00.9805	15.09	050030	01.3283	20.82
010040	01.6110	18.52	010134	00.8402	10.86	030046	.	15.15	040041	01.2969	17.08	050032	01.2557	19.03
010043	01.0482	11.63	010137	01.2387	18.84	030047	00.9292	18.63	040042	01.2531	15.12	050033	01.4508	24.74
010044	01.1011	15.92	010138	00.9403	12.43	030049	00.9914	20.75	040044	01.0535	13.02	050036	01.6560	19.69
010045	01.2072	14.77	010139	01.6765	20.38	030054	00.8332	14.41	040045	01.0079	17.86	050038	01.4510	29.35
010046	01.5051	17.67	010143	01.2742	15.07	030055	01.2002	17.42	040047	01.1007	15.48	050039	01.6076	21.59
010047	00.9884	12.14	010144	01.3453	16.64	030059	01.3005	22.74	040048	.	15.43	050040	01.2432	32.47
010049	01.1586	13.82	010145	01.3401	16.15	030060	01.1528	17.00	040050	01.1780	12.44	050042	01.2894	22.76
010050	01.1488	14.17	010146	01.2465	16.83	030061	01.6614	19.60	040051	01.1662	13.51	050043	01.5687	31.80
010051	00.9240	11.17	010148	00.9490	12.90	030062	01.2457	16.61	040053	01.1178	15.65	050045	01.2315	18.69
010052	01.0483	13.68	010149	01.3350	17.75	030064	01.7661	18.45	040054	01.0530	13.50	050046	01.1856	22.24
010053	01.0743	08.17	010150	01.1533	16.40	030065	01.7852	19.91	040055	01.4649	15.78	050047	01.5706	33.01
010054	01.1993	17.28	010152	01.2912	17.47	030067	01.0939	16.99	040058	01.0449	15.12	050051	01.1392	20.91
010055	01.4751	17.28	010155	01.0804	10.90	030068	01.1100	15.82	040060	00.9293	11.03	050054	01.1301	21.98
010056	01.3319	19.46	020001	01.5262	27.19	030069	01.4078	21.66	040062	01.6771	15.55	050055	01.3260	22.45
010058	00.9754	13.47	020002	01.0696	24.09	030071	01.0022	.	040064	01.0666	13.92	050056	01.3079	24.36
010059	01.0768	15.44	020004	01.1697	25.49	030072	00.8620	.	040066	01.1790	16.90	050057	01.5806	20.60
010061	01.1893	15.80	020005	00.9168	28.73	030073	01.0081	.	040067	01.2159	12.63	050058	01.4868	25.22
010062	01.0162	13.27	020006	01.1878	25.07	030074	00.9531	.	040069	01.1075	15.47	050060	01.5052	18.49
010064	01.7557	20.86	020007	00.9910	25.64	030075	00.8250	.	040070	00.9098	14.25	050061	01.3517	22.13
010065	01.3704	15.35	020008	01.1310	30.06	030076	00.9642	.	040071	01.6226	16.44	050063	01.4693	23.89
010066	00.9177	10.89	020009	00.8785	25.77	030077	00.8065	.	040072	01.0978	15.41	050065	01.7008	21.95
010068	01.2860	17.18	020010	01.0168	25.93	030078	01.0721	.	040074	01.2504	16.30	050066	01.2262	19.77
010069	01.1835	12.84	020011	00.9183	25.75	030079	00.8528	.	040075	01.0355	12.15	050067	01.3216	21.36
010072	01.1582	15.22	020012	01.2756	26.15	030080	01.4997	19.77	040076	01.0400	16.99	050068	01.1314	19.98

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010073	01.0648	12.80	020013	01.0120	26.76	030083	01.3785	22.10	040077	01.0620	12.57	050069	01.6228	24.96
010078	01.2575	17.97	020014	01.1244	22.90	030084	01.1231	.	040078	01.5114	22.64	050070	01.3710	31.44
010079	01.2413	14.94	020017	01.4916	25.14	030085	01.4614	18.59	040080	01.0792	16.38	050071	01.3831	33.07
010081	01.8276	17.69	020018	00.9680	.	030086	01.4306	20.19	040081	00.9676	10.85	050072	01.4408	32.14
010083	01.0329	15.64	020019	00.9067	.	030087	01.6548	19.77	040082	01.2208	14.71	050073	01.3052	33.68
010084	01.5036	18.27	020020	00.7334	.	030088	01.4222	19.42	040084	01.1017	16.62	050074	.	35.38
010085	01.2810	17.32	020021	00.8502	.	030089	01.6409	19.70	040085	01.1940	15.29	050075	01.3484	32.86
010086	01.0397	15.44	020024	01.1334	22.66	030092	01.6841	21.25	040088	01.4405	13.39	050076	01.9194	31.76
010087	01.6581	18.93	020025	01.0164	26.32	030093	01.3775	18.47	040090	00.9349	14.77	050077	01.6311	24.52
010089	01.2396	18.50	020026	01.2892	.	030094	01.2789	19.46	040091	01.1250	18.55	050078	01.3649	25.59
010090	01.6261	17.99	020027	01.0895	.	030095	01.0451	18.85	040093	00.9390	13.08	050079	01.5430	31.89
010091	01.0247	13.51	030001	01.3418	19.87	030098	.	15.81	040100	01.2389	12.91	050080	01.4197	19.44
010092	01.4018	15.82	030002	01.7918	20.96	030099	00.9422	.	040105	01.0352	13.05	050081	.	21.07
010094	01.2142	16.01	030003	02.0470	22.65	040001	01.1076	13.42	040106	01.0701	13.53	050082	01.6660	22.04
010095	00.9801	12.73	030004	01.1001	12.52	040002	01.1457	13.33	040107	01.1432	16.75	050084	01.6767	22.53

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1997 PAGE 2 OF 15
:HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 1999 WAGE INDEX

PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE
050088	00.9851	19.55	050186	01.2945	27.51	050296	01.1882	23.74	050420	01.3376	23.41	050545	00.8461	27.87
050089	01.3688	18.85	050188	01.4387	28.54	050298	01.3260	22.54	050421	.	18.76	050546	00.7101	31.14
050090	01.2680	23.85	050189	01.0803	22.39	050299	01.3625	20.49	050423	01.0169	19.31	050547	00.8468	36.25
050091	01.1395	21.99	050191	01.4722	20.67	050300	01.4962	22.71	050424	01.8145	23.48	050548	.	26.82
050092	00.9409	16.26	050192	01.1991	18.16	050301	01.2483	24.81	050425	01.3109	34.22	050549	01.7130	26.15
050093	01.5518	23.90	050193	01.3307	22.67	050302	01.3538	27.55	050426	01.3826	25.47	050550	01.4607	22.49
050095	.	30.92	050194	01.2431	27.41	050305	01.5542	29.10	050427	00.9189	19.93	050551	01.3294	24.98
050096	01.2422	21.29	050195	01.5857	33.92	050307	01.3027	19.99	050430	01.0619	19.53	050552	01.2280	20.52
050097	01.3881	19.76	050196	01.3091	15.36	050308	01.4827	28.01	050431	.	20.31	050557	01.5151	21.78
050099	01.4752	23.55	050197	01.8717	30.49	050309	01.3431	24.61	050432	01.6159	22.57	050559	01.3985	23.82
050100	01.7005	33.49	050204	01.5873	24.52	050310	01.0912	20.24	050433	01.1058	20.42	050560	.	21.01
050101	01.4169	30.72	050205	01.2713	21.52	050312	01.9259	24.36	050434	01.1365	19.87	050561	01.1992	32.53
050102	01.3683	17.01	050207	01.2683	20.02	050313	01.2036	22.00	050435	01.2208	29.08	050564	01.3328	21.23
050103	01.5669	23.46	050208	.	29.20	050315	01.3747	20.47	050436	00.9412	15.20	050565	01.3544	13.81
050104	01.4825	23.94	050211	01.3234	30.67	050317	01.2655	21.86	050438	01.8097	19.48	050566	00.9067	13.99
050107	01.4505	23.02	050213	01.5944	22.96	050320	01.2392	28.42	050440	01.3401	18.63	050567	01.6254	24.54
050108	01.8388	23.87	050214	01.4704	21.31	050324	01.9663	26.19	050441	02.0374	26.41	050568	01.4048	19.06
050109	.	26.23	050215	01.5505	29.63	050325	01.2357	21.08	050443	00.9065	18.92	050569	01.3810	23.26
050110	01.1656	20.55	050217	01.3766	19.08	050327	01.5632	18.67	050444	01.3068	22.54	050570	01.7109	23.79
050111	01.3589	20.16	050219	01.1132	18.83	050328	.	18.19	050446	00.9770	10.06	050571	01.5095	20.05
050112	01.4834	19.36	050222	01.6265	31.96	050329	01.2914	19.88	050447	01.0672	18.58	050573	01.6294	28.41
050113	01.3907	31.25	050224	01.5718	23.23	050331	01.4811	24.60	050448	01.0969	20.95	050575	01.1384	.
050114	01.3686	23.13	050225	01.6076	22.02	050333	01.1470	24.96	050449	01.3379	21.14	050577	01.4630	20.19
050115	01.5639	20.46	050226	01.4112	24.79	050334	01.7281	34.59	050454	01.8423	25.82	050578	01.4621	28.48
050116	01.4485	23.36	050228	01.2950	30.89	050335	01.4459	21.39	050455	01.7679	17.25	050579	01.5004	29.18
050117	01.4510	20.79	050230	01.3336	25.40	050336	01.3728	20.14	050456	01.1732	16.92	050580	01.4374	27.74
050118	01.1896	24.04	050231	01.6725	25.54	050337	.	27.81	050457	02.0333	31.03	050581	01.3940	24.65
050121	01.3531	24.60	050232	01.7131	21.50	050342	01.3702	17.71	050459	01.2995	29.51	050583	01.6267	22.06
050122	01.5968	26.92	050233	.	29.60	050343	01.0227	14.95	050464	01.8759	22.18	050584	01.2061	18.16
050124	01.3194	21.60	050234	01.2528	30.23	050348	01.6574	25.44	050468	01.3881	19.71	050585	01.2746	27.19
050125	01.3972	27.55	050235	01.6024	24.55	050349	00.8825	14.57	050469	01.0967	20.26	050586	01.3490	20.52
050126	01.5422	24.94	050236	01.4694	25.76	050350	01.3956	24.27	050470	01.1640	18.51	050588	01.3163	24.70
050127	01.3573	24.15	050238	01.5534	24.76	050351	01.4658	32.84	050471	01.8865	23.41	050589	01.2483	24.47
050128	01.6209	21.60	050239	01.5896	21.67	050352	01.3003	19.07	050476	01.3551	21.10	050590	01.3681	24.18
050129	01.6203	14.25	050240	01.4902	21.17	050353	01.6666	24.77	050477	01.4931	26.99	050591	01.3786	22.94
050131	01.3013	29.90	050241	01.2320	26.32	050355	00.9808	16.04	050478	00.9635	21.32	050592	01.3739	18.46
050132	01.4252	23.74	050242	01.4292	29.91	050357	01.4088	23.91	050481	01.4641	27.13	050593	01.1774	36.02
050133	01.2912	25.55	050243	01.5936	22.58	050359	01.2832	19.11	050482	01.0556	16.07	050594	01.6739	19.05
050135	01.3988	25.36	050245	01.4675	23.33	050360	01.4113	31.05	050483	01.1821	22.22	050597	01.2627	21.36
050136	01.4030	24.04	050248	01.2628	27.54	050366	01.3453	22.32	050485	01.6562	23.71	050598	01.3877	32.07
050137	01.4012	31.04	050251	01.0987	18.36	050367	01.2534	27.64	050486	01.3493	23.00	050599	01.6309	23.23
050138	01.9630	33.39	050253	01.2972	25.63	050369	01.2373	21.58	050488	01.3358	32.94	050601	01.6135	32.05
050139	01.2529	31.65	050254	01.2155	14.11	050373	01.4547	24.31	050491	01.1935	21.97	050603	01.4036	22.60
050140	01.2781	31.65	050256	01.7518	23.91	050376	01.3961	26.32	050492	01.4116	22.37	050604	01.5566	37.27
050144	01.6351	29.20	050257	01.1275	19.38	050377	00.9381	20.12	050494	01.2196	26.20	050607	01.1545	21.20
050145	01.3848	31.48	050260	01.0044	24.07	050378	01.1366	20.86	050496	01.7139	31.77	050608	01.3077	15.26
050146	01.4766	.	050261	01.2719	18.81	050379	00.9568	16.75	050497	00.8270	10.59	050609	01.4502	32.62
050147	.	10.27	050262	01.8636	27.43	050380	01.6798	29.30	050498	01.2448	24.96	050613	01.0770	31.83
050148	01.1187	21.00	050264	01.3346	27.45	050382	01.3989	23.86	050502	01.7223	22.74	050615	01.5964	23.72
050149	01.4725	22.78	050267	01.6534	28.61	050385	01.4016	26.64	050503	01.3377	23.15	050616	01.3605	22.68
050150	01.2718	23.95	050270	01.3568	24.13	050388	00.9055	15.88	050506	01.4491	27.00	050618	01.1196	22.63
050152	01.3877	23.39	050272	01.3713	21.55	050390	01.1854	16.75	050510	01.3784	31.86	050623	02.0034	27.51
050153	01.6264	28.40	050274	00.9903	23.00	050391	01.3343	21.68	050512	01.5755	33.03	050624	01.3564	22.18

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050155	01.0914	22.33	050276	01.2250	33.01	050392	00.9917	18.42	050515	01.3499	32.89	050625	01.6071	25.23
050158	01.3651	27.94	050277	01.4711	19.05	050393	01.4866	17.95	050516	01.5428	26.16	050630	01.3421	23.93
050159	01.3024	19.09	050278	01.5642	22.63	050394	01.5545	20.22	050517	01.1820	19.69	050633	01.3129	22.22
050167	01.3306	21.83	050279	01.3445	19.01	050396	01.6175	24.33	050522	01.2290	31.06	050635	.	35.35
050168	01.5282	22.10	050280	01.7671	25.90	050397	00.9890	19.89	050523	01.2392	28.96	050636	01.5041	26.10
050169	01.4408	24.49	050281	01.5489	33.56	050401	01.1249	19.64	050526	01.3230	26.71	050638	01.1066	24.90
050170	01.4906	21.04	050282	01.3068	23.58	050404	01.0833	15.96	050528	01.2847	19.70	050641	01.2588	12.97
050172	01.2526	19.87	050283	01.5223	26.89	050406	01.0854	19.56	050531	01.1749	20.18	050643	00.8179	.
050173	01.3744	21.40	050286	00.8525	18.46	050407	01.3591	29.45	050534	01.4670	23.83	050644	01.0478	22.44
050174	01.6829	29.40	050289	01.7008	30.78	050410	01.0632	13.08	050535	01.3748	23.70	050660	01.4610	.
050175	01.3655	23.84	050290	01.6859	36.10	050411	01.3593	33.52	050537	01.3670	18.57	050661	00.8186	20.05
050177	01.2704	16.69	050291	01.1594	30.54	050414	01.3032	23.74	050539	01.2670	19.52	050662	00.8651	33.41
050179	01.3035	21.09	050292	01.0403	22.19	050417	01.3165	20.45	050541	01.5656	33.47	050663	01.1555	24.12
050180	01.6047	32.17	050293	01.0911	20.70	050418	.	19.53	050542	01.1186	16.26	050666	00.9285	34.46
050183	01.1143	19.44	050295	01.4952	21.01	050419	01.4360	16.25	050543	00.9409	23.72	050667	01.0150	18.00

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1997 PAGE 3 OF 15
:HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 1999 WAGE INDEX

PROVIDER	CASE MIX INDEX	AVG HOUR WAGE
050668	01.1224	39.35
050670	00.7532	20.84
050674	01.3147	32.55
050675	01.9709	15.99
050676	00.9474	16.85
050677	01.3998	33.04
050678	01.2227	.
050680	01.2036	28.94
050682	00.8928	22.32
050684	01.2469	17.19
050685	01.2704	28.37
050686	01.3145	32.60
050688	01.2872	25.15
050689	01.4142	30.18
050690	01.5086	32.17
050693	01.3049	29.48
050694	01.3573	18.36
050695	01.0935	28.46
050696	02.3010	27.15
050697	01.4492	20.60
050698	00.9075	.
050699	00.6236	20.97
050700	01.5678	30.99
050701	01.3353	30.27
050702	.	13.04
050704	01.1278	15.23
050706	.	13.95
050707	01.0702	27.09
050708	01.2672	22.59
050709	01.3265	18.88
050710	01.3448	26.13
050711	.	27.76
050712	.	15.52
050713	00.8060	.
050714	01.3687	.
050715	01.7138	.
050716	03.8652	.
050717	00.8003	.
050718	00.9250	.
050899	00.5288	.
060001	01.6500	19.65
060003	01.3300	18.91
060004	01.2793	20.57
060006	01.1852	18.34
060007	01.1450	15.33
060008	01.1679	15.83
060009	01.4644	21.35
060010	01.5607	22.31
060011	01.3597	16.78
060012	01.4540	18.62
060013	01.3226	16.29
060014	01.7390	21.24
060015	01.5874	21.13
060037	01.0286	13.57
060038	01.0310	13.78
060041	00.9383	14.14
060042	01.0413	14.73
060043	00.8992	12.99
060044	01.1116	16.07
060046	01.0902	18.50
060047	00.9872	13.98
060049	01.3491	20.25
060050	01.2588	16.03
060052	01.0840	13.29
060053	01.1047	14.93
060054	01.3319	18.61
060056	00.9969	15.37
060057	01.0392	23.55
060058	00.9506	15.60
060060	00.9769	14.53
060062	00.9101	16.53
060063	.	12.11
060064	01.4893	21.56
060065	01.3263	22.85
060066	01.0208	15.09
060068	01.0462	18.74
060070	01.1142	17.17
060071	01.2186	16.52
060073	01.0655	16.43
060075	01.3136	24.88
060076	01.3890	19.28
060085	00.9345	12.76
060087	01.6777	21.08
060088	00.9906	23.16
060090	00.9696	13.54
060096	01.0686	21.94
060100	01.5075	20.86
060103	01.2893	23.16
060104	01.2507	21.91
060107	01.1292	.
070001	01.7652	25.86
070002	01.8091	24.34
070003	01.1456	25.30
070004	01.2345	24.34
070005	01.4109	24.84
070006	01.4147	28.70
070007	01.3959	24.35
070008	01.2535	22.94
070009	01.2940	24.56
070010	01.6781	26.26
070011	01.4560	23.69
070012	01.2490	23.36
070013	.	25.96
070015	01.4209	24.05
070016	01.3814	23.00
070017	01.3699	25.10
070035	01.4064	22.69
070036	01.5717	27.95
070038	01.0707	.
070039	00.9304	23.64
080001	01.7029	27.32
080002	01.2026	17.03
080003	01.3862	20.16
080004	01.3108	19.45
080005	.	15.45
080006	01.4175	21.83
080007	01.4565	16.75
090001	01.5882	23.58
090002	01.3122	19.74
090003	01.3702	25.82
090004	01.7420	24.43
090005	01.3445	24.44
090006	01.3211	20.39
090007	01.3590	19.91
090008	01.4935	20.70
090010	01.0223	21.67
090011	02.0090	25.88
090015	.	28.44
100001	01.4880	17.49
100002	01.4757	19.92
100004	01.0110	13.82
100005	.	16.49
100006	01.6408	20.10
100007	01.8868	20.64
100008	01.7090	20.20
100009	01.4914	21.67
100010	01.5259	24.50
100012	01.6951	16.63
100014	01.4914	21.94
100015	01.4352	17.47
100017	01.4976	17.71
100018	01.5086	21.15
100019	01.5279	19.50
100020	01.3355	23.86
100022	01.9191	24.49
100023	01.4357	17.35
100024	01.3643	19.67
100025	01.8456	18.06
100026	01.5853	18.06
100027	00.9972	15.86
100028	01.2337	18.09
100029	01.4165	19.56
100030	01.3058	19.01
100032	01.8880	17.78
100034	01.7619	19.44
100035	01.6064	18.04
100038	01.5808	18.23
100039	01.5401	21.36
100040	01.7626	18.11
100060	01.7358	21.02
100061	01.4819	21.68
100062	01.7480	18.11
100063	01.2940	18.35
100067	01.4084	16.94
100068	01.3718	17.72
100069	01.3145	15.88
100070	01.4963	18.80
100071	01.2940	16.97
100072	01.2359	23.32
100073	01.7506	20.04
100075	01.6534	18.22
100076	01.3183	17.07
100077	01.3751	17.47
100078	01.1969	16.33
100079	01.6519	19.15
100080	01.6323	22.70
100081	01.0505	14.21
100082	01.4627	18.91
100083	.	19.01
100084	01.4185	20.77
100085	01.3924	21.33
100086	01.2407	21.23
100087	01.8559	21.28
100088	01.6737	20.82
100090	01.3889	17.89
100092	01.5280	19.47
100093	01.5087	15.93
100098	01.1539	19.33
100099	01.2918	13.50
100102	01.0252	18.11
100103	00.9821	16.14
100105	01.4371	21.03
100106	01.0819	16.69
100107	01.3245	18.60
100108	01.0633	14.31
100109	01.3830	19.09
100110	01.4046	19.10
100112	00.9225	12.57
100113	02.1129	19.93
100114	01.4069	18.20
100117	01.3173	19.37
100118	01.2397	19.51
100121	01.2107	16.03
100122	01.3053	16.67
100124	01.3271	14.64
100125	01.3273	18.00
100126	01.4412	18.90
100127	01.6383	19.58
100128	02.1956	21.53
100129	01.2700	17.72
100130	01.2442	19.67
100131	01.3787	20.96
100156	01.2007	19.92
100157	01.5863	21.07
100159	00.9553	11.69
100160	01.2476	18.43
100161	01.7063	21.30
100162	01.4538	21.24
100165	01.1352	13.18
100166	01.4883	19.75
100167	01.4434	20.58
100168	01.3649	19.91
100169	01.8707	20.54
100170	01.4145	15.49
100172	01.3995	14.68
100173	01.6910	17.25
100174	01.3779	19.26
100175	01.2212	15.49
100176	02.0935	23.45
100177	01.3483	18.58
100179	01.7344	19.47
100180	01.4642	19.44
100181	01.2110	21.61
100183	01.2826	18.48
100186	.	15.77
100187	01.4161	19.92
100189	01.3954	24.14
100191	01.2948	20.39
100199	01.3613	19.76
100200	01.3437	21.55
100203	.	20.64
100204	01.6026	19.37
100206	01.3976	19.96
100207	.	17.28
100208	01.5831	22.72
100209	01.5830	21.10
100210	01.6008	18.18
100211	01.3278	20.26
100212	01.6618	20.46
100213	01.5196	18.60
100217	01.3387	18.88
100220	01.7265	26.34
100221	01.7376	25.21
100222	01.4127	20.13
100223	01.4863	18.81
100224	01.4057	20.57
100225	01.4011	20.58
100226	01.4005	18.53
100228	01.3284	20.31
100229	01.3024	18.10
100230	01.3655	22.35
100231	01.7043	16.97
100232	01.3657	19.83
100234	01.5347	18.94
100235	01.5726	18.77

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060016	01.2618	17.07	070018	01.4229	28.54	100043	01.3637	15.33	100132	01.3080	19.53	100236	01.4238	19.87
060018	01.2425	18.76	070019	01.2955	24.83	100044	01.4089	21.18	100134	00.9935	13.03	100237	02.2026	23.28
060020	01.6781	17.56	070020	01.3128	24.87	100045	01.4051	19.25	100135	01.6132	17.62	100238	01.5889	18.71
060022	01.6157	19.49	070021	01.2927	24.85	100046	01.4822	20.00	100137	01.3160	18.60	100239	01.4453	19.37
060023	01.6562	17.02	070022	01.8219	24.41	100047	01.7730	18.92	100138	01.0145	10.76	100240	00.7775	15.37
060024	01.7957	22.81	070024	01.3146	23.84	100048	00.9683	13.58	100139	01.1130	15.04	100241	00.9329	13.90
060027	01.6865	21.24	070025	01.8628	25.86	100049	01.3280	17.97	100140	01.2237	17.48	100242	01.4150	16.91
060028	01.4978	21.55	070026	01.1616	18.55	100050	01.1465	15.90	100142	01.2584	18.68	100243	01.4093	24.31
060029	00.8975	15.35	070027	01.2853	23.11	100051	01.2133	19.11	100144	01.2803	19.61	100244	01.4073	19.39
060030	01.3259	19.00	070028	01.5449	24.77	100052	01.4303	16.90	100145	.	18.25	100246	01.4101	20.73
060031	01.6378	19.53	070029	01.3573	21.95	100053	01.2251	18.09	100146	01.0872	16.15	100248	01.6272	18.92
060032	01.4779	20.78	070030	01.2475	25.18	100054	01.3282	17.76	100147	01.0611	14.54	100249	01.3512	18.85
060033	01.0758	13.41	070031	01.2537	23.12	100055	01.3759	17.93	100150	01.4014	19.96	100252	01.2839	21.94
060034	01.5650	19.78	070033	01.4150	26.38	100056	01.4068	19.38	100151	01.7257	18.08	100253	01.5078	20.97
060036	01.1681	15.76	070034	01.3840	29.14	100057	01.4207	18.63	100154	01.5962	19.74	100254	01.5805	18.66

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1997 PAGE 4 OF 15
:HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 1999 WAGE INDEX

PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE
100255	01.2896	24.34	110052	01.1633	08.57	110149	01.1382	18.93	120025	.	21.69	140030	01.7221	21.81
100256	02.0086	19.19	110054	01.3228	18.89	110150	01.4009	18.34	120026	01.2407	24.30	140031	01.2027	14.47
100258	01.6275	20.50	110056	01.1059	16.02	110152	01.0769	15.05	120027	01.4884	22.77	140032	01.3092	17.51
100259	01.4191	18.76	110059	01.3127	14.41	110153	01.0926	18.60	120028	01.2457	.	140033	01.2957	22.13
100260	01.4519	22.92	110061	01.0820	13.87	110154	01.0266	13.75	130001	00.9216	20.88	140034	01.1830	18.25
100262	01.3940	21.16	110062	00.8955	14.52	110155	01.1450	14.18	130002	01.3850	15.94	140035	01.0767	13.77
100263	01.2523	18.64	110063	01.1367	15.16	110156	01.0262	15.53	130003	01.3301	19.77	140036	01.2295	16.35
100264	01.4005	17.72	110064	01.3872	18.18	110161	01.3137	20.74	130005	01.4361	20.21	140037	01.0388	13.33
100265	01.3356	15.01	110065	01.0217	12.93	110162	00.8103	.	130006	01.8383	19.10	140038	01.2129	14.65
100266	01.3540	18.10	110066	01.4667	20.37	110163	01.5231	18.39	130007	01.6471	19.28	140039	.	09.90
100267	01.3418	19.83	110069	01.2796	18.52	110164	01.4291	19.88	130008	00.9914	12.07	140040	01.3081	15.90
100268	01.2239	22.74	110070	01.0993	17.18	110165	01.4035	18.70	130009	00.9354	15.62	140041	01.1963	16.33
100269	01.4240	20.37	110071	01.1356	11.04	110166	01.5149	18.65	130010	00.9097	19.14	140042	01.0251	14.60
100270	00.8851	20.06	110072	01.0167	12.51	110168	01.7225	20.47	130011	01.3511	19.35	140043	01.1690	17.93
100271	01.7433	20.02	110073	01.2255	14.32	110169	01.1904	18.66	130012	01.0014	22.02	140045	01.0482	15.21
100275	01.4126	20.36	110074	01.4598	17.24	110171	01.4969	20.53	130013	01.3104	19.25	140046	01.3164	15.70
100276	01.2728	22.13	110075	01.3598	16.51	110172	01.4227	21.62	130014	01.3701	17.03	140047	01.1735	16.57
100277	01.0531	15.24	110076	01.5108	20.04	110174	00.9675	15.24	130015	00.9255	17.50	140048	01.3311	21.58
100279	01.3774	12.47	110078	01.7628	21.73	110176	02.5217	20.96	130016	00.9197	17.25	140049	01.5511	21.12
100280	01.3549	16.99	110079	01.3867	19.30	110177	01.5787	19.87	130017	01.1403	16.55	140051	01.5094	19.42
100281	01.2976	22.78	110080	01.2082	18.22	110178	03.0828	16.83	130018	01.7382	17.35	140052	01.3969	17.19
100282	01.1124	17.70	110082	02.1046	21.81	110179	01.1095	20.42	130019	01.1689	17.99	140053	02.0099	18.24
110001	01.3066	16.27	110083	01.7184	19.95	110181	00.9478	14.94	130021	00.9795	15.30	140054	01.3757	22.90
110002	01.3066	16.54	110086	01.2327	13.04	110183	01.3855	21.18	130022	01.2402	18.53	140055	00.9261	14.04
110003	01.3841	15.24	110087	01.3474	20.67	110184	01.2696	19.37	130024	01.0801	18.00	140058	01.2946	16.54
110004	01.3871	18.05	110088	.	14.70	110185	01.1222	15.51	130025	01.1028	14.20	140059	01.2332	15.77
110005	01.1791	17.38	110089	01.2207	17.12	110186	01.3568	15.59	130026	01.1594	19.63	140061	01.1070	14.15
110006	01.3993	19.78	110091	01.3187	19.73	110187	01.3439	19.18	130027	00.8936	19.57	140062	01.2897	26.44
110007	01.6048	16.12	110092	01.1652	15.18	110188	01.3402	18.49	130028	01.2370	16.83	140063	01.4357	22.90
110008	01.2657	18.30	110093	00.9438	12.67	110189	01.1257	17.51	130029	01.1090	17.62	140064	01.3057	17.80
110009	01.1524	15.79	110094	01.0852	14.08	110190	01.0975	15.41	130030	00.8445	18.40	140065	01.5350	23.64
110010	02.1496	24.74	110095	01.3811	14.69	110191	01.3582	18.19	130031	00.9613	16.44	140066	01.2183	15.60
110011	01.2270	16.33	110096	01.1431	14.85	110192	01.4677	21.41	130034	01.0111	19.35	140067	01.7972	17.99
110013	01.1122	16.61	110097	01.0570	14.44	110193	01.2413	18.56	130035	01.0128	19.47	140068	01.2466	19.58
110014	01.0432	16.41	110098	00.9765	15.24	110194	00.9251	14.21	130036	01.3026	13.66	140069	01.0659	16.04
110015	01.1778	19.39	110100	01.0521	16.39	110195	01.1135	13.34	130037	01.2825	16.97	140070	01.2375	19.33
110016	01.2958	16.27	110101	01.1302	12.27	110198	01.3307	25.63	130043	00.9508	15.79	140074	01.0465	17.25
110017	00.8805	13.46	110103	00.9164	11.78	110200	01.8828	19.23	130044	01.1648	10.50	140075	01.4098	14.33
110018	01.1452	18.80	110104	01.0981	15.18	110201	01.5116	18.30	130045	00.9962	15.28	140077	01.2781	17.05
110020	01.3262	19.04	110105	01.2916	15.96	110203	00.9944	20.45	130048	01.0647	14.17	140079	01.2421	17.22
110023	01.2951	18.51	110107	01.8383	17.15	110204	00.8144	18.89	130049	01.2584	19.05	140080	01.6316	20.58
110024	01.4672	19.21	110108	00.9701	17.70	110205	01.0751	22.85	130054	00.8879	17.88	140081	01.0691	14.36
110025	01.4301	17.90	110109	01.0955	15.30	110207	01.1599	12.46	130056	00.8186	17.37	140082	01.4524	22.85
110026	01.2057	14.58	110111	01.1978	15.96	110208	00.9954	15.74	130058	.	15.44	140083	01.3057	18.82
110027	01.1272	16.30	110112	01.1280	18.83	110209	00.7372	16.57	130060	01.3043	20.72	140084	01.2305	19.27
110028	01.6852	20.65	110113	01.1047	14.21	110211	00.9586	.	130061	00.9427	09.29	140086	01.1655	15.72
110029	01.3702	19.61	110114	01.0548	15.27	110212	01.1645	.	130063	01.1768	.	140087	01.3939	17.07
110030	01.2733	17.81	110115	01.6775	22.61	110213	00.7483	.	140001	01.3065	15.14	140088	01.7043	21.97
110031	01.2746	19.47	110118	01.0544	14.15	110215	00.8967	.	140002	01.3205	18.33	140089	01.2392	17.29
110032	01.3097	15.70	110120	01.0680	12.89	120001	01.8384	27.16	140003	01.0442	15.69	140090	01.4959	23.24
110033	01.4405	20.65	110121	01.2127	14.26	120002	01.2602	23.92	140004	01.1070	16.55	140091	01.8248	18.10
110034	01.6520	18.31	110122	01.3689	18.25	120003	01.1202	24.14	140005	00.9493	10.22	140093	01.1843	18.79
110035	01.4389	23.29	110124	01.3270	14.58	120004	01.2185	24.46	140007	01.4918	21.24	140094	01.3078	20.25

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110036	01.7756	25.20	110125	01.2713	16.35	120005	01.3000	21.62	140008	01.5260	20.27	140095	01.3821	20.30
110037	.	11.88	110127	00.9214	14.72	120006	01.3288	24.67	140010	01.3796	23.35	140097	00.9245	15.85
110038	01.4846	17.24	110128	01.1834	18.34	120007	01.6762	21.82	140011	01.1985	16.35	140100	01.3023	20.50
110039	01.3746	19.83	110129	01.6935	17.69	120009	00.9574	19.58	140012	01.2717	19.28	140101	01.2320	18.41
110040	01.1391	16.03	110130	01.0655	11.85	120010	01.8242	23.63	140013	01.6025	16.59	140102	01.1145	15.46
110041	01.1918	16.68	110132	01.1278	13.98	120011	01.3285	32.97	140014	01.2397	18.98	140103	01.4698	16.09
110042	01.2316	16.85	110134	00.9054	12.22	120012	00.8744	21.42	140015	01.2851	14.54	140105	01.3567	20.16
110043	01.8015	16.83	110135	01.3168	17.76	120014	01.3441	23.53	140016	00.9816	12.09	140107	01.0761	14.19
110044	01.1825	15.11	110136	01.1773	15.43	120015	00.8942	23.63	140018	01.3540	19.82	140108	01.3538	22.83
110045	01.2018	19.00	110140	01.0355	15.81	120016	01.0773	26.99	140019	01.0885	14.25	140109	01.2291	14.65
110046	01.2698	19.27	110141	01.0418	13.17	120018	01.0119	22.29	140024	00.9820	13.82	140110	01.2270	18.89
110048	01.3005	14.77	110142	00.9281	10.94	120019	01.2087	20.93	140025	01.0844	16.04	140112	01.1475	14.27
110049	01.0592	13.95	110143	01.4295	20.93	120021	00.8363	19.89	140026	01.2535	16.60	140113	01.5983	18.16
110050	01.2643	17.24	110144	01.1034	18.17	120022	01.6965	17.36	140027	01.3191	17.12	140114	01.3447	19.18
110051	01.0326	13.87	110146	01.1077	16.74	120024	.	22.38	140029	01.4139	19.95	140115	01.3319	19.21

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1997 PAGE 5 OF 15
:HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 1999 WAGE INDEX

PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE
140116	01.2584	20.69	140207	01.3740	20.88	150026	01.2119	18.80	150105	01.3376	16.93	160056	01.1694	14.54
140117	01.5458	20.39	140208	01.6894	23.66	150027	01.0411	17.50	150106	01.0977	15.95	160057	01.3772	17.28
140118	01.6696	23.27	140209	01.6563	14.76	150029	01.3859	20.73	150109	01.4347	18.03	160058	01.7800	19.62
140119	01.7353	21.17	140210	01.0796	14.99	150030	01.2571	17.00	150110	01.0396	15.28	160060	01.1154	15.45
140120	01.4487	16.54	140211	01.2088	19.50	150031	01.0939	15.03	150111	01.1636	15.08	160061	01.1126	16.03
140121	01.4060	14.91	140212	.	20.90	150032	01.8604	19.49	150112	01.3267	18.92	160062	00.9443	15.66
140122	01.5940	22.76	140213	01.3165	21.51	150033	01.5978	21.73	150113	01.2282	18.47	160063	01.1840	16.85
140124	01.2207	25.20	140215	01.0884	14.05	150034	01.4907	21.18	150114	01.0691	17.02	160064	01.6255	18.72
140125	01.3383	16.31	140217	01.3117	22.52	150035	01.5634	19.66	150115	01.3593	17.18	160065	01.0208	16.04
140127	01.4412	18.66	140218	01.0485	15.20	150036	01.0371	18.92	150122	01.1381	18.53	160066	01.1494	15.76
140128	01.0558	16.08	140220	01.1003	17.26	150037	01.2570	18.31	150123	01.0560	14.07	160067	01.4070	17.52
140129	01.1945	16.56	140223	01.6063	23.21	150038	01.4474	18.96	150124	01.1341	15.08	160068	01.0212	15.43
140130	01.2712	24.16	140224	01.3507	22.21	150039	00.9703	16.62	150125	01.4487	19.03	160069	01.4921	17.39
140132	01.5146	23.60	140228	01.6505	17.83	150042	01.2848	16.54	150126	01.4681	21.26	160070	00.9582	14.86
140133	01.3439	20.51	140230	00.9339	15.97	150043	01.0387	16.96	150127	01.0315	17.60	160072	01.0741	14.19
140135	01.2982	16.16	140231	01.5685	21.90	150044	01.2381	18.05	150128	01.2772	18.07	160073	00.9700	13.66
140137	01.0455	17.24	140233	01.8350	18.16	150045	01.1321	16.21	150129	01.1207	25.10	160074	01.0485	15.71
140138	01.0982	15.13	140234	01.2342	17.76	150046	01.4956	16.70	150130	01.3485	16.53	160075	01.1791	15.77
140139	01.1164	15.86	140236	01.0025	14.29	150047	01.6146	23.16	150132	01.4892	18.89	160076	01.0409	17.07
140140	01.1927	18.58	140239	01.7396	18.19	150048	01.2268	18.58	150133	01.1599	17.44	160077	01.0913	11.38
140141	01.3144	14.79	140240	01.4381	22.78	150049	01.1399	15.85	150134	01.1630	17.56	160079	01.4240	17.85
140143	01.1500	17.94	140242	01.6616	22.15	150050	01.2348	16.20	150136	00.8607	21.05	160080	01.2024	17.07
140144	01.0421	17.37	140245	01.2211	15.19	150051	01.4668	18.63	150139	.	15.84	160081	01.0990	15.21
140145	01.1614	16.32	140246	01.1108	12.78	150052	01.1526	14.50	150142	.	23.05	160082	01.9393	17.26
140146	01.0616	16.77	140250	01.3078	22.61	150053	01.0119	18.92	150145	03.5517	.	160083	01.6758	17.82
140147	01.3930	15.62	140251	01.3485	20.32	150054	01.0961	16.81	160001	01.2878	18.33	160085	00.9879	15.41
140148	01.8186	17.46	140252	01.4851	23.55	150056	01.8464	23.16	160002	01.1613	14.48	160086	00.9593	15.78
140150	01.5679	25.02	140253	01.3958	16.02	150057	02.3145	18.25	160003	01.0270	14.39	160088	01.1906	16.87
140151	01.0722	19.64	140258	01.5886	22.07	150058	01.7735	20.30	160005	01.0993	15.72	160089	01.2259	16.16
140152	01.1749	21.63	140271	01.0365	14.78	150059	01.3569	21.47	160007	01.0149	13.81	160090	01.0106	15.53
140155	01.3100	18.12	140275	01.2389	16.99	150060	01.1408	14.72	160008	01.1629	14.74	160091	01.0707	12.74
140158	01.3842	22.91	140276	02.0450	21.39	150061	01.2257	15.33	160009	01.2239	15.87	160092	01.0611	15.37
140160	01.2137	16.52	140280	01.3639	17.80	150062	01.1254	18.14	160012	01.0016	15.93	160093	01.0603	15.71
140161	01.2204	18.07	140281	01.6894	22.14	150063	01.0544	16.90	160013	01.2083	16.74	160094	01.1208	15.60
140162	01.7884	17.93	140285	01.2539	26.86	150064	01.2795	16.23	160014	00.9578	14.41	160095	01.0625	14.27
140164	01.4530	20.29	140286	01.1509	18.53	150065	01.2094	18.66	160016	01.2445	17.25	160097	01.0916	14.59
140165	01.1045	13.70	140288	01.7459	22.93	150066	01.0070	17.04	160018	00.9388	13.77	160098	00.9990	15.05
140166	01.3268	17.36	140289	01.3502	16.32	150067	01.1741	16.20	160020	01.0873	13.88	160099	00.9158	12.91
140167	01.1275	15.06	140290	01.3913	20.06	150069	01.2630	17.78	160021	01.0634	15.16	160101	01.0566	17.55
140168	01.1809	16.36	140291	01.3987	23.45	150070	01.0556	17.12	160023	01.0283	14.75	160102	01.4141	16.83
140170	01.0913	13.81	140292	01.1448	20.62	150071	01.1147	14.38	160024	01.5213	18.26	160103	01.0464	16.71
140171	00.9828	12.95	140294	01.1806	18.17	150072	01.2164	16.13	160026	01.0781	17.30	160104	01.2769	17.47
140172	01.6569	18.91	140297	03.6141	42.09	150073	01.0419	20.53	160027	01.1359	15.04	160106	01.0219	15.39
140173	00.9180	16.52	140300	01.5813	23.72	150074	01.6416	19.08	160028	01.2439	29.74	160107	01.1889	15.98
140174	01.5908	20.01	150001	01.1162	19.10	150075	01.1500	15.63	160029	01.5668	20.19	160108	01.1210	15.98
140176	01.2376	19.86	150002	01.5612	18.51	150076	01.1723	21.36	160030	01.3926	18.00	160109	01.0917	14.76
140177	01.3453	17.27	150003	01.6995	19.07	150077	01.1446	17.40	160031	01.1027	14.50	160110	01.5886	15.04
140179	01.3418	20.09	150004	01.5032	19.67	150078	01.0709	17.70	160032	01.1320	16.27	160111	01.0055	12.29
140180	01.4495	20.79	150005	01.1832	18.97	150079	01.2088	15.90	160033	01.8230	17.57	160112	01.4178	16.06
140181	01.4066	19.27	150006	01.2849	18.75	150082	01.5718	18.22	160034	01.1386	15.15	160113	01.0159	13.97
140182	01.4415	21.36	150007	01.2084	23.06	150084	01.9308	21.85	160035	01.0002	16.77	160114	01.0198	15.40
140184	01.2674	15.18	150008	01.4480	20.34	150086	01.3605	16.73	160036	00.9914	19.22	160115	01.0114	15.21
140185	01.5338	17.67	150009	01.3604	17.37	150088	01.3862	18.67	160037	01.0673	17.12	160116	01.1393	16.05

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140186	01.3890	20.99	150010	01.3803	16.87	150089	01.4224	19.56	160039	01.0306	17.49	160117	01.4457	16.57
140187	01.4928	16.84	150011	01.2428	18.39	150090	01.2346	19.11	160040	01.3651	17.43	160118	01.0356	15.14
140188	00.9534	13.20	150012	01.6426	21.51	150091	01.0088	16.21	160041	01.1113	14.40	160120	01.0138	11.33
140189	01.2002	17.72	150013	01.1765	15.74	150092	01.0661	16.07	160043	01.0099	14.43	160122	01.0892	18.27
140190	01.1046	16.47	150014	01.5058	18.52	150094	00.9912	17.59	160044	01.2332	15.77	160123	.	09.60
140191	01.4385	22.26	150015	01.2414	20.85	150095	01.0947	18.41	160045	01.7247	18.63	160124	01.2975	16.47
140192	.	23.06	150017	01.8563	19.38	150096	01.0645	17.95	160046	00.9978	11.21	160126	01.0620	15.68
140193	01.1053	14.46	150018	01.3499	19.60	150097	01.1094	17.14	160047	01.3996	16.53	160129	01.0618	15.03
140197	01.2547	16.79	150019	01.1822	15.53	150098	01.1240	16.63	160048	01.0480	13.27	160130	01.2040	14.80
140199	01.1112	17.14	150020	01.1549	13.22	150099	01.2821	17.66	160049	00.9525	12.67	160131	01.0659	14.49
140200	01.4624	21.75	150021	01.6171	18.36	150100	01.6556	17.58	160050	01.0803	15.90	160134	00.9376	12.70
140202	01.3096	21.58	150022	01.1154	18.81	150101	01.1228	21.35	160051	00.9336	13.79	160135	01.0305	15.11
140203	01.1667	22.19	150023	01.6071	19.97	150102	01.1666	12.14	160052	01.0088	14.41	160138	01.0553	14.59
140205	00.9675	16.53	150024	01.3952	18.95	150103	00.9565	17.57	160054	01.0130	13.35	160140	01.1369	16.69
140206	01.2403	20.80	150025	01.4898	18.16	150104	01.0841	16.22	160055	00.9882	13.61	160142	01.0971	15.31

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1997 PAGE 6 OF 15
:HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 1999 WAGE INDEX

PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE
160143	00.9819	15.10	170079	00.9525	12.75	180002	01.1270	17.71	180093	01.3742	16.69	190046	01.4385	18.69
160145	01.1407	14.85	170080	00.9799	12.95	180004	01.1275	16.63	180094	01.0630	12.87	190048	01.2586	15.02
160146	01.4408	16.29	170081	00.9248	11.91	180005	01.2487	18.80	180095	01.1977	14.13	190049	00.9836	15.98
160147	01.3261	17.49	170082	00.9822	12.06	180006	00.9230	12.49	180099	01.2011	12.88	190050	01.1010	14.68
160151	01.1079	16.09	170084	00.9112	13.85	180007	01.4809	16.55	180101	01.2748	16.26	190053	01.1301	12.51
160152	00.9997	14.39	170085	00.9055	12.47	180009	01.4018	20.11	180102	01.4737	18.17	190054	01.3416	16.95
160153	01.8054	18.77	170086	01.7295	18.97	180010	01.9109	18.13	180103	02.2959	18.24	190059	00.8921	14.11
170001	01.1979	16.88	170087	.	18.79	180011	01.3448	19.02	180104	01.5611	17.30	190060	01.4340	14.94
170004	01.0679	13.57	170088	00.9532	10.70	180012	01.4122	18.41	180105	00.9455	15.32	190064	01.5709	22.67
170006	01.1597	15.87	170089	00.9736	12.13	180013	01.4173	16.57	180106	00.8760	13.14	190065	01.4937	18.08
170008	00.9797	13.42	170090	00.9999	11.36	180014	01.7278	18.00	180108	00.8327	13.64	190071	00.9048	12.68
170009	01.2054	17.07	170092	00.8320	12.01	180015	.	17.05	180115	01.0029	16.43	190077	00.9403	13.95
170010	01.3058	16.56	170093	00.9122	12.97	180016	01.3059	14.83	180116	01.3489	16.15	190078	01.1598	12.81
170011	.	15.56	170094	00.9330	16.97	180017	01.3622	14.82	180117	01.1374	17.24	190079	01.3233	17.02
170012	01.4251	16.16	170095	01.1350	13.41	180018	01.3351	15.32	180118	01.0477	12.96	190081	00.9317	13.70
170013	01.3067	16.51	170097	00.9892	14.06	180019	01.2535	16.67	180120	01.0385	16.25	190083	01.1019	16.51
170014	01.0324	17.65	170098	01.1652	14.54	180020	01.1243	16.90	180121	01.3157	14.05	190086	01.3460	15.04
170015	00.9911	15.24	170099	01.2148	12.86	180021	01.0700	14.24	180122	01.1046	15.93	190088	01.3402	19.01
170016	01.6814	22.29	170100	01.0100	13.73	180023	00.9119	14.80	180123	01.4012	18.92	190089	01.0953	12.63
170017	01.2089	18.08	170101	00.9159	13.46	180024	01.4442	14.34	180124	01.4303	16.94	190090	01.1128	16.03
170018	01.1373	14.10	170102	01.0142	13.01	180025	01.1790	16.40	180125	01.1087	18.02	190092	01.4163	21.19
170019	01.2205	16.26	170103	01.2882	15.92	180026	01.2506	13.57	180126	01.2146	11.42	190095	01.0410	15.54
170020	01.2931	15.69	170104	01.4490	20.16	180027	01.3131	15.33	180127	01.3568	16.72	190098	01.5065	19.10
170022	01.1323	16.84	170105	01.0726	15.22	180028	01.0868	17.78	180128	01.1777	16.18	190099	01.2333	17.67
170023	01.4103	17.25	170106	00.9715	10.48	180029	01.3044	16.86	180129	01.0384	15.30	190102	01.5822	18.10
170024	01.1513	13.04	170109	00.9934	16.20	180030	01.1600	16.40	180130	01.4197	17.60	190103	00.8978	11.00
170025	01.1906	16.10	170110	01.0069	15.05	180031	01.1174	14.02	180132	01.2847	16.14	190106	01.1710	17.85
170026	01.1060	13.47	170112	01.0528	13.55	180032	01.0939	17.05	180133	01.3197	22.68	190109	01.2506	14.31
170027	01.3167	16.03	170113	01.0911	15.23	180033	01.1836	15.96	180134	01.0966	14.44	190110	00.9671	13.76
170030	01.0475	12.94	170114	01.0303	14.05	180034	01.1380	15.67	180136	01.6678	19.72	190111	01.5374	19.83
170031	00.8786	12.82	170115	00.9926	12.43	180035	01.6053	19.41	180137	.	18.82	190112	01.6544	20.08
170032	01.0621	15.46	170116	01.0776	15.42	180036	01.2077	18.69	180138	01.2687	17.79	190113	01.3395	19.82
170033	01.3707	15.53	170117	00.9897	13.41	180037	01.3315	19.96	180139	01.1164	17.89	190114	01.0376	13.04
170034	01.0160	13.90	170119	00.9883	13.57	180038	01.4367	15.84	180140	01.0497	22.60	190115	01.2044	19.30
170035	00.8909	14.00	170120	01.3109	15.92	180040	01.9795	18.54	180141	01.7877	.	190116	01.1611	15.43
170036	00.9026	14.08	170122	01.7455	18.82	180041	01.1057	14.94	190001	00.9596	22.06	190118	01.0621	13.08
170037	01.0356	17.05	170123	01.7867	18.98	180042	01.1350	15.05	190002	01.7216	18.29	190120	01.0423	13.99
170038	00.9220	12.68	170124	00.9925	13.55	180043	01.1903	19.17	190003	01.4197	18.68	190122	01.3111	13.83
170039	01.0920	14.23	170126	00.9618	12.53	180044	01.2212	17.26	190004	01.4637	16.87	190124	01.6398	19.92
170040	01.6474	19.98	170128	00.9122	14.70	180045	01.3800	17.42	190005	01.5689	16.64	190125	01.5418	18.47
170041	01.0737	11.25	170131	01.1686	12.10	180046	01.1859	16.65	190006	01.3272	15.31	190128	01.0998	18.95
170043	.	13.01	170133	01.1002	16.69	180047	01.0281	15.61	190007	01.0323	14.17	190130	00.9694	12.14
170044	00.9917	13.97	170134	00.9044	13.04	180048	01.2725	16.28	190008	01.6740	19.37	190131	01.2289	17.54
170045	01.0391	15.18	170137	01.1643	17.98	180049	01.3908	16.09	190009	01.3045	14.70	190133	00.9626	12.86
170049	01.2902	18.48	170139	01.0787	13.05	180050	01.2657	17.30	190010	01.1216	16.24	190134	01.0050	16.50
170051	00.9111	13.41	170142	01.2873	17.06	180051	01.3709	15.43	190011	01.1671	15.32	190135	01.4536	19.59
170052	01.1183	14.31	170143	01.1870	15.24	180053	01.1047	14.96	190013	01.3465	16.26	190136	01.2060	11.11
170053	00.9902	13.91	170144	01.6580	13.79	180054	01.1313	15.82	190014	01.1454	16.03	190138	00.8637	20.29
170054	01.0987	13.64	170145	01.1080	14.38	180055	01.2313	14.70	190015	01.2588	18.74	190140	00.9883	11.98
170055	01.0862	14.51	170146	01.5299	18.68	180056	01.1291	16.33	190017	01.3997	14.84	190142	00.9321	14.53
170056	00.8967	14.93	170147	01.2057	18.29	180058	01.0271	13.04	190018	01.1580	15.95	190144	01.2651	16.26
170057	00.9942	12.90	170148	01.5032	17.77	180059	00.8671	15.17	190019	01.7302	19.64	190145	01.0074	14.74
170058	01.1568	17.58	170150	01.1547	14.00	180060	.	12.10	190020	01.1707	17.77	190146	01.6120	21.10

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170060	01.1064	14.95	170151	00.9808	13.15	180063	01.1793	11.94	190025	01.3427	13.33	190147	00.9692	14.36
170061	01.1673	14.17	170152	01.0368	14.21	180064	01.3244	14.70	190026	01.4984	18.00	190148	00.9727	13.91
170063	00.8588	11.84	170160	00.9993	11.81	180065	01.0035	12.89	190027	01.5421	17.46	190149	01.0104	14.40
170064	.	11.42	170164	01.0159	15.01	180066	01.1555	18.08	190029	01.1748	17.67	190151	01.2139	12.79
170066	01.0038	13.66	170166	01.1482	17.40	180067	01.9572	17.80	190033	00.9756	.	190152	01.4892	20.90
170067	01.0345	14.44	170168	.	13.56	180069	01.1530	17.37	190034	01.1811	15.36	190155	00.7261	16.10
170068	01.2557	17.01	170171	01.0693	12.88	180070	01.1559	13.57	190035	01.4078	.	190156	01.0201	12.27
170069	.	14.04	170174	.	12.86	180072	01.1749	15.81	190036	01.6986	20.46	190158	01.1965	20.87
170070	01.0322	12.73	170175	01.3967	17.67	180075	01.6587	12.68	190037	00.9052	11.28	190160	01.2801	17.06
170072	.	14.25	170176	01.6740	24.03	180078	01.0863	18.97	190039	01.4102	16.98	190161	01.0765	14.05
170073	01.1796	15.56	170180	.	18.09	180079	01.2467	12.71	190040	01.3258	20.34	190162	01.0966	19.57
170074	01.1203	13.41	170182	01.4638	21.54	180080	01.0618	15.09	190041	01.6026	20.22	190164	01.2766	14.89
170075	00.9167	10.71	170183	02.0428	15.05	180087	01.2984	14.29	190043	01.0723	12.52	190167	01.1704	18.78
170076	01.0539	12.55	170184	01.7569	.	180088	01.5747	20.75	190044	01.1584	21.11	190170	00.9109	13.69
170077	00.9613	12.58	180001	01.3953	17.87	180092	01.2244	15.98	190045	01.4325	21.34	190173	01.4304	19.67

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1997 PAGE 7 OF 15
:HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 1999 WAGE INDEX

PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE
190175	01.6177	20.46	200063	01.3056	18.34	220023	00.6116	19.30	220135	01.3046	26.15	230097	01.6124	19.12
190176	01.6882	21.21	200066	01.1625	16.74	220024	01.2166	21.22	220153	01.0232	22.56	230099	01.1457	19.68
190177	01.7758	18.90	210001	01.4923	21.16	220025	01.1311	18.70	220154	00.9399	22.42	230100	01.1671	15.57
190178	00.9823	10.60	210002	01.9803	18.07	220028	01.4723	20.84	220162	01.3216	.	230101	01.1097	18.36
190182	01.2638	19.89	210003	01.5992	21.93	220029	01.1851	24.16	220163	02.1239	27.44	230103	01.0397	20.72
190183	01.2015	15.22	210004	01.3652	23.18	220030	01.1527	17.73	220171	01.6204	23.56	230104	01.5914	22.43
190184	01.0316	15.61	210005	01.2766	19.38	220031	01.9268	28.44	230001	01.1893	18.07	230105	01.7553	20.27
190185	01.3457	19.22	210006	01.1399	17.16	220033	01.2841	20.97	230002	01.2768	20.96	230106	01.2988	20.51
190186	00.9220	14.11	210007	01.7368	25.17	220035	01.2839	24.51	230003	01.1597	18.62	230107	00.9125	14.72
190189	.	26.05	210008	01.3921	19.01	220036	01.5981	21.95	230004	01.7136	22.53	230108	01.2081	18.37
190190	00.8894	12.48	210009	01.8145	21.72	220038	01.3056	26.32	230005	01.2849	18.86	230110	01.3580	17.83
190191	01.2265	19.55	210010	01.1495	15.64	220041	01.2275	23.41	230006	01.1008	18.53	230111	.	20.21
190196	00.9611	16.22	210011	01.3414	18.75	220042	01.2460	24.56	230007	00.9571	18.95	230113	00.9211	19.49
190197	01.1853	17.51	210012	01.6377	22.07	220046	01.3694	23.14	230012	00.8477	12.18	230114	.	24.52
190199	01.2549	10.95	210013	01.3218	19.82	220049	01.3556	18.47	230013	01.4034	21.05	230115	01.0388	17.19
190200	01.6004	20.62	210015	01.2989	19.60	220050	01.1242	19.98	230015	01.2008	20.91	230116	00.9247	16.31
190201	01.0884	18.83	210016	01.8256	22.33	220051	01.2194	21.10	230017	01.5006	25.28	230117	01.9005	26.08
190202	01.2534	19.01	210017	01.2200	15.90	220052	01.3241	23.01	230019	01.4715	22.20	230118	01.2182	17.43
190203	01.5599	22.35	210018	01.3037	21.29	220053	01.2325	20.02	230020	01.7402	21.30	230119	01.2967	21.46
190204	01.4998	20.88	210019	01.5799	18.39	220055	01.2985	24.04	230021	01.5687	18.27	230120	01.1481	18.40
190205	01.9408	18.91	210022	01.5037	21.14	220057	01.4058	22.67	230022	01.2576	18.76	230121	01.2302	20.61
190206	01.6020	21.26	210023	01.3369	21.51	220058	01.1529	18.51	230024	01.4468	22.98	230122	01.3434	19.37
190207	01.2219	17.10	210024	01.5451	20.11	220060	01.2956	25.44	230027	01.1105	17.48	230124	01.1647	18.52
190208	00.8305	10.93	210025	01.3753	18.95	220062	00.5763	19.65	230029	01.5561	19.51	230125	.	15.03
190218	01.1695	17.36	210026	01.3869	17.97	220063	01.2665	19.84	230030	01.3293	16.78	230128	01.3983	23.12
190223	.	14.55	210027	01.2940	17.66	220064	01.2822	21.51	230031	01.4301	19.42	230130	01.6698	22.34
190227	00.8710	30.27	210028	01.2239	18.31	220065	01.2956	19.95	230032	01.7486	19.80	230132	01.3725	24.82
190231	01.4416	13.27	210029	01.2714	14.09	220066	01.3850	21.73	230034	01.2735	18.80	230133	01.2687	17.99
190233	.	27.39	210030	01.1576	19.24	220067	01.3234	22.80	230035	01.0904	18.74	230134	.	17.38
190234	.	19.01	210031	01.2844	16.76	220068	.	14.94	230036	01.2223	20.75	230135	01.3184	23.03
190235	01.6410	.	210032	01.1779	18.71	220070	01.2213	19.89	230037	01.1476	17.66	230137	01.1565	18.31
190236	01.4022	.	210033	01.2730	18.96	220071	01.9025	24.06	230038	01.6681	21.58	230141	01.6302	22.96
200001	01.4089	16.84	210034	01.3514	20.17	220073	01.3126	24.84	230040	01.1820	20.58	230142	01.3099	19.01
200002	01.1092	23.41	210035	01.3097	19.08	220074	01.4393	25.62	230041	01.2513	19.27	230143	01.3116	18.35
200003	01.1424	16.08	210037	01.2736	18.27	220075	01.4777	21.83	230042	01.2302	20.08	230144	01.1457	20.61
200006	01.0131	18.67	210038	01.4097	21.87	220076	01.1814	21.47	230046	01.9345	23.28	230145	01.1932	18.05
200007	01.0247	16.64	210039	01.1830	19.69	220077	01.7982	24.81	230047	01.3803	19.18	230146	01.2743	19.36
200008	01.2489	20.05	210040	01.2968	23.05	220079	01.1935	21.38	230053	01.6040	24.58	230147	01.3983	17.47
200009	01.8253	20.71	210043	01.3137	21.29	220080	01.3077	19.50	230054	01.8071	19.80	230149	01.1502	16.14
200012	01.1249	16.83	210044	01.3429	21.63	220081	01.0938	27.20	230055	01.1704	19.01	230151	01.4022	21.20
200013	01.1170	15.39	210045	01.0242	11.01	220082	01.2894	19.87	230056	00.9643	15.57	230153	01.1456	16.66
200015	01.2669	17.80	210046	.	08.62	220083	01.1674	21.49	230058	01.0992	18.45	230154	00.9500	14.32
200016	01.0371	16.48	210048	01.2483	22.46	220084	01.3390	25.27	230059	01.5037	19.06	230155	01.0484	17.35
200018	01.2186	16.45	210049	01.1653	17.20	220086	01.7766	24.29	230060	01.2256	18.53	230156	01.7161	23.80
200019	01.2451	18.12	210051	01.4197	22.78	220088	01.6380	23.76	230062	00.9648	15.71	230157	01.2007	22.20
200020	01.1290	19.42	210054	01.3635	21.94	220089	01.2538	21.52	230063	01.3172	19.89	230159	01.3434	20.64
200021	01.1596	18.52	210055	01.2727	22.10	220090	01.2771	21.07	230065	01.3095	20.37	230162	01.0605	19.93
200023	00.9003	14.08	210056	01.3995	17.67	220092	01.2563	32.24	230066	01.3706	21.26	230165	01.8765	22.95
200024	01.4141	19.55	210057	01.4710	24.67	220094	01.4476	17.90	230068	.	21.62	230167	01.7983	19.63
200025	01.1632	19.60	210058	01.4804	18.67	220095	01.2250	18.87	230069	01.1371	22.24	230169	01.3462	23.25
200026	01.0452	15.97	210059	01.2600	21.98	220098	01.3468	20.29	230070	01.6308	20.99	230171	01.0177	14.52
200027	01.2321	16.90	210060	01.2554	.	220099	.	13.53	230071	01.1848	22.62	230172	01.1896	19.10
200028	00.9877	16.14	210061	01.1777	18.56	220100	01.2691	24.68	230072	01.2721	19.89	230174	01.3661	20.84

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200031	01.2519	15.04	220001	01.2758	27.10	220101	01.4772	24.24	230075	01.4809	20.07	230175	03.7062	.
200032	01.2961	17.40	220002	01.5411	22.94	220104	01.4461	23.60	230076	01.3287	22.99	230176	01.2157	22.12
200033	01.7953	20.86	220003	01.1351	17.95	220105	01.3505	20.60	230077	01.9347	19.36	230178	00.9930	17.48
200034	01.2205	18.06	220004	.	19.66	220106	01.2302	22.80	230078	01.2555	16.56	230180	01.1695	14.55
200037	01.2183	16.94	220006	01.4322	21.10	220107	.	20.20	230080	01.2452	19.94	230184	01.1622	18.23
200038	01.1278	19.07	220008	01.2878	21.58	220108	01.1985	22.25	230081	01.2592	16.66	230186	01.2436	.
200039	01.2922	19.74	220010	01.3443	21.70	220110	02.0159	29.14	230082	01.1144	17.08	230188	01.1168	15.81
200040	01.1310	19.00	220011	01.1587	28.81	220111	01.2641	22.15	230085	01.0950	18.91	230189	00.9581	15.39
200041	01.1543	18.64	220012	01.3404	34.76	220116	01.9394	25.79	230086	00.9537	17.36	230190	01.0724	24.98
200043	00.7389	18.38	220015	01.1936	22.77	220118	.	25.42	230087	01.0870	16.19	230191	00.9612	17.58
200050	01.1566	17.35	220016	01.3682	21.55	220119	01.3309	23.90	230089	01.2754	23.86	230193	01.2584	17.77
200051	01.0095	19.57	220017	01.3972	23.30	220123	01.0607	23.94	230092	01.3559	19.28	230194	.	15.97
200052	01.0413	15.56	220019	01.1631	19.12	220126	01.3576	19.87	230093	01.2752	19.05	230195	01.3372	22.07
200055	01.1614	17.37	220020	01.2267	18.74	220128	00.8929	21.47	230095	01.1797	17.06	230197	01.4211	21.38
200062	00.9477	15.91	220021	.	24.31	220133	00.9081	27.36	230096	01.1017	21.02	230199	01.1164	19.29

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1997 PAGE 8 OF 15
:HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 1999 WAGE INDEX

PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE
230201	01.1441	15.09	240044	01.1838	18.04	240129	01.0143	17.56	250033	01.0515	15.66	250136	00.8778	17.66
230204	01.4322	21.66	240045	01.0514	21.34	240130	00.9625	15.66	250034	01.6518	14.46	250138	01.2910	17.90
230205	01.0432	16.37	240047	01.5458	21.26	240132	01.2204	22.37	250035	00.8652	13.84	250141	01.2595	15.71
230207	01.2690	19.90	240048	01.2443	22.64	240133	01.2042	17.72	250036	00.9695	14.48	250145	00.8231	10.04
230208	01.3231	17.40	240049	01.7758	22.43	240135	00.8725	14.11	250037	00.9171	10.05	250146	00.9619	13.97
230211	00.9035	21.59	240050	01.1637	24.71	240137	01.2316	18.97	250038	00.9696	14.37	250148	01.0951	19.08
230212	01.0821	23.46	240051	01.0101	18.49	240138	00.9529	12.97	250039	00.9936	13.36	250149	00.8917	12.04
230213	00.9989	15.25	240052	01.3099	18.64	240139	00.9670	16.59	250040	01.3042	16.41	260001	01.7077	18.05
230216	01.5676	18.16	240053	01.5217	20.25	240141	01.1732	21.09	250042	01.2802	15.45	260002	01.4640	21.40
230217	01.2516	22.94	240056	01.2477	21.74	240142	01.1442	18.96	250043	00.9855	12.80	260003	01.1285	13.48
230219	00.8764	19.28	240057	01.8135	22.67	240143	00.9565	13.94	250044	01.0267	15.20	260004	01.0516	13.31
230221	00.8721	24.54	240058	00.9712	14.79	240144	01.0329	16.74	250045	01.1997	18.75	260005	01.6194	20.37
230222	01.4500	19.43	240059	01.0990	21.81	240145	01.0312	15.57	250047	00.9714	15.45	260006	01.5008	20.55
230223	01.3326	21.85	240061	01.8121	24.36	240146	00.9340	19.10	250048	01.5488	15.39	260008	01.3615	16.53
230227	01.4715	21.56	240063	01.4361	22.81	240148	01.0498	14.55	250049	00.8904	11.34	260009	01.2591	16.29
230230	01.6776	22.01	240064	01.2963	21.93	240150	00.9178	12.84	250050	01.2737	13.43	260011	01.6973	18.75
230232	00.9510	17.15	240065	01.0310	12.44	240152	01.0165	19.91	250051	00.8863	10.57	260012	01.1062	13.18
230235	01.0956	16.27	240066	01.3842	21.19	240153	01.0079	15.23	250057	01.2308	15.59	260013	01.1932	15.48
230236	01.3257	21.58	240069	01.1906	19.01	240154	01.0531	17.00	250058	01.1863	14.40	260014	.	21.19
230239	01.1386	13.72	240071	01.1104	19.55	240155	00.8952	19.40	250059	01.0404	14.21	260015	01.2702	16.27
230241	01.1657	17.52	240072	01.0196	16.80	240157	01.0893	14.13	250060	00.7820	08.90	260017	01.2328	15.54
230244	01.3975	21.17	240073	00.9372	16.40	240160	01.0030	16.30	250061	00.8857	17.01	260018	00.9017	12.37
230253	00.9911	18.85	240075	01.1813	19.91	240161	00.9970	14.99	250063	00.8517	12.44	260019	01.0919	14.52
230254	01.2652	21.20	240076	01.0698	20.86	240162	01.0706	16.59	250065	00.9231	12.61	260020	01.7332	20.07
230257	00.7894	18.51	240077	00.9437	14.31	240163	00.9935	17.79	250066	00.9111	13.53	260021	01.4662	17.59
230259	01.1876	21.59	240078	01.4831	23.66	240166	01.1119	15.60	250067	01.1363	14.76	260022	01.2882	18.09
230264	01.6939	14.86	240079	01.0280	15.37	240169	00.9128	15.98	250068	00.8476	11.36	260023	01.4994	16.39
230269	01.3775	22.69	240080	01.5726	22.34	240170	01.1054	17.38	250069	01.3522	17.35	260024	00.9679	12.96
230270	01.1736	20.20	240082	01.1938	17.03	240171	01.0764	15.79	250071	00.9304	11.63	260025	01.3102	14.68
230273	01.4462	22.48	240083	01.3133	17.78	240172	00.9553	15.82	250072	01.4188	18.43	260027	01.6204	21.47
230275	00.5262	19.58	240084	01.2448	20.04	240173	00.8945	16.66	250076	.	13.07	260029	01.2379	19.02
230276	00.6643	21.40	240085	00.9737	17.41	240179	01.0128	16.66	250077	00.9292	11.97	260030	01.1850	10.36
230277	01.2452	23.05	240086	01.0838	17.64	240184	00.9886	13.04	250078	01.4795	14.93	260031	01.6087	18.38
230278	01.4214	17.82	240087	01.2051	14.87	240187	01.1980	18.31	250079	00.8803	17.37	260032	01.6641	19.04
230279	00.6592	15.95	240088	01.3850	19.81	240193	01.0207	17.61	250081	01.3261	16.03	260034	01.0575	16.57
230280	00.9974	12.33	240089	00.9840	17.72	240196	00.6319	21.89	250082	01.4034	13.51	260035	01.0029	11.74
240001	01.5454	22.78	240090	01.0465	14.69	240200	00.8668	14.48	250083	00.9521	12.27	260036	01.0142	15.34
240002	01.7519	20.94	240093	01.3276	17.86	240205	00.9138	.	250084	01.1840	17.73	260037	.	17.50
240004	01.5910	21.10	240094	00.9622	20.49	240206	00.8394	.	250085	00.9744	12.58	260039	01.1237	13.86
240005	00.9324	17.38	240096	00.9794	17.63	240207	01.2120	21.80	250088	01.0034	16.71	260040	01.6648	15.24
240006	01.1342	20.97	240097	01.0211	21.79	240210	01.2801	22.90	250089	01.2121	13.89	260042	01.2599	17.67
240007	01.0647	15.50	240098	00.9535	20.33	240211	00.8956	14.75	250093	01.1336	14.36	260044	01.0519	15.91
240008	01.1157	19.71	240099	01.0619	13.30	240212	.	23.29	250094	01.3198	15.45	260047	01.4789	17.30
240009	00.9228	14.31	240100	01.2914	18.97	250001	01.5523	17.39	250095	01.0047	15.92	260048	01.2952	22.43
240010	01.9906	24.41	240101	01.1821	20.41	250002	00.9816	17.30	250096	01.1998	17.01	260050	01.0428	16.49
240011	01.1539	17.81	240102	00.9603	12.87	250003	01.0042	18.40	250097	01.3212	15.83	260052	01.3366	19.75
240013	01.3431	18.17	240103	01.0488	16.28	250004	01.4896	18.02	250098	00.8376	16.66	260053	01.1744	11.73
240014	01.0781	20.29	240104	01.2319	21.76	250005	00.9342	09.95	250099	01.2611	14.04	260054	01.3164	16.07
240016	01.3893	18.22	240105	00.9597	13.46	250006	00.9866	14.60	250100	01.2911	15.26	260055	00.9908	10.97
240017	01.0597	17.25	240106	01.4052	26.55	250007	01.2806	19.42	250101	00.8837	16.65	260057	01.1510	16.96
240018	01.2876	17.23	240107	00.9916	17.31	250008	00.9810	13.33	250102	01.6110	17.67	260059	01.2680	14.66
240019	01.2647	21.39	240108	01.0004	17.24	250009	01.2338	17.50	250104	01.4496	17.79	260061	01.1006	14.06
240020	01.1653	20.01	240109	00.9475	13.19	250010	01.0399	12.77	250105	00.9445	13.40	260062	01.2031	18.91

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240021	01.0438	16.96	240110	00.9668	16.33	250012	00.9312	19.88	250107	00.8814	14.53	260063	01.0697	15.91
240022	01.1134	19.13	240111	01.0666	19.00	250015	01.0855	10.44	250109	00.8961	15.37	260064	01.3244	16.92
240023	00.9928	19.88	240112	00.9996	14.73	250017	00.9989	16.64	250112	00.9713	13.07	260065	01.8219	18.25
240025	01.1399	16.29	240114	00.9257	14.74	250018	00.9513	13.02	250117	01.0766	14.70	260066	01.0264	15.01
240027	01.0268	16.33	240115	01.6167	21.50	250019	01.4342	17.00	250119	01.1170	12.45	260067	00.8671	13.74
240028	01.1533	18.52	240116	00.9360	13.96	250020	00.9461	13.80	250120	01.1115	13.09	260068	01.6717	20.25
240029	01.1637	18.10	240117	01.1575	18.18	250021	00.8815	08.57	250122	01.2478	16.93	260070	01.0421	14.48
240030	01.2832	17.99	240119	00.8219	20.58	250023	00.9588	12.77	250123	01.2806	18.73	260073	01.1405	12.89
240031	00.9756	16.71	240121	00.9390	21.27	250024	00.9071	13.60	250124	00.9129	11.59	260074	01.3020	13.93
240036	01.5644	20.26	240122	01.0519	18.93	250025	01.2061	18.06	250125	01.3190	16.81	260077	01.7248	17.21
240037	01.0214	18.19	240123	01.0055	15.03	250027	00.9581	11.90	250126	00.9739	14.17	260078	01.1773	14.62
240038	01.4979	24.41	240124	00.9666	18.39	250029	00.8778	12.96	250127	00.8269	.	260079	01.0769	14.32
240040	01.2468	20.15	240125	00.9263	11.73	250030	00.9735	14.45	250128	01.0942	12.43	260080	01.0512	11.77
240041	01.1627	17.48	240127	01.1085	14.25	250031	01.3095	18.54	250131	01.0232	11.03	260081	01.6073	18.98
240043	01.1966	17.00	240128	01.1221	15.77	250032	01.2556	16.21	250134	00.9923	16.70	260082	01.1768	13.93

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1997 PAGE 9 OF 15
:HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 1999 WAGE INDEX

PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE
260085	01.5724	19.71	270006	00.9249	16.35	280028	01.1079	15.15	280117	01.0899	15.93	310015	01.9526	26.27
260086	01.0978	15.09	270007	00.8854	12.23	280029	01.1288	15.52	280118	00.9339	16.45	310016	01.2563	24.44
260089	.	12.65	270009	01.1183	19.32	280030	01.7063	27.82	280119	00.8718	.	310017	01.3833	23.95
260091	01.7207	19.94	270011	01.0341	18.28	280031	01.0141	13.61	280123	00.8938	15.97	310018	01.1259	21.90
260094	01.1962	16.48	270012	01.5937	18.33	280032	01.3019	17.79	280125	01.2409	.	310019	01.6757	24.23
260095	01.4483	17.58	270013	.	18.58	280033	01.0506	15.69	290001	01.6993	23.03	310020	01.3892	22.80
260096	01.5946	22.03	270014	01.8312	17.81	280034	.	14.23	290002	00.9144	16.13	310021	01.3810	23.92
260097	01.2017	14.79	270016	00.9039	15.97	280035	01.0337	13.65	290003	01.6802	25.76	310022	01.3160	21.20
260100	01.0365	15.72	270017	01.2369	19.09	280037	01.0432	15.48	290005	01.4935	20.79	310024	01.3017	23.65
260102	01.0436	18.57	270019	01.0021	15.86	280038	01.0023	15.49	290006	01.2550	19.14	310025	01.2003	22.10
260103	01.2881	17.51	270021	01.1723	16.67	280039	01.0466	15.70	290007	01.8517	28.55	310026	01.2039	23.29
260104	01.7543	18.42	270023	01.3032	21.22	280040	01.6283	19.18	290008	01.2106	19.60	310027	01.3268	22.00
260105	01.9041	20.26	270024	.	14.59	280041	00.9116	12.05	290009	01.6230	23.33	310028	01.2532	22.00
260107	01.4570	19.81	270026	00.8835	14.97	280042	01.0331	15.14	290010	01.2389	14.00	310029	01.9471	23.08
260108	01.8633	21.29	270027	01.1127	12.40	280043	01.0135	15.47	290011	00.9088	15.52	310031	02.8632	24.16
260109	00.9878	12.92	270028	01.1318	15.50	280045	01.0969	16.10	290012	01.3751	21.50	310032	01.3473	22.63
260110	01.6887	15.14	270029	00.9581	18.18	280046	01.1071	12.37	290013	01.0527	18.62	310034	01.2595	21.62
260111	.	22.44	270032	01.1220	16.20	280047	01.0907	18.01	290014	00.9712	17.46	310036	01.1891	19.37
260112	.	19.41	270033	00.8603	16.34	280048	01.2131	13.82	290015	00.9212	15.49	310037	01.3656	27.57
260113	01.1466	14.76	270035	01.0091	18.28	280049	01.0412	15.08	290016	01.1800	22.67	310038	01.9532	26.16
260115	01.2596	17.02	270036	00.8802	12.78	280050	00.9266	13.71	290019	01.3445	20.03	310039	01.2827	21.61
260116	01.0837	15.06	270039	01.0036	15.36	280051	01.0812	15.19	290020	01.0445	17.29	310040	01.2350	24.89
260119	01.2305	15.30	270040	01.1080	18.24	280052	01.0834	13.32	290021	01.6240	21.94	310041	01.4067	23.77
260120	01.1999	16.64	270041	01.1236	15.74	280054	01.2607	17.91	290022	01.7018	19.65	310042	01.2414	23.65
260122	01.1741	12.73	270044	01.1515	13.98	280055	00.9176	14.40	290027	00.9528	17.23	310043	01.1413	20.86
260123	01.0812	14.05	270046	00.9619	14.85	280056	00.9752	14.45	290029	01.0009	.	310044	01.2855	20.94
260127	01.0109	15.92	270048	01.1039	16.41	280057	00.9835	15.40	290032	01.4112	22.30	310045	01.4636	27.72
260128	01.0114	10.96	270049	01.7945	20.21	280058	01.3027	18.34	290036	00.9333	51.78	310047	01.3689	24.35
260129	01.2317	15.69	270050	01.1001	17.98	280060	01.5884	19.24	290038	00.9957	19.95	310048	01.2808	23.05
260131	01.2481	18.04	270051	01.3404	21.08	280061	01.4334	17.06	290039	01.3228	.	310049	01.2915	25.80
260134	01.1690	15.67	270052	01.0383	17.86	280062	01.0987	13.35	300001	01.3955	21.34	310050	01.2294	23.17
260137	01.7186	15.26	270053	.	10.60	280064	01.0290	15.52	300003	01.9460	23.98	310051	01.3566	24.87
260138	01.8747	21.26	270057	01.2434	18.93	280065	01.2785	18.72	300005	01.2969	20.28	310052	01.2958	22.63
260141	01.9101	17.28	270058	00.9045	13.38	280066	01.0672	12.50	300006	01.1904	19.05	310054	01.3494	24.94
260142	01.1144	15.65	270059	00.7751	15.90	280068	00.9650	09.45	300007	01.0998	18.33	310056	.	20.89
260143	00.9980	12.75	270060	00.9593	15.08	280070	01.0094	11.19	300008	01.2851	19.56	310057	01.3335	21.31
260147	00.9734	13.55	270063	00.9892	14.82	280073	01.0056	13.68	300009	01.1330	19.41	310058	01.1081	25.47
260148	00.9270	10.32	270068	.	14.81	280074	01.1152	14.29	300010	01.1969	19.48	310060	01.2007	18.91
260158	01.0224	12.65	270072	00.8066	13.85	280075	01.1773	13.70	300011	01.3754	22.48	310061	01.2584	21.39
260159	00.9823	19.26	270073	01.1914	11.83	280076	01.0550	14.37	300012	01.3346	21.77	310062	01.3076	20.98
260160	01.0550	15.82	270074	00.9056	.	280077	01.3188	17.95	300013	01.1886	17.57	310063	01.3693	20.30
260162	01.5551	20.64	270075	00.9172	.	280079	01.0646	10.61	300014	01.2860	19.49	310064	01.3236	25.51
260163	01.2239	14.59	270076	00.7724	.	280080	01.1041	13.61	300015	01.2368	18.54	310067	01.3168	22.77
260164	00.9521	13.24	270079	00.8978	13.71	280081	01.7825	18.66	300016	01.2347	18.83	310069	01.2896	22.25
260166	01.2363	19.78	270080	01.1923	16.88	280082	01.0111	13.50	300017	01.3032	21.18	310070	01.4153	23.42
260172	00.9977	12.55	270081	01.0195	12.52	280083	01.0434	15.04	300018	01.3146	20.16	310072	01.3114	21.57
260173	01.0314	12.21	270082	01.0679	16.17	280084	01.0067	11.42	300019	01.2127	19.97	310073	01.6312	25.97
260175	01.1180	16.34	270083	01.0915	15.30	280085	.	20.93	300020	01.3052	20.45	310074	01.4184	23.70
260176	01.6518	17.62	270084	00.8800	14.83	280088	01.7601	.	300021	01.0885	17.07	310075	01.4302	24.77
260177	01.2847	20.19	280001	01.1067	14.99	280089	01.0543	17.29	300022	01.0553	17.35	310076	01.4462	29.78
260178	01.4987	20.94	280003	02.1160	20.20	280090	00.9608	14.34	300023	01.3848	20.45	310077	01.6805	25.17
260179	01.6441	22.01	280005	01.4161	17.90	280091	01.1064	14.54	300024	01.2608	19.20	310078	01.4033	24.29
260180	01.7064	18.96	280009	01.7521	18.19	280092	00.9797	13.94	300028	01.2144	17.28	310081	01.3294	21.87

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260183	01.5184	16.58	280010	.	16.26	280094	01.1327	15.40	300029	01.3671	22.33	310083	01.3146	22.81
260186	01.4343	17.35	280011	00.8691	12.42	280097	00.9690	11.94	300033	01.1392	16.28	310084	01.3934	22.06
260188	01.2183	18.37	280012	.	15.04	280098	00.9782	10.71	300034	02.0346	22.41	310086	01.2200	21.44
260189	00.8526	10.87	280013	01.9350	21.09	280101	01.1002	13.51	310001	01.8045	26.88	310087	01.3353	20.44
260190	01.2059	18.00	280014	00.9234	13.35	280102	00.9272	12.45	310002	01.8210	26.75	310088	01.2208	20.83
260191	01.2514	18.58	280015	01.0351	15.29	280104	00.9942	13.11	310003	01.2818	25.98	310090	01.3658	25.21
260193	01.2934	26.66	280017	01.1164	14.01	280105	01.2732	18.10	310005	01.2325	21.46	310091	01.2913	21.39
260195	01.2216	16.53	280018	01.0384	13.73	280106	00.9818	14.48	310006	01.2748	22.76	310092	01.3167	22.21
260197	01.1400	25.99	280020	01.6434	19.29	280107	01.0910	11.45	310008	01.3528	23.49	310093	01.1659	20.43
260198	01.3052	16.46	280021	01.2618	16.90	280108	01.1283	15.09	310009	01.3126	23.63	310096	01.8815	24.31
260200	01.2650	19.63	280022	01.0382	14.17	280109	00.9214	10.58	310010	01.2849	21.05	310105	01.3012	24.52
260205	01.3611	.	280023	01.3979	17.13	280110	01.0019	11.44	310011	01.2115	21.51	310108	01.4421	23.10
270002	01.3016	14.48	280024	00.9571	12.45	280111	01.2510	18.27	310012	01.6591	26.14	310110	01.2746	20.54
270003	01.2687	21.02	280025	00.9312	12.87	280114	00.9171	13.00	310013	01.4189	21.63	310111	01.3812	23.23
270004	01.6928	18.01	280026	01.2085	14.79	280115	00.9329	16.12	310014	01.6972	26.36	310112	01.3444	21.93

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1997 PAGE 10 OF 15
:HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 1999 WAGE INDEX

PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE
310113	01.2710	21.81	330027	01.3674	31.82	330132	01.1996	13.55	330233	01.4934	30.49	330398	01.3767	29.40
310115	01.3328	21.37	330028	01.4702	25.53	330133	01.3718	32.48	330234	02.3193	31.88	330399	01.2652	28.85
310116	01.2762	22.96	330029	01.0090	19.40	330135	01.2030	19.14	330235	01.1221	19.21	340001	01.4789	17.91
310118	01.2683	22.84	330030	01.2589	16.43	330136	01.2892	19.26	330236	01.4065	28.47	340002	01.8410	18.45
310119	01.7164	31.69	330033	01.2709	16.66	330140	01.7771	18.97	330238	01.1746	15.02	340003	01.1253	17.00
310120	01.0930	20.80	330034	00.6402	30.46	330141	01.3837	24.49	330239	01.1681	16.21	340004	01.4496	18.79
310121	.	19.11	330036	01.3073	23.40	330144	00.9394	15.19	330240	01.3326	27.67	340005	01.1635	14.94
320001	01.3972	17.43	330037	01.1538	15.46	330148	01.0767	15.47	330241	01.9769	21.66	340006	01.0439	14.76
320002	01.3672	19.50	330038	01.2344	15.80	330151	01.1186	14.68	330242	01.3423	25.14	340007	01.1689	17.20
320003	01.1254	13.29	330039	.	14.18	330152	01.4141	30.20	330245	01.3069	17.81	340008	01.1291	18.36
320004	01.2821	14.84	330041	01.3048	36.69	330153	01.7370	16.99	330246	01.3851	25.91	340009	.	22.70
320005	01.3572	20.75	330043	01.3151	26.75	330154	01.7385	.	330247	00.8964	27.38	340010	01.2990	17.72
320006	01.4176	18.44	330044	01.3083	18.10	330157	01.3497	19.72	330249	01.1947	16.18	340011	01.1621	15.71
320009	01.6250	17.17	330045	01.4171	27.45	330158	01.4958	20.48	330250	01.2872	17.98	340012	01.3170	17.04
320011	01.0144	17.05	330046	01.4623	30.06	330159	01.2906	17.96	330252	00.9461	16.84	340013	01.2792	17.55
320012	00.9927	16.53	330047	01.1766	16.85	330160	01.4719	30.75	330254	01.1687	17.12	340014	01.5598	22.23
320013	01.1521	17.67	330048	01.2916	17.45	330161	.	18.36	330258	01.3347	30.01	340015	01.3003	20.37
320014	01.1512	14.63	330049	01.2376	18.56	330162	01.2139	27.01	330259	01.5019	23.38	340016	01.1909	16.24
320016	01.1215	15.17	330053	01.1886	14.83	330163	01.1898	19.14	330261	01.2943	26.17	340017	01.2480	14.31
320017	01.2109	16.75	330055	01.6240	29.81	330164	01.4956	19.87	330263	01.0302	17.91	340018	01.2451	16.25
320018	01.5859	18.43	330056	01.4381	30.74	330166	01.0120	13.56	330264	01.2135	21.71	340019	01.0233	20.26
320019	01.4818	19.57	330057	01.6793	19.00	330167	01.6554	29.65	330265	01.3947	16.33	340020	01.1985	19.04
320021	01.7539	16.92	330058	01.3085	17.32	330169	01.4654	32.41	330267	01.3654	23.95	340021	01.2340	17.72
320022	01.2186	16.24	330059	01.5820	33.40	330171	01.4021	23.94	330268	00.9666	15.02	340022	01.0614	16.91
320023	01.0801	16.73	330061	01.3193	24.36	330175	01.1896	15.21	330270	01.9886	27.64	340023	01.3737	17.91
320030	01.1495	16.84	330062	01.0736	17.10	330177	00.9629	14.78	330273	01.3060	25.72	340024	01.1402	16.33
320031	00.8261	17.05	330064	01.4952	32.11	330179	00.9031	14.60	330275	01.2898	22.07	340025	01.2240	15.47
320032	00.9014	17.10	330065	01.2031	18.54	330180	01.1968	16.27	330276	01.1701	17.92	340027	01.2055	16.89
320033	01.1516	22.76	330066	01.2776	17.98	330181	01.3527	31.07	330277	01.1083	16.57	340028	01.5990	16.85
320035	01.0300	22.89	330067	01.3928	21.13	330182	02.5509	30.48	330279	01.3572	19.05	340030	02.0184	21.06
320037	01.2216	23.31	330072	01.4098	29.70	330183	01.4673	19.94	330285	01.8495	22.59	340031	01.0063	12.52
320038	01.2357	16.83	330073	01.2242	15.85	330184	01.3273	27.70	330286	01.3400	24.38	340032	01.3619	18.77
320046	01.2948	20.88	330074	01.3118	19.70	330185	01.2921	24.72	330288	.	21.97	340035	01.1538	17.23
320048	01.2863	14.43	330075	01.0575	17.83	330186	00.5686	20.30	330290	01.6900	32.27	340036	01.2132	18.25
320057	00.9549	.	330078	01.4266	17.96	330188	01.1814	18.71	330293	01.1956	15.17	340037	01.0875	14.57
320058	00.7512	.	330079	01.2413	17.22	330189	01.2646	16.54	330304	01.2340	27.04	340038	01.1014	16.68
320059	01.0073	.	330080	01.3291	28.28	330191	01.3279	18.17	330306	01.4247	28.10	340039	01.2701	19.91
320060	00.8691	.	330084	01.0694	17.68	330193	01.3535	28.64	330307	01.2663	19.39	340040	01.8225	19.60
320061	01.1814	.	330085	01.2971	18.59	330194	01.7796	31.41	330308	.	31.87	340041	01.2092	17.69
320062	00.8839	.	330086	01.2664	26.87	330195	01.6422	31.94	330309	.	18.70	340042	01.2220	15.70
320063	01.3033	16.68	330088	01.0369	22.43	330196	01.2591	27.80	330314	01.3786	21.50	340044	01.1018	18.87
320065	01.2877	16.05	330090	01.5971	17.89	330197	01.1285	16.79	330315	16.0413	30.36	340045	00.9992	14.02
320067	00.8593	15.74	330091	01.3575	18.01	330198	01.3831	23.07	330316	01.3101	22.23	340047	01.8378	20.26
320068	00.9287	16.40	330092	01.0537	14.25	330199	01.3555	25.90	330327	00.9713	17.20	340048	01.0275	05.23
320069	00.9757	10.83	330094	01.2392	17.69	330201	01.6864	40.72	330331	01.3119	29.10	340049	01.0355	17.75
320070	00.9755	.	330095	01.2451	18.40	330202	01.3935	27.41	330332	01.2887	26.99	340050	01.1998	17.96
320074	01.0965	18.00	330096	01.1877	16.08	330203	01.3963	19.61	330333	01.2447	22.91	340051	01.3362	16.79
320079	01.1735	17.24	330097	01.2199	15.32	330204	01.3601	28.88	330336	01.3171	30.29	340052	01.0198	21.14
330001	01.1965	25.94	330100	00.7930	28.22	330205	01.1754	19.85	330338	01.2343	20.92	340053	01.6467	19.44
330002	01.4736	25.99	330101	01.8152	30.39	330208	01.2267	26.41	330339	00.9280	18.87	340054	01.2232	14.35
330003	01.3221	18.26	330102	01.3339	17.00	330209	01.1796	24.53	330340	01.2346	22.43	340055	01.2792	17.43
330004	01.2935	19.69	330103	01.2459	16.63	330211	01.2017	18.46	330350	01.6754	28.46	340060	01.1285	17.75
330005	01.8253	24.07	330104	01.4305	27.96	330212	01.1426	24.26	330353	01.2853	31.43	340061	01.7297	20.31

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330006	01.2729	26.60	330106	01.7010	34.04	330213	01.1763	18.39	330354	01.5657	.	340063	01.0171	26.30
330007	01.3118	18.07	330107	01.3321	26.04	330214	01.8166	32.02	330357	01.3812	34.81	340064	01.2354	17.11
330008	01.1595	16.96	330108	01.2468	16.97	330215	01.2020	17.11	330359	00.9373	29.31	340065	01.2886	15.89
330009	01.2887	30.94	330111	01.0734	15.22	330218	01.0527	20.44	330372	01.1947	22.25	340067	01.1570	18.20
330010	01.3708	15.48	330114	00.9490	15.82	330219	01.6682	21.21	330381	01.2828	29.21	340068	01.2126	16.25
330011	01.2991	19.95	330115	01.2400	16.12	330221	01.2915	25.48	330385	01.1900	30.87	340069	01.8489	20.34
330012	01.6983	29.74	330116	00.9596	15.34	330222	01.2600	18.36	330386	01.2168	23.42	340070	01.3018	18.73
330013	02.0925	18.56	330118	01.6628	20.00	330223	01.0775	16.39	330387	00.7965	30.68	340071	01.0888	15.86
330014	01.3530	29.23	330119	01.7665	32.28	330224	01.2572	21.50	330389	01.7321	31.92	340072	01.1277	15.86
330016	01.0685	16.90	330121	01.0423	15.02	330225	01.1751	25.21	330390	01.3758	29.91	340073	01.5385	19.84
330019	01.3051	27.77	330122	01.0651	22.75	330226	01.2584	18.27	330393	01.7530	26.22	340075	01.1915	17.17
330020	01.0453	14.30	330125	01.9195	20.66	330229	01.3254	16.25	330394	01.5407	18.30	340080	01.0338	15.37
330023	01.2639	23.66	330126	01.1530	23.01	330230	01.3796	29.27	330395	01.3533	33.37	340084	01.0893	16.12
330024	01.8382	31.66	330127	01.3393	29.65	330231	01.0667	29.53	330396	01.1799	31.55	340085	01.1659	16.33
330025	01.1051	15.55	330128	01.2588	29.68	330232	01.2447	17.76	330397	01.3134	30.46	340087	01 1181	16.56

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1997 PAGE 11 OF 15
:HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 1999 WAGE INDEX

PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE
340088	01.1251	18.21	350008	00.9423	17.25	360035	01.6184	20.73	360112	01.8003	23.62	360204	01.2412	19.09
340089	01.0111	13.52	350009	01.1488	17.35	360036	01.3574	19.04	360113	01.3628	18.81	360210	01.2014	20.61
340090	01.1447	17.83	350010	01.1049	14.45	360037	02.0578	21.38	360114	01.1021	17.48	360211	01.2663	19.77
340091	01.7019	19.89	350011	01.8832	20.62	360038	01.5824	20.60	360115	01.2545	17.90	360212	01.3977	20.10
340093	01.0694	13.96	350012	01.1086	13.55	360039	01.3144	17.40	360116	01.0977	17.49	360213	01.2686	18.05
340094	01.4785	18.27	350013	01.1046	16.64	360040	01.3479	17.81	360118	01.3492	18.34	360218	01.3083	18.29
340096	01.1479	17.40	350014	00.9842	13.44	360041	01.3368	18.83	360121	01.2423	19.22	360230	01.5619	21.16
340097	01.1442	17.69	350015	01.7367	16.91	360042	01.1870	18.02	360123	01.2758	19.33	360231	01.1474	12.39
340098	01.6837	19.47	350016	01.0963	12.06	360044	01.1205	15.83	360124	.	18.58	360234	01.3459	19.10
340099	01.2118	13.03	350017	01.3986	17.21	360045	01.4761	20.73	360125	01.0987	17.41	360236	01.2876	25.36
340101	01.0634	11.87	350018	01.0846	17.93	360046	01.1441	17.71	360126	01.2172	20.75	360239	01.3029	19.65
340104	00.9970	11.37	350019	01.6864	18.65	360047	01.1314	14.51	360127	01.1848	17.85	360241	00.4699	21.14
340105	01.3725	18.85	350021	01.0260	12.30	360048	01.8346	21.60	360128	01.1314	15.05	360242	01.8158	.
340106	01.2503	20.04	350023	00.9286	15.16	360049	01.1850	19.60	360129	00.9700	15.10	360243	00.7269	14.26
340107	01.3601	17.08	350024	01.0351	16.47	360050	01.0987	12.40	360130	01.1237	15.93	360244	.	14.90
340109	01.3291	17.47	350025	01.0095	14.00	360051	01.6404	22.98	360131	01.3444	18.99	360245	00.7297	15.21
340111	01.2126	14.63	350027	00.9546	14.46	360052	01.7679	18.65	360132	01.4274	18.38	360246	.	18.10
340112	00.9917	15.25	350029	00.8728	12.98	360054	01.2923	16.53	360133	01.5954	18.70	360247	00.4164	.
340113	01.8572	20.67	350030	01.0487	16.65	360055	01.2587	19.64	360134	01.7256	19.60	360248	01.7504	.
340114	01.5511	20.34	350033	00.9204	14.73	360056	01.4268	20.89	360135	.	17.80	370001	01.7835	20.06
340115	01.5716	19.35	350034	00.9924	17.48	360057	01.1603	15.46	360136	01.0851	16.90	370002	01.1536	13.71
340116	01.8195	19.81	350035	00.9005	10.21	360058	01.2694	17.56	360137	01.6537	19.95	370004	01.2315	16.67
340119	01.2979	17.57	350038	01.0946	15.28	360059	01.6984	21.65	360140	00.9783	18.52	370005	01.0047	14.07
340120	01.0840	13.56	350039	01.0288	14.75	360062	01.5153	20.51	360141	01.5660	23.32	370006	01.2653	15.48
340121	01.0639	15.43	350041	01.0442	18.10	360063	01.1355	18.29	360142	01.0240	16.62	370007	01.2099	14.36
340122	.	09.50	350042	01.1132	15.19	360064	01.6107	21.73	360143	01.4295	19.90	370008	01.3785	17.77
340123	01.0900	15.61	350043	01.5662	14.65	360065	01.3003	18.23	360144	01.3306	19.89	370011	01.0545	12.91
340124	01.0126	13.98	350044	00.8726	11.49	360066	01.5069	19.49	360145	01.6877	18.18	370012	00.8717	09.87
340125	01.4791	19.28	350047	01.1932	16.88	360067	01.1481	13.91	360147	01.2310	16.40	370013	01.8467	19.24
340126	01.3946	16.54	350049	01.3355	13.86	360068	01.7405	20.90	360148	01.1745	17.80	370014	01.2834	19.35
340127	01.3345	17.53	350050	00.9616	11.91	360069	01.1491	17.25	360149	01.2137	18.68	370015	01.2184	17.16
340129	01.3010	18.11	350051	00.9832	15.98	360070	01.6986	16.22	360150	01.2769	20.02	370016	01.3726	16.52
340130	01.3221	20.02	350053	01.0115	11.88	360071	01.3662	14.35	360151	01.3424	17.15	370017	01.1948	11.23
340131	01.5209	18.16	350055	01.0108	13.76	360072	01.2273	17.70	360152	01.5171	18.20	370018	01.3515	18.25
340132	01.3264	16.27	350056	00.9564	13.88	360074	01.3341	18.00	360153	01.1317	13.86	370019	01.3576	14.79
340133	01.1254	14.74	350058	00.9239	12.53	360075	01.4441	21.40	360154	01.0128	13.29	370020	01.3057	11.86
340136	.	29.42	350060	00.8587	08.80	360076	01.3633	18.67	360155	01.3656	20.38	370021	00.9226	10.38
340137	01.1374	15.62	350061	01.0639	15.32	360077	01.5871	19.38	360156	01.2888	18.45	370022	01.3207	17.34
340138	01.0618	16.94	350063	00.8745	.	360078	01.2492	19.90	360159	01.2109	19.93	370023	01.3369	16.03
340141	01.7220	20.29	350064	00.8364	.	360079	01.8676	21.06	360161	01.2554	13.69	370025	01.3419	16.09
340142	01.2345	15.79	360001	01.3785	17.65	360080	01.1453	15.68	360162	.	19.54	370026	01.4961	16.53
340143	01.4223	19.62	360002	01.1851	17.82	360081	01.3757	19.70	360163	01.8048	20.26	370028	01.9151	20.31
340144	01.3667	18.96	360003	01.7551	22.63	360082	01.3250	23.27	360164	00.9634	15.60	370029	01.2597	13.51
340145	01.4334	18.88	360006	01.8367	20.93	360083	.	17.07	360165	01.1710	17.81	370030	01.1834	16.49
340146	01.1100	14.28	360007	01.0611	15.95	360084	01.6053	20.53	360166	01.1884	16.01	370032	01.5944	16.17
340147	01.2536	19.38	360008	01.2417	17.78	360085	01.8342	21.47	360169	.	20.51	370033	01.0591	12.34
340148	01.4989	18.55	360009	01.4873	17.38	360086	01.4345	17.81	360170	01.3816	16.53	370034	01.2330	14.36
340151	01.2077	15.67	360010	01.2462	17.61	360087	01.4277	18.51	360172	01.3454	17.89	370035	01.6539	16.77
340153	01.8785	19.87	360011	01.3404	18.91	360088	01.3700	19.09	360174	01.3263	18.44	370036	01.0721	10.54
340155	01.3846	20.84	360012	01.3134	19.72	360089	01.1772	17.84	360175	01.1956	20.19	370037	01.7140	18.63
340156	00.7966	.	360013	01.1378	18.36	360090	01.2412	19.71	360176	01.1319	15.34	370038	01.0049	11.68
340158	01.1254	16.49	360014	01.2186	18.99	360091	01.2832	20.40	360177	01.2949	18.27	370039	01.2624	13.93
340159	01.1375	16.21	360016	01.6170	18.50	360092	01.1253	19.58	360178	01.2446	17.16	370040	01.0957	14.35

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340160	01.1683	14.11	360017	01.8636	21.51	360093	01.1651	17.64	360179	01.3416	20.22	370041	00.9736	16.47
340162	01.1800	16.56	360018	01.6289	20.29	360094	01.3927	18.15	360180	02.1580	23.00	370042	00.8807	13.98
340164	01.4560	20.69	360019	01.2686	21.76	360095	01.2616	19.83	360184	00.4293	18.76	370043	00.9440	15.18
340166	01.2727	19.59	360020	01.4425	20.74	360096	01.1266	17.46	360185	01.2251	18.13	370045	00.9950	10.14
340168	00.4868	14.27	360021	.	18.70	360098	01.4267	18.26	360186	01.1527	10.45	370046	00.9818	10.89
340170	.	10.79	360024	01.3741	17.75	360099	01.0501	19.53	360187	01.4088	17.67	370047	01.3896	15.04
340171	01.2023	.	360025	01.3560	19.40	360100	01.2881	17.73	360188	00.9758	17.11	370048	01.2229	15.40
340173	01.2143	.	360026	01.3481	16.21	360101	01.3886	21.04	360189	01.1631	16.98	370049	01.3323	15.44
350001	00.9857	14.53	360027	01.4672	20.14	360102	01.2867	19.14	360192	01.3660	21.31	370051	00.9873	11.30
350002	01.8569	16.86	360028	01.4877	17.21	360103	01.3563	19.87	360193	01.2960	16.98	370054	01.4690	16.32
350003	01.1700	16.97	360029	01.1863	17.75	360104	.	18.64	360194	01.2814	17.89	370056	01.5233	18.44
350004	01.9183	18.32	360030	01.2916	16.65	360106	01.1032	16.08	360195	01.1583	19.33	370057	01.1154	15.27
350005	01.0604	14.58	360031	01.2799	19.32	360107	01.2445	17.37	360197	01.1686	19.16	370059	01.0971	17.49
350006	01.5172	16.44	360032	01.0734	17.88	360108	01.0938	16.45	360200	01.0256	15.62	370060	01.1240	13.90
350007	00.8879	13.31	360034	01.3209	14.77	360109	01.1107	18.64	360203	01.2085	14.41	370063	01.1593	16.95

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1997 PAGE 12 OF 15
:HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 1999 WAGE INDEX

PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE
370064	00.9589	10.71	370194	.	24.57	390001	01.4124	17.93	390079	01.7811	18.60	390168	01.2838	18.12
370065	00.9924	15.36	370195	.	19.69	390002	01.2993	19.69	390080	01.3142	18.40	390169	01.2824	18.85
370071	01.0532	10.05	370196	00.8240	.	390003	01.2271	17.48	390081	01.3465	21.33	390170	01.8849	22.18
370072	00.8623	14.04	370197	00.9846	.	390004	01.3959	17.85	390083	01.2286	17.49	390173	01.2067	18.08
370076	01.2644	12.45	370198	01.8637	.	390005	01.0447	16.61	390084	01.1856	15.92	390174	01.6835	28.75
370077	.	16.50	380001	01.2887	20.12	390006	01.7998	19.53	390086	01.1617	17.91	390176	01.1620	18.54
370078	01.7417	16.06	380002	01.2713	18.07	390007	01.2150	20.72	390088	01.3421	21.04	390178	01.3127	19.22
370079	00.9541	15.91	380003	01.2247	28.86	390008	01.1475	17.18	390090	01.7983	20.56	390179	01.3568	21.31
370080	00.9730	14.18	380004	01.6999	23.04	390009	01.6952	19.72	390091	01.1405	18.58	390180	01.4775	23.29
370082	00.9096	13.82	380005	01.2210	22.81	390010	01.2668	17.30	390093	01.1564	15.95	390181	01.0475	19.10
370083	00.9487	12.81	380006	01.2867	19.61	390011	01.2788	18.82	390095	01.2039	15.21	390183	01.1761	18.03
370084	01.0819	13.65	380007	01.6905	24.92	390012	01.2237	19.42	390096	01.5027	17.87	390184	01.1057	18.24
370085	00.8704	13.21	380008	01.0545	19.56	390013	01.2402	18.21	390097	01.2965	22.07	390185	01.2217	17.20
370086	01.1757	11.51	380009	01.8917	22.90	390015	01.1529	13.06	390098	.	20.21	390189	01.1420	19.19
370089	01.2572	15.23	380010	01.0534	22.58	390016	01.2451	17.77	390100	01.6667	20.56	390191	01.2274	16.80
370091	01.7245	19.16	380011	01.0533	19.05	390017	01.2160	15.92	390101	01.2046	17.62	390192	01.1577	15.64
370092	01.0308	14.09	380013	01.3155	20.62	390018	01.3173	19.26	390102	01.3762	20.18	390193	01.2087	17.26
370093	01.8548	18.16	380014	01.6295	22.02	390019	01.1403	16.01	390103	01.1437	18.62	390194	01.1432	19.66
370094	01.5133	19.25	380017	01.9396	25.87	390022	01.3629	20.49	390104	01.0944	14.75	390195	01.8455	22.76
370095	00.9969	11.75	380018	01.7998	20.92	390023	01.2391	18.03	390106	01.0528	15.96	390196	01.3759	.
370097	01.3706	17.38	380019	01.2865	21.45	390024	01.0782	23.53	390107	01.3463	19.43	390197	01.3007	17.67
370099	01.1743	14.07	380020	01.5028	21.41	390025	00.6347	15.62	390108	01.3669	19.36	390198	01.2133	15.83
370100	01.0064	14.49	380021	01.2902	21.57	390026	01.2991	21.98	390109	01.2791	14.91	390199	01.3230	16.07
370103	00.9324	16.27	380022	01.1713	22.57	390027	01.8594	24.83	390110	01.6334	19.36	390200	01.0961	17.18
370105	01.9784	18.43	380023	01.2279	18.43	390028	01.9023	20.42	390111	01.8517	29.97	390201	01.2783	20.25
370106	01.5543	18.37	380025	01.3453	25.35	390029	01.9718	18.87	390112	01.2892	13.72	390203	01.3914	22.11
370108	01.1217	11.81	380026	01.1611	19.09	390030	01.2429	18.43	390113	01.2293	17.07	390204	01.3047	20.57
370112	01.0610	14.65	380027	01.2948	22.82	390031	01.1864	18.94	390114	01.2153	20.63	390205	.	31.31
370113	01.1873	15.11	380029	01.1624	18.33	390032	01.2564	19.11	390115	01.3816	23.95	390206	01.3931	19.09
370114	01.6453	15.79	380031	00.9843	22.48	390035	01.2505	17.14	390116	01.2713	23.74	390209	01.0699	16.37
370121	01.1699	16.84	380033	01.7744	24.22	390036	01.4677	19.18	390117	01.1842	16.64	390211	01.2514	17.87
370122	01.1283	12.45	380035	01.2903	21.53	390037	01.3925	19.24	390118	01.1799	17.07	390213	01.1615	17.31
370123	01.3349	17.25	380036	01.0566	20.79	390039	01.1342	16.41	390119	01.3515	18.05	390215	01.2951	24.51
370125	00.9720	12.01	380037	01.2748	20.52	390040	00.9663	15.43	390121	01.3607	19.61	390217	01.2299	20.29
370126	00.9821	12.07	380038	01.3403	25.28	390041	01.2912	18.92	390122	01.1014	18.49	390219	01.3265	20.50
370131	00.9654	15.71	380039	01.3203	21.51	390042	01.5678	21.41	390123	01.3782	20.31	390220	01.2027	18.22
370133	01.1458	11.04	380040	01.2615	21.08	390043	01.1564	17.28	390125	01.1997	15.48	390222	01.2837	20.89
370138	01.0868	14.95	380042	01.0847	17.33	390044	01.6709	19.33	390126	01.2830	19.99	390223	01.5375	22.49
370139	01.1095	11.70	380047	01.7002	21.14	390045	01.8024	17.86	390127	01.2449	21.41	390224	00.9063	15.35
370140	01.0042	11.92	380048	01.0727	15.35	390046	01.5539	20.19	390128	01.2402	19.93	390225	01.1778	17.76
370141	01.3415	16.19	380050	01.4635	18.30	390047	01.9125	30.25	390130	01.1626	16.56	390226	01.7896	23.71
370146	01.2114	11.23	380051	01.6008	20.79	390048	01.1812	18.24	390131	01.3309	16.73	390228	01.2810	19.19
370148	01.4903	27.04	380052	01.2228	17.97	390049	01.6720	21.29	390132	01.2817	22.21	390231	01.4326	26.80
370149	01.2910	15.69	380055	01.0479	25.16	390050	02.1825	22.47	390133	01.8259	23.25	390233	01.3151	18.36
370153	01.0661	14.06	380056	01.1097	16.82	390051	02.1733	25.65	390135	01.2359	21.67	390235	01.5361	23.39
370154	01.0422	14.12	380060	01.4528	22.62	390052	01.1796	15.47	390136	01.1254	14.77	390236	01.1869	16.40
370156	01.0569	17.29	380061	01.5018	21.24	390054	01.1928	16.20	390137	01.5145	16.40	390237	01.6160	19.08
370158	01.0247	12.09	380062	01.2198	18.32	390055	01.8809	26.53	390138	01.3401	17.99	390238	01.4870	18.78
370159	01.3982	15.22	380063	01.2398	18.55	390056	01.1595	16.53	390139	01.5328	23.14	390242	01.3211	18.77
370163	01.0015	14.57	380064	01.3645	18.24	390057	01.3191	19.58	390142	01.6037	28.56	390244	00.9028	12.10
370165	01.1284	11.97	380065	01.2655	22.48	390058	01.2751	18.70	390145	01.3636	20.30	390245	01.4262	21.37
370166	01.1320	15.55	380066	01.3525	20.01	390060	01.2061	16.42	390146	01.2704	16.85	390246	01.2382	17.91
370169	01.0581	11.91	380068	00.9929	21.72	390061	01.5146	20.08	390147	01.2523	20.55	390247	01.0888	20.42

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370170	01.0046	.	380069	01.1224	19.35	390062	01.1867	16.47	390150	01.1852	21.17	390249	01.0120	12.79
370171	01.0194	.	380070	01.3838	25.32	390063	01.7713	20.28	390151	01.2239	19.85	390256	01.8203	24.05
370172	00.9183	.	380071	01.3004	20.13	390065	01.2441	19.96	390152	01.0834	17.35	390258	01.3936	20.92
370173	01.0982	.	380072	00.9530	16.03	390066	01.2978	19.58	390153	01.2345	21.88	390260	01.2311	23.05
370174	01.0115	.	380075	01.3787	19.99	390067	01.7899	19.93	390154	01.2163	17.53	390262	01.8664	18.22
370176	01.2219	16.29	380078	00.9861	18.28	390068	01.3051	19.04	390156	01.4420	20.56	390263	01.4754	19.89
370177	00.9776	10.48	380081	01.1286	18.28	390069	01.3380	19.19	390157	01.3763	18.98	390265	01.3031	19.06
370178	01.0012	11.20	380082	01.3116	21.55	390070	01.3347	19.37	390158	01.5588	19.47	390266	01.2205	17.07
370179	00.7442	15.19	380083	01.2989	21.90	390071	01.0949	15.08	390160	01.2920	19.68	390267	01.3141	18.72
370180	00.9126	.	380084	01.2579	21.98	390072	01.0877	15.49	390161	01.1315	13.75	390268	01.3483	21.17
370183	01.0305	05.77	380087	01.0869	12.91	390073	01.6218	19.86	390162	01.5616	21.16	390270	01.3598	17.69
370186	00.9921	13.17	380088	01.0207	18.65	390074	01.2640	16.62	390163	01.2269	16.11	390272	00.4583	.
370189	.	08.12	380089	01.3285	23.92	390075	01.3629	17.79	390164	02.1596	21.67	390277	00.5229	23.14
370190	01.5473	26.42	380090	01.2847	25.49	390076	01.4265	21.99	390166	01.1129	18.45	390278	00.6751	16.94
370192	01.2229	16.30	380091	01.3026	24.95	390078	01.0789	19.14	390167	01.3682	21.84	390279	01.0391	14.40

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1997 PAGE 13 OF 15
:HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 1999 WAGE INDEX

PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE
390281	.	21.69	420006	01.1740	17.68	430013	01.2623	16.44	440024	01.3290	17.96	440146	.	16.76
400001	01.2753	09.39	420007	01.5040	17.78	430014	01.3442	18.19	440025	01.2051	13.85	440147	01.6141	16.28
400002	01.6163	10.99	420009	01.2423	17.01	430015	01.1463	16.09	440026	.	11.43	440148	01.1654	16.26
400003	01.3178	09.72	420010	01.2030	15.22	430016	01.8314	18.86	440029	01.3134	17.57	440149	01.1555	14.35
400004	01.1980	08.16	420011	01.1847	15.88	430018	00.9266	14.23	440030	01.2440	13.96	440150	01.3207	18.41
400005	01.0804	06.50	420014	01.0524	15.49	430022	00.9270	11.69	440031	01.0360	13.97	440151	01.3029	17.69
400006	01.2069	07.62	420015	01.3572	17.27	430023	00.9018	11.59	440032	01.0487	14.25	440152	01.9093	18.01
400007	01.1613	07.13	420016	00.9922	14.27	430024	01.0343	14.51	440033	01.1470	11.81	440153	01.2223	16.01
400009	01.0380	07.64	420018	01.8053	19.64	430026	.	13.59	440034	01.5653	19.30	440156	01.5821	22.43
400010	00.9135	10.07	420019	01.1943	14.81	430027	01.7782	18.58	440035	01.2848	17.58	440157	01.0566	15.33
400011	01.0604	07.81	420020	01.2603	17.64	430028	01.0637	15.50	440039	01.8052	20.13	440159	01.3511	13.80
400012	01.1928	07.69	420023	01.4439	21.40	430029	01.0211	15.69	440040	01.0272	14.47	440161	01.9017	20.03
400013	01.2834	08.10	420026	01.8877	18.73	430031	00.9243	12.23	440041	01.0201	12.77	440162	.	15.49
400014	01.3801	07.24	420027	01.3576	17.34	430033	00.9805	13.99	440046	01.2316	14.28	440166	01.6200	18.67
400015	01.3800	10.64	420029	.	15.22	430034	01.0577	12.76	440047	00.9266	16.03	440168	01.0799	16.29
400016	01.3725	11.37	420030	01.2960	17.68	430036	01.0972	12.56	440048	01.8535	16.82	440173	01.6698	18.02
400017	01.2065	06.56	420031	00.9553	12.23	430037	00.8770	14.57	440049	01.6612	17.56	440174	01.0419	15.12
400018	01.2974	09.29	420033	01.2736	19.69	430038	00.9865	11.26	440050	01.3811	16.99	440175	01.1538	17.31
400019	01.7676	09.60	420036	01.4352	18.46	430039	.	12.60	440051	00.9593	14.08	440176	01.4258	19.42
400021	01.4608	09.43	420037	01.1992	21.62	430040	01.0299	13.65	440052	01.1451	15.14	440178	01.2426	22.63
400022	01.3452	11.18	420038	01.3327	15.74	430041	00.9365	14.87	440053	01.3843	17.37	440180	01.2404	16.19
400024	01.0267	07.45	420039	01.1536	16.21	430043	01.1664	12.87	440054	01.1897	13.52	440181	01.0472	10.98
400026	00.9852	06.87	420042	01.1039	14.67	430044	00.8239	16.48	440056	01.1267	14.40	440182	00.9998	16.20
400027	01.1410	09.66	420043	01.2288	18.79	430047	01.0586	14.80	440057	01.0456	12.35	440183	01.5900	20.71
400028	01.0099	07.98	420048	01.2481	13.44	430048	01.2187	17.49	440058	01.2271	16.08	440184	01.3805	19.32
400029	01.0884	10.05	420049	01.1741	17.98	430049	00.8987	13.24	440059	01.3572	16.96	440185	01.2482	18.83
400031	01.2293	09.18	420051	01.6261	17.99	430051	00.9847	16.00	440060	01.2764	16.56	440186	01.0953	17.87
400032	01.2529	08.99	420053	01.2029	16.08	430054	01.0247	13.37	440061	01.2358	16.75	440187	01.2079	16.44
400044	01.1766	09.84	420054	01.2963	17.01	430056	00.8539	13.33	440063	01.6987	18.02	440189	01.5757	18.56
400048	01.1540	08.23	420055	01.0155	15.72	430057	00.8887	13.52	440064	01.1641	17.44	440192	01.2265	16.54
400061	01.6694	14.42	420056	01.0850	13.21	430060	00.9648	09.05	440065	01.2578	19.20	440193	01.2800	18.04
400079	01.2798	10.43	420057	01.1686	14.71	430062	.	10.22	440067	01.2533	17.02	440194	01.2792	22.34
400087	01.4424	10.90	420059	00.9778	15.11	430064	01.1084	13.30	440068	01.2832	17.51	440196	.	17.30
400094	01.0401	07.04	420061	01.1698	17.58	430065	.	12.43	440070	01.0735	15.23	440197	01.3854	19.67
400098	01.3630	08.48	420062	01.4640	15.61	430066	00.9328	12.75	440071	01.3824	15.29	440200	01.1109	16.93
400102	01.1681	07.11	420064	01.1127	14.58	430073	01.0259	15.30	440072	01.4364	17.03	440203	00.9501	14.18
400103	01.4510	09.30	420065	01.3461	18.10	430076	00.9397	11.73	440073	01.3077	18.15	440205	01.1295	14.78
400104	01.3458	09.05	420066	00.9592	16.85	430077	01.6475	17.05	440078	01.0126	12.13	440206	01.0259	14.58
400105	01.2555	08.85	420067	01.2604	18.10	430079	00.9851	13.14	440081	01.1637	15.02	440208	.	16.50
400106	01.2498	08.61	420068	01.4352	17.58	430080	.	14.58	440082	02.0452	21.84	440210	00.8638	.
400109	01.4916	09.61	420069	01.0573	17.78	430081	00.9008	.	440083	01.1504	12.07	440211	00.8662	.
400110	01.0663	08.99	420070	01.2275	16.89	430082	00.9079	.	440084	01.1523	13.82	440212	01.5698	.
400111	01.1917	08.78	420071	01.3083	18.25	430083	00.7926	.	440087	.	21.62	440213	03.6765	.
400112	01.1080	08.91	420072	00.9784	11.63	430084	00.8722	.	440090	.	08.85	450002	01.5054	20.29
400113	01.2149	08.29	420073	01.2994	20.68	430085	00.8586	.	440091	01.6228	18.53	450004	01.1692	14.25
400114	01.0743	08.19	420074	00.9973	13.73	430087	00.7737	10.24	440100	01.0732	14.88	450005	01.2865	16.20
400115	01.0702	08.58	420075	00.9375	13.75	430089	00.8652	.	440102	01.1375	13.79	450007	01.2376	14.85
400117	01.1921	09.28	420078	01.8479	20.40	430090	01.6056	.	440103	01.2108	17.04	450008	01.3027	15.35
400118	01.2647	10.06	420079	01.5769	19.19	430091	01.2774	.	440104	01.6343	18.95	450010	01.3462	15.79
400120	01.3235	09.45	420080	01.3745	24.17	440001	01.1359	14.55	440105	01.5362	15.40	450011	01.5107	15.84
400121	00.9061	06.57	420081	.	22.70	440002	01.6193	17.64	440109	01.1667	13.89	450014	01.0616	16.69
400122	01.0071	07.20	420082	01.5223	18.32	440003	01.2548	17.39	440110	01.0518	16.01	450015	01.6503	16.82
400123	01.1922	08.54	420083	01.2924	19.79	440006	01.4822	20.63	440111	01.3638	20.00	450016	01.5956	18.10

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400124	02.6950	11.18	420085	01.4928	17.31	440007	01.0161	10.84	440114	01.0926	14.77	450018	01.4757	23.31
410001	01.3894	21.15	420086	01.4462	18.16	440008	00.9876	14.52	440115	01.0518	15.54	450020	00.9723	17.49
410004	01.3528	21.95	420087	01.6785	18.66	440009	01.2550	14.35	440120	01.5986	18.82	450021	01.8372	20.79
410005	01.3894	22.97	420088	01.1387	16.65	440010	00.9638	12.82	440125	01.5455	18.57	450023	01.1085	17.41
410006	01.3046	21.58	420089	01.2832	21.79	440011	01.3881	17.79	440130	01.1768	14.86	450024	01.3819	17.07
410007	01.6876	21.22	420091	01.2802	17.20	440012	01.6090	18.49	440131	01.1535	14.49	450025	01.4873	16.78
410008	01.2632	20.03	420093	01.0288	.	440014	00.9603	14.66	440132	01.1250	13.67	450028	01.5641	18.21
410009	01.3199	23.49	430004	01.1534	16.77	440015	01.7449	18.14	440133	01.5625	19.98	450029	01.5975	15.23
410010	01.0609	26.80	430005	01.3586	15.32	440016	01.0128	12.66	440135	01.2264	17.51	450031	01.4992	18.63
410011	01.2373	24.14	430007	01.0640	13.91	440017	01.7261	19.76	440137	01.0945	13.42	450032	01.3493	14.10
410012	01.8358	21.15	430008	01.1439	16.06	440018	01.3674	16.68	440141	01.0485	16.14	450033	01.6521	17.18
410013	01.2926	24.44	430009	.	16.55	440019	01.6960	20.37	440142	01.0730	12.75	450034	01.6293	18.76
420002	01.3844	21.83	430010	01.1316	14.54	440020	01.2401	15.68	440143	01.0951	17.23	450035	01.4215	19.26
420004	01.8532	19.28	430011	01.2629	15.79	440022	.	17.13	440144	01.2965	17.94	450037	01.6093	19.44
420005	01.1723	15.14	430012	01.3118	16.98	440023	01.1509	14.25	440145	00.9611	13.88	450039	01.4600	21.00

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1997 PAGE 14 OF 15
:HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 1999 WAGE INDEX

PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE
450040	01.5373	17.84	450149	01.5178	19.99	450288	01.1736	15.16	450469	01.4053	19.15	450649	00.9863	15.11
450042	01.7794	17.32	450150	00.9612	13.08	450289	01.3995	17.39	450473	01.0191	13.97	450651	01.7580	21.33
450044	01.5703	19.82	450151	01.1411	14.57	450292	01.1574	19.97	450475	01.1203	13.56	450652	00.8806	14.52
450046	01.4565	16.44	450152	01.2741	16.98	450293	00.9373	14.97	450484	01.4925	19.64	450653	01.1829	16.63
450047	01.1064	11.09	450153	01.5923	18.88	450296	01.4168	19.20	450488	01.3286	18.88	450654	00.9613	10.99
450050	00.9974	12.42	450154	01.1537	14.43	450299	01.4080	17.64	450489	01.0335	13.90	450656	01.4619	18.35
450051	01.6370	20.16	450155	01.0379	14.13	450303	01.0135	10.40	450497	01.1605	14.88	450658	00.9767	12.49
450052	01.0576	13.70	450157	01.1327	12.26	450306	01.3002	13.64	450498	00.9811	12.66	450659	01.5023	21.19
450053	01.0823	15.50	450160	00.9527	16.62	450307	00.8869	14.50	450508	01.3610	18.09	450660	.	19.04
450054	01.6320	21.89	450162	01.2650	21.24	450309	01.0737	12.52	450514	01.1701	21.10	450661	01.1962	21.13
450055	01.0919	12.18	450163	01.0701	16.72	450315	01.0574	19.04	450517	00.9348	10.56	450662	01.6020	16.76
450056	01.6527	18.64	450164	01.2204	15.46	450320	01.2415	18.72	450518	01.5830	18.37	450665	00.9019	15.04
450058	01.6079	17.15	450165	01.0926	13.31	450321	00.9611	14.07	450523	01.5482	20.21	450666	01.3331	17.90
450059	01.3545	13.67	450166	00.9359	10.68	450322	00.6639	17.10	450530	01.2361	14.42	450668	01.5947	18.91
450063	00.9170	13.00	450169	00.7896	12.56	450324	01.6387	16.95	450534	00.9911	15.71	450669	01.4221	18.87
450064	01.4486	15.32	450170	00.9584	11.25	450325	.	12.58	450535	01.2408	21.39	450670	01.3483	18.30
450065	01.1111	21.72	450176	01.3492	14.31	450327	01.0202	16.18	450537	01.3379	20.33	450672	01.6955	21.04
450068	01.8940	24.39	450177	01.2787	13.96	450330	01.1874	17.95	450538	.	17.56	450673	01.0682	13.79
450070	.	14.65	450178	00.9723	13.80	450334	01.0424	12.16	450539	01.4058	16.13	450674	01.2022	19.92
450072	01.2268	19.03	450181	01.0431	11.50	450337	01.1325	15.71	450544	01.2273	18.82	450675	01.4613	18.10
450073	01.2013	20.15	450184	01.5028	23.51	450340	01.4643	14.54	450545	01.2789	16.58	450677	01.3326	21.70
450076	01.6731	.	450185	01.0459	10.84	450341	01.0639	17.56	450547	01.1421	14.03	450678	01.4411	20.87
450078	00.9846	09.74	450187	01.2641	19.67	450346	01.5170	17.40	450550	.	37.02	450683	01.3457	20.83
450079	01.4696	20.51	450188	01.0352	14.02	450347	01.1686	17.43	450551	01.0969	13.10	450684	01.2078	18.70
450080	01.2211	17.32	450190	.	24.75	450348	01.0270	12.22	450558	01.8449	18.40	450686	01.4963	15.12
450081	01.0650	15.82	450191	01.0301	19.15	450351	01.2350	20.05	450559	.	13.27	450688	01.3626	18.60
450082	01.0020	13.31	450192	01.2311	17.99	450352	01.2370	17.91	450561	01.6286	16.94	450690	01.4256	18.54
450083	01.7318	19.48	450193	02.0290	22.67	450353	01.2533	18.38	450563	01.2529	26.72	450694	01.1119	20.41
450085	01.0846	12.24	450194	01.2918	20.99	450355	01.1328	14.56	450565	01.2488	16.37	450696	01.8786	18.73
450087	01.4913	19.35	450196	01.4460	16.99	450358	02.0772	22.35	450570	01.0924	15.49	450697	01.5422	15.65
450090	01.2444	13.64	450200	01.4035	18.07	450362	01.0820	14.11	450571	01.4613	16.09	450698	00.9602	13.36
450092	01.2224	12.47	450201	01.0005	17.34	450369	01.0290	11.78	450573	01.0273	14.01	450700	01.0540	14.08
450094	01.3067	19.26	450203	01.2387	18.59	450370	01.1847	09.42	450574	00.9415	11.88	450702	01.5382	17.73
450096	01.4608	23.59	450209	01.5945	18.69	450371	01.3121	12.05	450575	01.0533	17.94	450703	01.5077	.
450097	01.4472	18.03	450210	01.1066	13.30	450372	01.2336	21.35	450578	00.9715	15.05	450704	01.3189	18.39
450098	01.1794	16.58	450211	01.3875	16.48	450373	01.1809	18.71	450580	01.1429	14.05	450705	00.8680	17.81
450099	01.2419	17.53	450213	01.6839	16.75	450374	00.9884	12.21	450583	01.0017	11.81	450706	01.3743	20.77
450101	01.4648	17.66	450214	01.3523	19.24	450376	.	17.43	450584	01.1366	13.75	450709	01.2553	18.28
450102	01.7073	17.83	450217	01.0709	11.24	450378	01.0691	21.74	450586	01.0871	12.54	450711	01.6380	26.65
450104	01.1802	14.98	450219	01.1721	13.78	450379	01.5460	20.99	450587	01.2166	17.55	450712	00.7368	15.41
450107	01.6569	19.78	450221	01.2379	19.52	450381	01.0325	15.63	450591	01.2298	17.41	450713	01.5242	20.73
450108	01.0038	14.79	450222	01.5740	17.18	450388	01.8171	16.85	450596	01.3167	18.97	450715	01.4420	18.46
450109	00.9070	14.10	450224	01.3931	24.15	450389	01.2982	17.53	450597	01.0269	16.76	450716	01.4009	19.33
450110	01.3519	18.61	450229	01.6472	15.99	450393	01.3204	17.13	450603	00.7219	14.21	450717	01.3231	22.11
450111	01.2694	19.21	450231	01.6397	17.02	450395	01.0611	16.79	450604	01.3496	15.46	450718	01.2779	17.49
450112	01.3290	14.83	450234	01.0135	14.04	450399	00.9637	10.76	450605	01.2166	16.69	450723	01.4090	18.47
450113	01.2925	16.69	450235	01.0286	14.62	450400	01.1990	14.50	450609	00.8687	13.34	450724	01.3090	18.28
450118	01.5987	18.24	450236	01.1413	12.89	450403	01.3180	19.63	450610	01.4648	19.05	450725	01.0043	19.85
450119	01.4443	19.05	450237	01.5549	16.41	450411	00.9257	13.36	450614	01.0531	12.77	450726	.	09.67
450121	01.5291	18.89	450239	01.0928	17.42	450417	01.2265	15.17	450615	01.1315	12.36	450727	01.0868	16.87
450123	01.1158	18.31	450241	00.9361	17.05	450418	01.4858	21.54	450617	01.3493	19.91	450728	00.8867	11.16
450124	01.7041	18.29	450243	00.9835	10.20	450419	01.2123	20.33	450620	01.1105	13.72	450730	01.2653	21.13
450126	01.4332	17.01	450246	.	18.10	450422	00.8593	25.07	450623	01.1985	19.22	450733	01.6048	17.77

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450128	01.2111	13.18	450249	00.9530	10.87	450423	01.4768	22.62	450626	01.0214	17.48	450735	00.9833	16.47
450130	01.4813	18.04	450250	00.9991	15.71	450424	01.2917	15.76	450628	00.9890	17.19	450742	01.2753	20.17
450131	01.2712	20.21	450253	01.1708	12.65	450429	01.0852	12.61	450630	01.6098	19.66	450743	01.4277	17.77
450132	01.6816	17.96	450258	01.0480	12.74	450431	01.6014	18.46	450631	01.6905	24.01	450746	01.0074	14.71
450133	01.6195	17.50	450259	.	19.75	450438	01.2750	14.16	450632	01.0398	11.43	450747	01.3436	17.69
450135	01.6566	20.43	450264	00.8616	16.51	450446	00.7434	15.16	450633	01.5664	13.06	450749	00.9935	14.54
450137	01.5276	21.67	450269	01.0586	16.18	450447	01.3800	17.19	450634	01.7244	23.78	450750	01.0131	12.54
450140	00.9524	20.17	450270	01.1891	12.49	450450	.	10.23	450638	01.5548	25.07	450751	01.3175	19.24
450142	.	19.05	450271	01.2434	16.22	450451	01.1660	18.07	450639	01.4590	23.25	450754	00.9226	14.12
450143	00.9922	13.55	450272	01.3034	17.19	450457	01.7806	18.77	450641	01.0830	17.56	450755	01.1386	18.08
450144	01.0335	12.72	450276	01.0688	12.98	450460	01.0156	13.83	450643	01.2098	15.34	450757	00.9012	13.23
450145	00.8532	14.82	450278	00.9644	12.60	450462	01.7458	19.89	450644	01.5168	18.19	450758	01.9441	19.90
450146	01.0028	25.23	450280	01.5129	19.14	450464	01.0020	13.20	450646	01.5431	20.32	450760	01.2017	18.55
450147	01.3910	16.89	450283	01.0383	12.79	450465	01.3374	14.37	450647	01.9051	20.84	450761	01.0213	11.87
450148	01.2800	19.65	450286	.	12.94	450467	00.9857	17.15	450648	00.9457	14.58	450763	00.9981	18.22

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1997 PAGE 15 OF 15
:HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 1999 WAGE INDEX

PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE
450766	02.0880	21.59	460047	01.7357	19.89	490067	01.2743	16.60	500028	01.1088	17.84	500141	01.3422	22.31
450769	00.8730	11.77	460049	02.0126	19.97	490069	01.4209	14.56	500029	00.9727	17.28	500143	00.6018	15.77
450770	01.0206	16.69	460050	01.3197	19.33	490071	01.4285	17.73	500030	01.4677	23.76	500146	01.1943	17.52
450771	01.7977	22.61	460051	01.2255	13.29	490073	01.4926	22.82	500031	01.3085	22.42	510001	01.8124	18.22
450774	01.6443	20.17	470001	01.2559	20.25	490074	01.4074	17.39	500033	01.3569	20.98	510002	01.3468	17.06
450775	01.3186	19.23	470003	01.8555	20.10	490075	01.4395	18.79	500036	01.3790	20.93	510004	.	17.17
450776	00.9856	10.17	470004	01.1207	15.87	490077	01.2415	19.03	500037	01.1782	20.35	510005	00.9803	14.53
450777	00.9822	18.41	470005	01.2354	21.12	490079	01.3599	15.63	500039	01.3853	22.97	510006	01.2878	17.40
450779	01.2810	22.50	470006	01.2079	18.07	490083	.	15.74	500041	01.2881	24.11	510007	01.5321	19.91
450780	01.6074	19.16	470008	01.2543	17.91	490084	01.2516	16.78	500042	01.4126	21.93	510008	01.2361	16.30
450781	.	16.72	470010	01.1454	20.06	490085	01.2519	15.50	500043	01.0815	19.43	510012	01.0188	15.51
450785	00.9638	13.31	470011	01.1744	20.37	490088	01.1852	16.50	500044	01.9240	23.59	510013	01.1630	16.85
450788	01.5116	16.06	470012	01.2882	18.28	490089	01.1285	16.41	500045	01.0504	22.10	510015	01.0278	13.81
450794	01.4587	16.66	470013	.	18.46	490090	01.1674	16.31	500048	00.9665	19.03	510016	.	09.07
450795	01.1502	11.54	470015	01.1636	19.34	490091	01.2213	19.80	500049	01.5558	22.21	510018	01.1356	14.07
450796	01.0983	18.43	470018	01.2011	20.89	490092	01.2432	15.10	500050	01.3759	20.94	510020	01.0654	12.22
450797	00.6077	20.39	470020	00.9543	16.28	490093	01.3893	15.78	500051	01.6481	24.14	510022	01.8750	19.32
450798	00.7932	13.86	470023	01.2897	20.06	490094	01.1170	16.40	500052	01.2052	.	510023	01.2460	15.36
450800	.	22.74	470024	01.1732	19.52	490095	01.4744	18.10	500053	01.3353	21.20	510024	01.4909	18.06
450801	01.4763	17.21	490001	01.1943	22.18	490097	01.2411	15.08	500054	01.8556	22.51	510026	01.0370	13.05
450802	01.3938	21.70	490002	01.1328	13.34	490098	01.2764	13.23	500055	01.1179	22.34	510027	00.9885	16.52
450803	00.9015	14.23	490003	00.6057	17.48	490099	00.9710	16.66	500057	01.2911	17.73	510028	01.1082	14.91
450804	01.7385	18.83	490004	01.2257	17.71	490100	01.5547	18.36	500058	01.5119	21.64	510029	01.2725	16.91
450807	00.8978	10.41	490005	01.5928	15.95	490101	01.2287	23.60	500059	01.0870	22.72	510030	01.0625	15.76
450808	01.2265	20.55	490006	01.1504	14.40	490104	00.8469	21.14	500060	01.4652	23.67	510031	01.4600	16.76
450809	01.6061	11.29	490007	02.0628	17.85	490105	00.5902	30.04	500061	01.0054	20.43	510033	01.3702	16.09
450810	00.9015	.	490009	01.9249	21.78	490106	00.8464	21.07	500062	01.1028	19.07	510035	01.3469	18.82
450811	02.1713	.	490010	01.1768	18.22	490107	01.3532	22.35	500064	01.6827	24.85	510036	01.0358	12.45
450812	01.4107	.	490011	01.4563	17.74	490108	00.9546	19.84	500065	01.2336	20.87	510038	01.1248	14.36
450813	00.9625	.	490012	01.2151	13.77	490109	00.9167	20.42	500068	01.0663	18.61	510039	01.3361	15.69
460001	01.7552	20.89	490013	01.2177	16.55	490110	01.3430	15.76	500069	01.1725	19.05	510043	00.9435	14.14
460003	01.6585	13.31	490014	01.5100	22.68	490111	01.2039	16.18	500071	01.3933	20.91	510046	01.3045	17.25
460004	01.7681	21.05	490015	01.4423	21.35	490112	01.6582	19.70	500072	01.2457	24.49	510047	01.2942	18.92
460005	01.6708	17.23	490017	01.3687	14.13	490113	01.2990	22.73	500073	01.0182	18.07	510048	01.1291	18.03
460006	01.3435	20.09	490018	01.3424	17.21	490114	01.1158	15.90	500074	01.1010	18.46	510050	01.6031	16.38
460007	01.4924	20.38	490019	01.2348	16.41	490115	01.1954	16.62	500077	01.3355	22.82	510053	01.0087	14.63
460008	01.4248	16.77	490020	01.2244	16.07	490116	01.1886	16.24	500079	01.3441	21.42	510055	01.2828	22.31
460009	01.8570	20.44	490021	01.3828	18.79	490117	01.1944	10.66	500080	00.8366	13.35	510058	01.2636	17.21
460010	02.0782	21.33	490022	01.4783	20.52	490118	01.7255	20.56	500084	01.2431	21.72	510059	02.4160	15.17
460011	01.4411	15.84	490023	01.2763	18.89	490119	01.4053	17.02	500085	01.0524	18.46	510060	01.0676	15.10
460013	01.4710	18.36	490024	01.8235	17.17	490120	01.3763	18.00	500086	01.3440	21.47	510061	01.0316	10.95
460014	01.3259	16.46	490027	01.1423	14.52	490122	01.4087	23.30	500088	01.3200	23.74	510062	01.2790	17.19
460015	01.2641	20.24	490028	.	21.09	490123	01.1230	15.73	500089	01.1001	16.55	510063	.	10.31
460016	00.9283	18.35	490030	01.1720	10.88	490124	01.1221	15.81	500090	00.9245	14.09	510065	.	13.16
460017	01.4942	17.56	490031	01.1306	13.85	490126	01.4062	16.47	500092	00.9907	19.29	510066	01.1568	13.24
460018	00.9764	16.14	490032	01.7765	20.09	490127	01.0282	16.49	500094	00.9181	17.96	510067	01.1869	16.39
460019	01.1703	16.25	490033	01.1971	17.39	490129	01.1053	23.65	500096	01.0069	18.80	510068	01.1335	15.46
460020	00.9855	17.05	490035	01.0236	07.57	490130	01.2354	15.91	500097	01.1635	19.47	510070	01.3893	15.31
460021	01.3877	20.05	490037	01.1886	14.98	490131	.	15.00	500098	01.0907	14.96	510071	01.3478	15.76
460022	00.9250	18.19	490038	01.2692	14.98	490132	01.0058	.	500101	00.9709	19.08	510072	01.0528	13.30
460023	01.2159	20.38	490040	01.4423	21.78	500001	01.4116	21.87	500102	00.9662	20.71	510077	01.1543	15.63
460024	.	13.13	490041	01.2682	16.49	500002	01.4114	21.64	500104	01.1745	22.63	510080	01.2045	16.32
460025	00.7973	20.08	490042	01.3042	16.38	500003	01.4113	24.03	500106	00.9621	19.85	510081	01.1989	13.50

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460026	01.0546	17.32	490043	01.3799	19.82	500005	01.8017	21.24	500107	01.2359	16.68	510082	01.2103	13.50
460027	00.8896	20.53	490044	01.3517	17.17	500007	01.3067	23.24	500108	01.7225	20.48	510084	00.9683	12.91
460029	01.0308	17.00	490045	01.2262	20.83	500008	01.9336	25.09	500110	01.1917	20.80	510085	01.3271	18.21
460030	01.1366	17.92	490046	01.5215	17.89	500011	01.3302	22.98	500118	01.1805	22.66	510086	01.1887	13.59
460032	01.0587	20.55	490047	01.1475	16.65	500012	01.5430	22.34	500119	01.3049	21.86	520002	01.2683	18.86
460033	00.9178	16.42	490048	01.5936	17.94	500014	01.5362	22.94	500122	01.2799	22.76	520003	01.0633	15.78
460035	00.9427	12.43	490050	01.4821	20.95	500015	01.4371	22.41	500123	00.9001	16.33	520004	01.1859	18.46
460036	01.0247	20.56	490052	01.6349	16.50	500016	01.5218	24.13	500124	01.3303	23.75	520006	01.0484	20.59
460037	00.9601	18.38	490053	01.3142	15.12	500019	01.3849	22.33	500125	01.1430	15.98	520007	01.0769	14.87
460039	01.1022	23.84	490054	01.0146	15.45	500021	01.4785	18.72	500129	01.7638	23.34	520008	01.6418	22.59
460041	01.3300	20.51	490057	01.5486	18.87	500023	01.2234	21.48	500132	00.9434	17.26	520009	01.6491	18.07
460042	01.4547	14.11	490059	01.6271	19.93	500024	01.6953	25.17	500134	00.5741	17.47	520010	01.2081	20.11
460043	00.9829	21.91	490060	01.1216	18.19	500025	01.8623	25.48	500138	06.3360	.	520011	01.2486	19.56
460044	01.1846	20.42	490063	01.7915	23.63	500026	01.4301	24.13	500139	01.4926	20.79	520013	01.3635	18.64
460046	02.1883	17.71	490066	01.2907	20.77	500027	01.6090	25.88	500140	.	18.06	520014	01.1474	16.47

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1997 PAGE 16 OF 15
:HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 1999 WAGE INDEX

PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE	PROVIDER	CASE MIX INDEX	AVG HOUR WAGE
520015	01.1674	17.69	520107	01.3304	18.75	530026	01.1674	21.55						
520016	01.1202	12.53	520109	00.9879	18.27	530027	00.9464	32.50						
520017	01.1591	18.49	520110	01.2494	18.59	530029	01.0362	14.86						
520018	01.1396	17.55	520111	00.9934	17.44	530031	00.8621	18.36						
520019	01.3092	19.27	520112	01.1346	17.67	530032	01.1799	20.84						
520021	01.3153	19.71	520113	01.2572	19.14									
520024	01.1076	13.94	520114	01.1453	15.59									
520025	01.1200	16.59	520115	01.2488	17.57									
520026	01.0683	18.95	520116	01.2392	19.24									
520027	01.2320	20.05	520117	01.0212	17.30									
520028	01.4025	20.13	520118	00.8786	12.73									
520029	00.9252	17.80	520120	00.8917	16.22									
520030	01.6638	20.22	520121	00.9808	16.30									
520031	01.1175	15.70	520122	01.0140	16.52									
520032	01.1639	16.87	520123	01.0605	17.45									
520033	01.2076	17.42	520124	01.0903	16.50									
520034	01.0837	17.18	520130	01.0258	14.89									
520035	01.3487	17.15	520131	01.0434	17.56									
520037	01.6603	19.33	520132	01.2010	17.01									
520038	01.3409	17.69	520134	01.0766	16.37									
520039	01.0186	18.09	520135	00.9815	14.02									
520040	01.4403	19.39	520136	01.5425	19.31									
520041	01.1401	15.58	520138	01.8978	14.96									
520042	01.1047	17.13	520139	01.2895	20.36									
520044	01.4368	17.04	520140	01.6204	19.68									
520045	01.6773	18.60	520141	.	16.28									
520047	00.9952	17.42	520142	00.8907	16.53									
520048	01.4618	18.04	520144	01.0203	16.36									
520049	01.9637	19.12	520145	00.9508	16.85									
520051	01.8017	15.77	520146	01.0701	15.76									
520053	01.1459	15.87	520148	01.1566	16.73									
520054	01.0412	19.44	520149	00.9337	12.72									
520056	.	19.80	520151	01.0416	16.58									
520057	01.1770	18.10	520152	01.1252	17.97									
520058	01.1331	18.45	520153	00.9596	14.95									
520059	01.3512	19.76	520154	01.1635	18.07									
520060	01.4225	17.08	520156	01.1758	19.10									
520062	01.3071	17.21	520157	01.0942	15.30									
520063	01.1999	20.08	520159	00.9415	19.52									
520064	01.5698	20.70	520160	01.7756	19.26									
520066	01.5309	19.84	520161	01.0384	17.96									
520068	00.9883	18.59	520170	01.2523	21.23									
520069	01.1837	18.14	520171	00.9052	14.86									
520070	01.5721	17.44	520173	01.1600	19.58									
520071	01.2458	18.44	520174	.	20.01									
520074	01.0377	16.81	520177	01.6352	19.38									
520075	01.4610	18.96	520178	01.1177	16.98									
520076	01.1659	16.36	520187	00.5303	.									
520077	00.9725	14.51	530002	01.2346	21.84									
520078	01.6270	18.24	530003	00.8835	14.70									
520082	01.2967	17.60	530004	00.9570	14.14									
520083	01.7074	21.38	530005	01.0465	14.61									
520084	01.0865	17.62	530006	01.1201	20.18									

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520087	01.7195	18.61	530007	01.1111	14.87
520088	01.2621	18.97	530008	01.2980	17.24
520089	01.4900	20.44	530009	00.9964	18.12
520090	01.2914	17.51	530010	01.2151	18.65
520091	01.3195	19.68	530011	01.1617	17.22
520092	01.1555	16.83	530012	01.5598	18.08
520094	00.7875	19.19	530014	01.4025	16.93
520095	01.3850	19.05	530015	01.2689	18.80
520096	01.3959	18.60	530016	01.2996	17.19
520097	01.2981	19.05	530017	00.8709	15.80
520098	01.8390	20.96	530018	01.0972	16.71
520100	01.2823	18.08	530019	01.0350	11.26
520101	01.0895	17.84	530022	01.1153	17.60
520102	01.1584	20.05	530023	00.8946	19.55
520103	01.3298	18.39	530025	01.2196	21.13

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH MARCH 1998

BILLING CODE 4120-01-C

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS

Urban area (Constituent counties)	Wage index	GAF
0040 Abilene, TX	0.8083	0.8644
Taylor, TX		
0060 Aguadilla, PR	0.4738	0.5996
Aguada, PR		
Aguadilla, PR		
Moca, PR		
0080 Akron, OH	0.9954	0.9968
Portage, OH		
Summit, OH		
0120 Albany, GA	0.7993	0.8578
Dougherty, GA		
Lee, GA		
0160 Albany-Schenectady-Troy, NY	0.8629	0.9040
Albany, NY		
Montgomery, NY		
Rensselaer, NY		
Saratoga, NY		
Schenectady, NY		
Schoharie, NY		
0200 Albuquerque, NM	0.8632	0.9042
Bernalillo, NM		
Sandoval, NM		
Valencia, NM		
0220 Alexandria, LA	0.8544	0.8978
Rapides, LA		
0240 Allentown-Bethlehem-Easton, PA	1.0226	1.0154
Carbon, PA		
Lehigh, PA		
Northampton, PA		
0280 Altoona, PA	0.9355	0.9554
Blair, PA		
0320 Amarillo, TX	0.8509	0.8953
Potter, TX		
Randall, TX		
0380 Anchorage, AK	1.3007	1.1973
Anchorage, AK		
0440 Ann Arbor, MI	1.1057	1.0712
Lenawee, MI		
Livingston, MI		
Washtenaw, MI		
0450 Anniston, AL	0.8676	0.9073
Calhoun, AL		
0460 Appleton-Oshkosh-Neenah, WI	0.8844	0.9193
Calumet, WI		
Outagamie, WI		
Winnebago, WI		
0470 Arecibo, PR	0.4878	0.6117
Arecibo, PR		
Camuy, PR		
Hatillo, PR		
0480 Asheville, NC	0.8960	0.9276
Buncombe, NC		
Madison, NC		
0500 Athens, GA	0.8692	0.9085
Clarke, GA		
Madison, GA		
Oconee, GA		
0520 [1] Atlanta, GA	0.9936	0.9956
Barrow, GA		
Bartow, GA		
Carroll, GA		
Cherokee, GA		
Clayton, GA		
Cobb, GA		
Coweta, GA		
DeKalb, GA		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (Constituent counties)	Wage index	GAF
Douglas, GA		
Fayette, GA		
Forsyth, GA		
Fulton, GA		
Gwinnett, GA		
Henry, GA		
Newton, GA		
Paulding, GA		
Pickens, GA		
Rockdale, GA		
Spalding, GA		
Walton, GA		
0560 Atlantic-Cape May, NJ.		
Atlantic, NJ		
Cape May, NJ	1.0377	1.0257
0600 Augusta-Aiken, GA–SC	0.9253	0.9482
Columbia, GA		
McDuffie, GA		
Richmond, GA		
Aiken, SC		
Edgefield, SC		
0640 [1] Austin-San Marcos, TX	0.8442	0.8905
Bastrop, TX		
Caldwell, TX		
Hays, TX		
Travis, TX		
Williamson, TX		
0680 [2] Bakersfield, CA	0.9959	0.9972
Kern, CA		
0720 [1] Baltimore, MD	0.9663	0.9768
Anne Arundel, MD		
Baltimore, MD		
Baltimore City, MD		
Carroll, MD		
Harford, MD		
Howard, MD		
Queen Anne's, MD		
0733 Bangor, ME	0.9495	0.9651
Penobscot, ME		
0743 Barnstable-Yarmouth, MA	1.5415	1.3449
Barnstable, MA		
0760 Baton Rouge, LA	0.8891	0.9227
Ascension, LA		
East Baton Rouge, LA		
Livingston, LA		
West Baton Rouge, LA		
0840 Beaumont-Port Arthur, TX	0.9071	0.9354
Hardin, TX		
Jefferson, TX		
Orange, TX		
0860 Bellingham, WA	1.1459	1.0978
Whatcom, WA		
0870 [2] Benton Harbor, MI	0.8903	0.9235
Berrien, MI		
0875 [1] Bergen-Passaic, NJ	1.1774	1.1183
Bergen, NJ		
Passaic, NJ		
0880 Billings, MT	0.9162	0.9418
Yellowstone, MT		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (Constituent counties)	Wage index	GAF
0920 Biloxi-Gulfport-Pascagoula, MS	0.8294	0.8798
Hancock, MS		
Harrison, MS		
Jackson, MS		
0960 Binghamton, NY	0.9078	0.9359
Broome, NY		
Tioga, NY		
1000 Birmingham, AL	0.9092	0.9369
Blount, AL		
Jefferson, AL		
St. Clair, AL		
Shelby, AL		
1010 Bismarck, ND	0.8042	0.8614
Burleigh, ND		
Morton, ND		
1020 Bloomington, IN	0.8984	0.9293
Monroe, IN		
1040 Bloomington-Normal, IL	0.8870	0.9212
McLean, IL		
1080 Boise City, ID	0.9209	0.9451
Ada, ID		
Canyon, ID		
1123 [1] Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH	1.1307	1.0878
Bristol, MA		
Essex, MA		
Middlesex, MA		
Norfolk, MA		
Plymouth, MA		
Suffolk, MA		
Worcester, MA		
Hillsborough, NH		
Merrimack, NH		
Rockingham, NH		
Strafford, NH		
1125 Boulder-Longmont, CO	1.0059	1.0040
Boulder, CO		
1145 Brazoria, TX	0.8925	0.9251
Brazoria, TX		
1150 Bremerton, WA	1.1079	1.0727
Kitsap, WA		
1240 Brownsville-Harlingen-San Benito, TX	0.8255	0.8769
Cameron, TX		
1260 Bryan-College Station, TX	0.8084	0.8645
Brazos, TX		
1280 [1] Buffalo-Niagara Falls, NY	0.9607	0.9729
Erie, NY		
Niagara, NY		
1303 Burlington, VT	0.9616	0.9735
Chittenden, VT		
Franklin, VT		
Grand Isle, VT		
1310 Caguas, PR	0.4419	0.5716
Caguas, PR		
Cayey, PR		
Cidra, PR		
Gurabo, PR		
San Lorenzo, PR		
1320 Canton-Massillon, OH	0.8827	0.9181

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (Constituent counties)	Wage index	GAF
Carroll, OH		
Stark, OH		
1350 Casper, WY	0.9170	0.9424
Natrona, WY		
1360 Cedar Rapids, IA	0.8833	0.9185
Linn, IA		
1400 Champaign-Urbana, IL	0.8789	0.9154
Champaign, IL		
1440 Charleston-North Charleston, SC	0.9134	0.9399
Berkeley, SC		
Charleston, SC		
Dorchester, SC		
1480 Charleston, WV	0.9009	0.9310
Kanawha, WV		
Putnam, WV		
1520 [1] Charlotte-Gastonia-Rock Hill, NC–SC	0.9562	0.9698
Cabarrus, NC		
Gaston, NC		
Lincoln, NC		
Mecklenburg, NC		
Rowan, NC		
Stanly, NC		
Union, NC		
York, SC		
1540 Charlottesville, VA	1.0294	1.0200
Albemarle, VA		
Charlottesville City, VA		
Fluvanna, VA		
Greene, VA		
1560 Chattanooga, TN–GA	0.9093	0.9370
Catoosa, GA		
Dade, GA		
Walker, GA		
Hamilton, TN		
Marion, TN		
1580 [2] Cheyenne, WY	0.8787	0.9153
Laramie, WY		
1600 [1] Chicago, IL	1.0469	1.0319
Cook, IL		
DeKalb, IL		
DuPage, IL		
Grundy, IL		
Kane, IL		
Kendall, IL		
Lake, IL		
McHenry, IL		
Will, IL		
1620 Chico-Paradise, CA	1.0167	1.0114
Butte, CA		
1640 [2] Cincinnati, OH–KY–IN	0.9615	0.9735
Dearborn, IN		
Ohio, IN		
Boone, KY		
Campbell, KY		
Gallatin, KY		
Grant, KY		
Kenton, KY		
Pendleton, KY		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (Constituent counties)	Wage index	GAF
Brown, OH		
Clermont, OH		
Hamilton, OH		
Warren, OH		
1660 Clarksville-Hopkinsville, TN–KY	0.8231	0.8752
Christian, KY		
Montgomery, TN		
1680 [1] Cleveland-Lorain-Elyria, OH	0.9907	0.9936
Ashtabula, OH		
Cuyahoga, OH		
Geauga, OH		
Lake, OH		
Lorain, OH		
Medina, OH		
1720 Colorado Springs, CO	0.9410	0.9592
El Paso, CO		
1740 Columbia, MO	0.8961	0.9276
Boone, MO		
1760 Columbia, SC	0.9310	0.9522
Lexington, SC		
Richland, SC		
1800 Columbus, GA–AL.		
Russell, AL	0.8529	0.8968
Chattahoochee, GA		
Harris, GA		
Muscogee, GA		
1840 [1] Columbus, OH	0.9802	0.9864
Delaware, OH		
Fairfield, OH		
Franklin, OH		
Licking, OH		
Madison, OH		
Pickaway, OH		
1880 Corpus Christi, TX	0.8549	0.8982
Nueces, TX		
San Patricio, TX		
1900 [2] Cumberland, MD–WV (Maryland Hospitals)	0.8574	0.9000
Allegany, MD		
Mineral, WV		
1900 Cumberland, MD–WV (West Virginia Hospital)	0.8259	0.8772
Allegany, MD		
Mineral, WV		
1920 [1] Dallas, TX	0.9364	0.9560
Collin, TX		
Dallas, TX		
Denton, TX		
Ellis, TX		
Henderson, TX		
Hunt, TX		
Kaufman, TX		
Rockwall, TX		
1950 Danville, VA	0.9065	0.9350
Danville City, VA		
Pittsylvania, VA		
1960 DavenportMoline-Rock Island, IA–IL	0.8431	0.8897
Scott, IA		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (Constituent counties)	Wage index	GAF
Henry, IL		
Rock Island, IL		
2000 Dayton-Springfield, OH	0.9584	0.9713
Clark, OH		
Greene, OH		
Miami, OH		
Montgomery, OH		
2020 Daytona Beach, FL	0.9153	0.9412
Flagler, FL		
Volusia, FL		
2030 Decatur, AL	0.8251	0.8766
Lawrence, AL		
Morgan, AL		
2040 Decatur, IL	0.8052	0.8621
Macon, IL		
2080 [1] Denver, CO	1.0059	1.0040
Adams, CO		
Arapahoe, CO		
Denver, CO		
Douglas, CO		
Jefferson, CO		
2120 Des Moines, IA	0.8494	0.8942
Dallas, IA		
Polk, IA		
Warren, IA		
2160 [1] Detroit, MI	1.0567	1.0385
Lapeer, MI		
Macomb, MI		
Monroe, MI		
Oakland, MI		
St. Clair, MI		
Wayne, MI		
2180 Dothan, AL	0.7909	0.8516
Dale, AL		
Houston, AL		
2190 Dover, DE	0.9383	0.9573
Kent, DE		
2200 Dubuque, IA	0.8240	0.8758
Dubuque, IA		
2240 Duluth-Superior, MN–WI	1.0031	1.0021
St. Louis, MN		
Douglas, WI		
2281 Dutchess County, NY	0.9904	0.9934
Dutchess, NY		
2290 [2] Eau Claire, WI	0.8729	0.9111
Chippewa, WI		
Eau Claire, WI		
2320 El Paso, TX	0.9235	0.9470
El Paso, TX		
2330 Elkhart-Goshen, IN	0.9388	0.9577
Elkhart, IN		
2335 [2] Elmira, NY	0.8605	0.9022
Chemung, NY		
2340 Enid, OK	0.7969	0.8560
Garfield, OK		
2360 Erie, PA	0.9290	0.9508
Erie, PA		
2400 Eugene-Springfield, OR	1.1217	1.0818
Lane, OR		
2440 Evansville-Henderson, IN–KY	0.8547	0.8981

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (Constituent counties)	Wage index	GAF
Posey, IN		
Vanderburgh, IN		
Warrick, IN		
Henderson, KY		
2520 Fargo-Moorhead, ND–MN	0.9537	0.9681
Clay, MN		
Cass, ND		
2560 Fayetteville, NC	0.8407	0.8880
Cumberland, NC		
2580 Fayetteville-Springdale-Rogers, AR	0.8632	0.9042
Benton, AR		
Washington, AR		
2620 Flagstaff, AZ–UT	0.9543	0.9685
Coconino, AZ		
Kane, UT		
2640 Flint, MI	1.1054	1.0710
Genesee, MI		
2650 Florence, AL	0.7692	0.8355
Colbert, AL		
Lauderdale, AL		
2655 Florence, SC	0.8520	0.8961
Florence, SC		
2670 Fort Collins-Loveland, CO	1.0319	1.0217
Larimer, CO		
2680 [1] Ft. Lauderdale, FL	0.9867	0.9909
Broward, FL		
2700 Fort Myers-Cape Coral, FL	0.8936	0.9259
Lee, FL		
2710 Fort Pierce-Port St. Lucie, FL	1.0263	1.0179
Martin, FL		
St. Lucie, FL		
2720 Fort Smith, AR–OK	0.7639	0.8316
Crawford, AR		
Sebastian, AR		
Sequoyah, OK		
2750 [2] Fort Walton Beach, FL	0.8896	0.9230
Okaloosa, FL		
2760 Fort Wayne, IN	0.9066	0.9351
Adams, IN		
Allen, IN		
De Kalb, IN		
Huntington, IN		
Wells, IN		
Whitley, IN		
2800 [1] Forth Worth-Arlington, TX	0.9729	0.9814
Hood, TX		
Johnson, TX		
Parker, TX		
Tarrant, TX		
2840 Fresno, CA	1.0409	1.0278
Fresno, CA		
Madera, CA		
2880 Gadsden, AL	0.8799	0.9161
Etowah, AL		
2900 Gainesville, FL	0.9482	0.9642
Alachua, FL		
2920 Galveston-Texas City, TX	1.0848	1.0573
Galveston, TX		
2960 Gary, IN	0.9482	0.9642
Lake, IN		
Porter, IN		
2975 [2] Glens Falls, NY	0.8605	0.9022
Warren, NY		
Washington, NY		
2980 Goldsboro, NC	0.8548	0.8981
Wayne, NC		
2985 Grand Forks, ND–MN	0.8918	0.9246
Polk, MN		
Grand Forks, ND		
2995 Grand Junction, CO	0.9099	0.9374
Mesa, CO		
3000 [1] Grand Rapids-Muskegon-Holland, MI	0.9992	0.9995
Allegan, MI		
Kent, MI		
Muskegon, MI		
Ottawa, MI		
3040 Great Falls, MT	0.9304	0.9518
Cascade, MT		
3060 Greeley, CO	0.9477	0.9639
Weld, CO		
3080 Green Bay, WI	0.9268	0.9493
Brown, WI		
3120 [1] Greensboro-Winston-Salem-High Point, NC	0.9567	0.9701
Alamance, NC		
Davidson, NC		
Davie, NC		
Forsyth, NC		
Guilford, NC		
Randolph, NC		
Stokes, NC		
Yadkin, NC		
3150 Greenville, NC	0.9454	0.9623
Pitt, NC		
3160 Greenville-Spartanburg-Anderson, SC	0.9242	0.9475
Anderson, SC		
Cherokee, SC		
Greenville, SC		
Pickens, SC		
Spartanburg, SC		
3180 Hagerstown, MD	1.0204	1.0139
Washington, MD		
3200 Hamilton-Middletown, OH	0.9253	0.9482
Butler, OH		
3240 Harrisburg-Lebanon-Carlisle, PA	1.0082	1.0056
Cumberland, PA		
Dauphin, PA		
Lebanon, PA		
Perry, PA		
3283 [1, 2] Hartford, CT	1.2100	1.1394
Hartford, CT		
Litchfield, CT		
Middlesex, CT		
Tolland, CT		
3285 [2] Hattiesburg, MS	0.7327	0.8082
Forrest, MS		
Lamar, MS		
3290 Hickory-Morganton-Lenoir, NC	0.8668	0.9067
Alexander, NC		
Burke, NC		
Caldwell, NC		
Catawba, NC		
3320 Honolulu, HI	1.1535	1.1027
Honolulu, HI		
3350 Houma, LA	0.8215	0.8740
Lafourche, LA		
Terrebonne, LA		
3360 [1] Houston, TX	0.9904	0.9934
Chambers, TX		
Fort Bend, TX		
Harris, TX		
Liberty, TX		
Montgomery, TX		
Waller, TX		
3400 Huntington-Ashland, WV–KY–OH	0.9668	0.9771
Boyd, KY		
Carter, KY		
Greenup, KY		
Lawrence, OH		
Cabell, WV		
Wayne, WV		
3440 Huntsville, AL	0.8403	0.8877
Limestone, AL		
Madison, AL		
3480 [1] Indianapolis, IN	0.9852	0.9898
Boone, IN		
Hamilton, IN		
Hancock, IN		
Hendricks, IN		
Johnson, IN		
Madison, IN		
Marion, IN		
Morgan, IN		
Shelby, IN		
3500 Iowa City, IA	0.9502	0.9656
Johnson, IA		
3520 Jackson, MI	0.9244	0.9476
Jackson, MI		
3560 Jackson, MS	0.8310	0.8809
Hinds, MS		
Madison, MS		
Rankin, MS		
3580 Jackson, TN	0.8578	0.9003
Madison, TN		
Chester, TN		
3600 [1] Jacksonville, FL	0.8919	0.9246
Clay, FL		
Duval, FL		
Nassau, FL		
St. Johns, FL		
3605 [2] Jacksonville, NC	0.8130	0.8678
Onslow, NC		
3610 [2] Jamestown, NY	0.8605	0.9022
Chautauqua, NY		
3620 Janesville-Beloit, WI	0.9071	0.9354
Rock, WI		
3640 Jersey City, NJ	1.1623	1.1085
Hudson, NJ		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (Constituent counties)	Wage index	GAF
3660 Johnson City-Kingsport-Bristol, TN–VA	0.8792	0.9156
Carter, TN		
Hawkins, TN		
Sullivan, TN		
Unicoi, TN		
Washington, TN		
Bristol City, VA		
Scott, VA		
Washington, VA		
3680 [2] Johnstown, PA	0.8683	0.9078
Cambria, PA		
Somerset, PA		
3700 Jonesboro, AR	0.7595	0.8283
Craighead, AR		
3710 Joplin, MO	0.7890	0.8502
Jasper, MO		
Newton, MO		
3720 Kalamazoo-Battlecreek, MI	1.1355	1.0909
Calhoun, MI		
Kalamazoo, MI		
Van Buren, MI		
3740 Kankakee, IL	0.9438	0.9612
Kankakee, IL		
3760 [1] Kansas City, KS–MO	0.9666	0.9770
Johnson, KS		
Leavenworth, KS		
Miami, KS		
Wyandotte, KS		
Cass, MO		
Clay, MO		
Clinton, MO		
Jackson, MO		
Lafayette, MO		
Platte, MO		
Ray, MO		
3800 Kenosha, WI	0.9149	0.9409
Kenosha, WI		
3810 Killeen-Temple, TX	1.0131	1.0090
Bell, TX		
Coryell, TX–		
3840 Knoxville, TN	0.8937	0.9259
Anderson, TN		
Blount, TN		
Knox, TN		
Loudon, TN		
Sevier, TN		
Union, TN		
3850 Kokomo, IN	0.9295	0.9512
Howard, IN		
Tipton, IN		
3870 La Crosse, WI–MN	0.8933	0.9256
Houston, MN		
La Crosse, WI		
3880 Lafayette, LA	0.8311	0.8810
Acadia, LA		
Lafayette, LA		
St. Landry, LA		
St. Martin, LA		
3920 Lafayette, IN	0.8928	0.9253
Clinton, IN		
Tippecanoe, IN		
3960 Lake Charles, LA	0.7690	0.8354
Calcasieu, LA		
3980 Lakeland-Winter Haven, FL	0.8896	0.9230
Polk, FL		
4000 Lancaster, PA	0.9581	0.9711
Lancaster, PA		
4040 Lansing-East Lansing, MI	1.0112	1.0077
Clinton, MI		
Eaton, MI		
Ingham, MI		
4080 [2] Laredo, TX	0.7441	0.8168
Webb, TX		
4100 Las Cruces, NM	0.8989	0.9296
Dona Ana, NM		
4120 [1] Las Vegas, NV–AZ	1.1438	1.0964
Mohave, AZ		
Clark, NV		
Nye, NV		
4150 Lawrence, KS	0.8674	0.9072
Douglas, KS		
4200 Lawton, OK	0.8716	0.9102
Comanche, OK		
4243 Lewiston-Auburn, ME	0.9169	0.9423
Androscoggin, ME		
4280 Lexington, KY	0.8525	0.8965
Bourbon, KY		
Clark, KY		
Fayette, KY		
Jessamine, KY		
Madison, KY		
Scott, KY		
Woodford, KY		
4320 Lima, OH	0.8968	0.9281
Allen, OH		
Auglaize, OH		
4360 Lincoln, NE	0.9323	0.9531
Lancaster, NE		
4400 Little Rock-North Little Rock, AR	0.8553	0.8985
Faulkner, AR		
Lonoke, AR		
Pulaski, AR		
Saline, AR		
4420 Longview-Marshall, TX	0.8717	0.9103
Gregg, TX		
Harrison, TX		
Upshur, TX		
4480 [1] Los Angeles-Long Beach, CA	1.2070	1.1375
Los Angeles, CA		
4520 Louisville, KY–IN	0.9113	0.9384
Clark, IN		
Floyd, IN		
Harrison, IN		
Scott, IN		
Bullitt, KY		
Jefferson, KY		
Oldham, KY		
4600 Lubbock, TX	0.8514	0.8957
Lubbock, TX		
4640 Lynchburg, VA	0.8919	0.9246
Amherst, VA		
Bedford, VA		
Bedford City, VA		
Campbell, VA		
Lynchburg City, VA		
4680 Macon, GA	0.8629	0.9040
Bibb, GA		
Houston, GA		
Jones, GA		
Peach, GA		
Twiggs, GA		
4720 Madison, WI	1.0040	1.0027
Dane, WI		
4800 Mansfield, OH	0.8552	0.8984
Crawford, OH		
Richland, OH		
4840 Mayaguez, PR	0.4188	0.5510
Anasco, PR		
Cabo Rojo, PR		
Hormigueros, PR		
Mayaguez, PR		
Sabana Grande, PR		
San German, PR		
4880 McAllen-Edinburg-Mission, TX	0.8506	0.8951
Hidalgo, TX		
4890 Medford-Ashland, OR	1.0042	1.0029
Jackson, OR		
4900 Melbourne-Titusville-Palm Bay, FL	0.9236	0.9470
Brevard, FL		
4920 [1] Memphis, TN–AR–MS	0.8371	0.8854
Crittenden, AR		
DeSoto, MS		
Fayette, TN		
Shelby, TN		
Tipton, TN		
4940 Merced, CA	1.0240	1.0164
Merced, CA		
5000 [1] Miami, FL	1.0038	1.0026
Dade, FL		
5015 [1] Middlesex-Somerset-Hunterdon, NJ	1.0785	1.0531
Hunterdon, NJ		
Middlesex, NJ		
Somerset, NJ		
5080 [1] Milwaukee-Waukesha, WI	0.9135	0.9399
Milwaukee, WI		
Ozaukee, WI		
Washington, WI		
Waukesha, WI		
5120 [1] Minneapolis-St. Paul, MN–WI	1.0877	1.0593
Anoka, MN		
Carver, MN		
Chisago, MN		
Dakota, MN		
Hennepin, MN		
Isanti, MN		
Ramsey, MN		
Scott, MN		
Sherburne, MN		
Washington, MN		
Wright, MN		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (Constituent counties)	Wage index	GAF
Pierce, WI		
St. Croix, WI		
5140 Missoula, MT	0.9208	0.9451
Missoula, MT		
5160 Mobile, AL	0.8395	0.8871
Baldwin, AL		
Mobile, AL		
5170 Modesto, CA	1.0368	1.0251
Stanislaus, CA		
5190 [1] Monmouth-Ocean, NJ	1.1341	1.0900
Monmouth, NJ		
Ocean, NJ		
5200 Monroe, LA	0.8236	0.8756
Ouachita, LA		
5240 Montgomery, AL	0.7877	0.8492
Autauga, AL		
Elmore, AL		
Montgomery, AL		
5280 Muncie, IN	0.9434	0.9609
Delaware, IN		
5330 Myrtle Beach, SC	0.8196	0.8726
Horry, SC		
5345 Naples, FL	1.0199	1.0136
Collier, FL		
5360 [1] Nashville, TN	0.9500	0.9655
Cheatham, TN		
Davidson, TN		
Dickson, TN		
Robertson, TN		
Rutherford TN		
Sumner, TN		
Williamson, TN		
Wilson, TN		
5380 [1] Nassau-Suffolk, NY	1.3579	1.2331
Nassau, NY		
Suffolk, NY		
5483 [1] New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	1.2271	1.1504
Fairfield, CT		
New Haven, CT		
5523 [2] New London-Norwich, CT	1.2100	1.1394
New London, CT		
5560 [1] New Orleans, LA	0.9330	0.9536
Jefferson, LA		
Orleans, LA		
Plaquemines, LA		
St. Bernard, LA		
St. Charles, LA		
St. James, LA		
St. John The Baptist, LA		
St. Tammany, LA		
5600 [1] New York, NY	1.4431	1.2855
Bronx, NY		
Kings, NY		
New York, NY		
Putnam, NY		
Queens, NY		
Richmond, NY		
Rockland, NY		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (Constituent counties)	Wage index	GAF
Westchester, NY		
5640 [1] Newark, NJ	1.0895	1.0605
Essex, NJ		
Morris, NJ		
Sussex, NJ		
Union, NJ		
Warren, NJ		
5660 Newburgh, NY-PA	1.1247	1.0838
Orange, NY		
Pike, PA		
5720 [1] Norfolk-Virginia Beach-Newport News, VA-NC	0.8214	0.8740
Currituck, NC		
Chesapeake City, VA		
Gloucester, VA		
Hampton City, VA		
Isle of Wight, VA		
James City, VA		
Mathews, VA		
Newport News City, VA		
Norfolk City, VA		
Poquoson City, VA		
Portsmouth City, VA		
Suffolk City, VA		
Virginia Beach City, VA		
Williamsburg City, VA		
York, VA		
5775 [1] Oakland, CA	1.5194	1.3317
Alameda, CA		
Contra Costa, CA		
5790 Ocala, FL	0.9172	0.9425
Marion, FL		
5800 Odessa-Midland, TX	0.8683	0.9078
Ector, TX		
Midland, TX		
5880 [1] Oklahoma City, OK	0.8727	0.9110
Canadian, OK		
Cleveland, OK		
Logan, OK		
McClain, OK		
Oklahoma, OK		
Pottawatomie, OK		
5910 Olympia, WA	1.1547	1.1035
Thurston, WA		
5920 Omaha, NE–IA	0.9993	0.9995
Pottawattamie, IA		
Cass, NE		
Douglas, NE		
Sarpy, NE		
Washington, NE		
5945 [1] Orange County, CA	1.1472	1.0986
Orange, CA		
5960 [1] Orlando, FL	0.9834	0.9886
Lake, FL		
Orange, FL		
Osceola, FL		
Seminole, FL		
5990 [2] Owensboro, KY	0.7861	0.8481
Daviess, KY		
6015 [2] Panama City, FL	0.8896	0.9230

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (Constituent counties)	Wage index	GAF
Bay, FL		
6020 Parkersburg-Marietta, WV–OH (West Virginia Hospitals)	0.8034	0.8608
Washington, OH		
Wood, WV		
6020 [2] Parkersburg-Marietta, WV–OH (Ohio Hospitals)	0.8537	0.8973
Washington, OH		
Wood, WV		
6080 [2] Pensacola, FL	0.8896	0.9230
Escambia, FL		
Santa Rosa, FL		
6120 Peoria-Pekin, IL	0.8081	0.8642
Peoria, IL		
Tazewell, IL		
Woodford, IL		
6160 [1] Philadelphia, PA–NJ	1.1382	1.0927
Burlington, NJ		
Camden, NJ		
Gloucester, NJ		
Salem, NJ		
Bucks, PA		
Chester, PA		
Delaware, PA		
Montgomery, PA		
Philadelphia, PA		
6200 [1] Phoenix-Mesa, AZ	0.9611	0.9732
Maricopa, AZ		
Pinal, AZ		
6240 Pine Bluff, AR	0.7929	0.8531
Jefferson, AR		
6280 [1] Pittsburgh, PA	0.9809	0.9869
Allegheny, PA		
Beaver, PA		
Butler, PA		
Fayette, PA		
Washington, PA		
Westmoreland, PA		
6323 [2] Pittsfield, MA	1.0857	1.0579
Berkshire, MA		
6340 Pocatello, ID	0.8811	0.9170
Bannock, ID		
6360 Ponce, PR	0.4799	0.6049
Guayanilla, PR		
Juana Diaz, PR		
Penuelas, PR		
Ponce, PR		
Villalba, PR		
Yauco, PR		
6403 Portland, ME	0.9595	0.9721
Cumberland, ME		
Sagadahoc, ME		
York, ME		
6440 [1] Portland-Vancouver, OR–WA	1.1202	1.0808
Clackamas, OR		
Columbia, OR		
Multnomah, OR		
Washington, OR		
Yamhill, OR		
Clark, WA		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (Constituent counties)	Wage index	GAF
6483 [1] Providence-Warwick-Pawtucket, RI	1.0824	1.0557
Bristol, RI		
Kent, RI		
Newport, RI		
Providence, RI		
Washington, RI		
6520 Provo-Orem, UT	0.9907	0.9936
Utah, UT		
6560 Pueblo, CO	0.8731	0.9113
Pueblo, CO		
6580 Punta Gorda, FL	0.9050	0.9339
Charlotte, FL		
6600 Racine, WI	0.9149	0.9409
Racine, WI		
6640 [1] Raleigh-Durham-Chapel Hill, NC	0.9833	0.9885
Chatham, NC		
Durham, NC		
Franklin, NC		
Johnston, NC		
Orange, NC		
Wake, NC		
6660 Rapid City, SD	0.8226	0.8748
Pennington, SD		
6680 Reading, PA	0.9254	0.9483
Berks, PA		
6690 Redding, CA	1.1883	1.1254
Shasta, CA		
6720 Reno, NV	1.1118	1.0753
Washoe, NV		
6740 [2] Richland-Kennewick-Pasco, WA	1.0512	1.0348
Benton, WA		
Franklin, WA		
6760 Richmond-Petersburg, VA	0.9231	0.9467
Charles City County, VA		
Chesterfield, VA		
Colonial Heights City, VA		
Dinwiddie, VA		
Goochland, VA		
Hanover, VA		
Henrico, VA		
Hopewell City, VA		
New Kent, VA		
Petersburg City, VA		
Powhatan, VA		
Prince George, VA		
Richmond City, VA		
6780 [1] Riverside-San Bernardino, CA	1.0141	1.0096
Riverside, CA		
San Bernardino, CA		
6800 Roanoke, VA	0.8528	0.8967
Botetourt, VA		
Roanoke, VA		
Roanoke City, VA		
Salem City, VA		
6820 Rochester, MN	1.1723	1.1150
Olmsted, MN		
6840 [1] Rochester, NY	0.9677	0.9778
Genesee, NY		
Livingston, NY		
Monroe, NY		
Ontario, NY		
Orleans, NY		
Wayne, NY		
6880 Rockford, IL	0.8634	0.9043
Boone, IL		
Ogle, IL		
Winnebago, IL		
6895 Rocky Mount, NC	0.9031	0.9326
Edgecombe, NC		
Nash, NC		
6920 [1] Sacramento, CA	1.1864	1.1242
El Dorado, CA		
Placer, CA		
Sacramento, CA		
6960 Saginaw-Bay City-Midland, MI	0.9507	0.9660
Bay, MI		
Midland, MI		
Saginaw, MI		
6980 St. Cloud, MN	0.9607	0.9729
Benton, MN		
Stearns, MN		
7000 St. Joseph, MO	0.9910	0.9938
Andrew, MO		
Buchanan, MO		
7040 [1] St. Louis, MO-IL	0.9171	0.9425
Clinton, IL		
Jersey, IL		
Madison, IL		
Monroe, IL		
St. Clair, IL		
Franklin, MO		
Jefferson, MO		
Lincoln, MO		
St. Charles, MO		
St. Louis, MO		
St. Louis City, MO		
Warren, MO		
7080 [2] Salem, OR	0.9933	0.9954
Marion, OR		
Polk, OR		
7120 Salinas, CA	1.5175	1.3306
Monterey, CA		
7160 [1] Salt Lake City-Ogden, UT	0.9400	0.9585
Davis, UT		
Salt Lake, UT		
Weber, UT		
7200 San Angelo, TX	0.7662	0.8333
Tom Green, TX		
7240 [1] San Antonio, TX	0.8117	0.8669
Bexar, TX		
Comal, TX		
Guadalupe, TX		
Wilson, TX		
7320 [1] San Diego, CA	1.2336	1.1546
San Diego, CA		
7360 [1] San Francisco, CA	1.3507	1.2286
Marin, CA		
San Francisco, CA		
San Mateo, CA		
7400 [1] San Jose, CA	1.3724	1.2421
Santa Clara, CA		
7440 [1] San Juan-Bayamon, PR	0.4633	0.5904
Aguas Buenas, PR		
Barceloneta, PR		
Bayamon, PR		
Canovanas, PR		
Carolina, PR		
Catano, PR		
Ceiba, PR		
Comerio, PR		
Corozal, PR		
Dorado, PR		
Fajardo, PR		
Florida, PR		
Guaynabo, PR		
Humacao, PR		
Juncos, PR		
Los Piedras, PR		
Loiza, PR		
Luguillo, PR		
Manati, PR		
Morovis, PR		
Naguabo, PR		
Naranjito, PR		
Rio Grande, PR		
San Juan, PR		
Toa Alta, PR		
Toa Baja, PR		
Trujillo Alto, PR		
Vega Alta, PR		
Vega Baja, PR		
Yabucoa, PR		
7460 San Luis Obispo-Atascadero-Paso Robles, CA	1.0739	1.0500
San Luis Obispo, CA		
7480 Santa Barbara-Santa Maria-Lompoc, CA	1.1218	1.0819
Santa Barbara, CA		
7485 Santa Cruz-Watsonville, CA	1.4011	1.2598
Santa Cruz, CA		
7490 Santa Fe, NM	0.9623	0.9740
Los Alamos, NM		
Santa Fe, NM		
7500 Santa Rosa, CA	1.3099	1.2031
Sonoma, CA		
7510 Sarasota-Bradenton, FL	0.9553	0.9692
Manatee, FL		
Sarasota, FL		
7520 Savannah, GA	1.0081	1.0055
Bryan, GA		
Chatham, GA		
Effingham, GA		
7560 [2] Scranton—Wilkes-Barre—Hazleton, PA	0.8683	0.9078
Columbia, PA		
Lackawanna, PA		
Luzerne, PA		
Wyoming, PA		
7600 [1] Seattle-Bellevue-Everett, WA	1.1560	1.1044

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (Constituent counties)	Wage index	GAF
Island, WA		
King, WA		
Snohomish, WA		
7610 Sharon, PA	0.8866	0.9209
Mercer, PA		
7620 [2] Sheboygan, WI	0.8729	0.9111
Sheboygan, WI		
7640 Sherman-Denison, TX	0.8588	0.9010
Grayson, TX		
7680 Shreveport-Bossier City, LA	0.9400	0.9585
Bossier, LA		
Caddo, LA		
Webster, LA		
7720 Sioux City, IA–NE	0.8499	0.8946
Woodbury, IA		
Dakota, NE		
7760 Sioux Falls, SD	0.8931	0.9255
Lincoln, SD		
Minnehaha, SD		
7800 South Bend, IN	0.9880	0.9918
St. Joseph, IN		
7840 Spokane, WA	1.0952	1.0643
Spokane, WA		
7880 Springfield, IL	0.8739	0.9118
Menard, IL		
Sangamon, IL		
7920 Springfield, MO	0.8088	0.8647
Christian, MO		
Greene, MO		
Webster, MO		
8003 Springfield, MA	1.0857	1.0579
Hampden, MA		
Hampshire, MA		
8050 State College, PA	0.9469	0.9633
Centre, PA		
8080 [2] Steubenville-Weirton, OH–WV (Ohio Hospitals)	0.8537	0.8973
Jefferson, OH		
Brooke, WV		
Hancock, WV		
8080 Steubenville-Weirton, OH–WV (West Virginia Hospitals)	0.8447	0.8909
Jefferson, OH		
Brooke, WV		
Hancock, WV		
8120 Stockton-Lodi, CA	1.1099	1.0740
San Joaquin, CA		
8140 Sumter, SC	0.8144	0.8688
Sumter, SC		
8160 Syracuse, NY	0.9420	0.9599
Cayuga, NY		
Madison, NY		
Onondaga, NY		
Oswego, NY		
8200 [2] Tacoma, WA	1.0512	1.0348
Pierce, WA		
8240 [2] Tallahassee, FL	0.8896	0.9230
Gadsden, FL		
Leon, FL		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (Constituent counties)	Wage index	GAF
8280 [1] Tampa-St. Petersburg-Clearwater, FL	0.9203	0.9447
Hernando, FL		
Hillsborough, FL		
Pasco, FL		
Pinellas, FL		
8320 Terre Haute, IN	0.9010	0.9311
Clay, IN		
Vermillion, IN		
Vigo, IN		
8360 Texarkana, AR-Texarkana, TX	0.8542	0.8977
Miller, AR		
Bowie, TX		
8400 Toledo, OH	1.0012	1.0008
Fulton, OH		
Lucas, OH		
Wood, OH		
8440 Topeka, KS	0.9833	0.9885
Shawnee, KS		
8480 Trenton, NJ	1.0532	1.0361
Mercer, NJ		
8520 Tucson, AZ	0.9047	0.9337
Pima, AZ		
8560 Tulsa, OK	0.8481	0.8933
Creek, OK		
Osage, OK		
Rogers, OK		
Tulsa, OK		
Wagoner, OK		
8600 Tuscaloosa, AL	0.7658	0.8330
Tuscaloosa, AL		
8640 Tyler, TX	0.8837	0.9188
Smith, TX		
8680 [2] Utica-Rome, NY	0.8605	0.9022
Herkimer, NY		
Oneida, NY		
8720 Vallejo-Fairfield-Napa, CA	1.2845	1.1870
Napa, CA		
Solano, CA		
8735 Ventura, CA	1.0715	1.0484
Ventura, CA		
8750 Victoria, TX	0.8400	0.8875
Victoria, TX		
8760 Vineland-Millville-Bridgeton, NJ	1.0463	1.0315
Cumberland, NJ		
8780 Visalia-Tulare-Porterville, CA	1.0105	1.0072
Tulare, CA		
8800 Waco, TX	0.8389	0.8867
McLennan, TX		
8840 [1] Washington, DC–MD–VA–WV	1.0812	1.0549
District of Columbia, DC		
Calvert, MD		
Charles, MD		
Frederick, MD		
Montgomery, MD		
Prince Georges, MD		
Alexandria City, VA		
Arlington, VA		
Clarke, VA		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (Constituent counties)	Wage index	GAF
Culpeper, VA		
Fairfax, VA		
Fairfax City, VA		
Falls Church City, VA		
Fauquier, VA		
Fredericksburg City, VA		
King George, VA		
Loudoun, VA		
Manassas City, VA		
Manassas Park City, VA		
Prince William, VA		
Spotsylvania, VA		
Stafford, VA		
Warren, VA		
Berkeley, WV		
Jefferson, WV		
8920 Waterloo-Cedar Falls, IA	0.8350	0.8838
Black Hawk, IA		
8940 Wausau, WI	0.9753	0.9830
Marathon, WI		
8960 [1] West Palm Beach-Boca Raton, FL	1.0203	1.0139
Palm Beach, FL		
9000 [2] Wheeling, WV-OH (West Virginia Hospitals)	0.7892	0.8503
Belmont, OH		
Marshall, WV		
Ohio, WV		
9000 [2] Wheeling, WV-OH (Ohio Hospitals)	0.8537	0.8973
Belmont, OH		
Marshall, WV		
Ohio, WV		
9040 Wichita, KS	0.8917	0.9245
Butler, KS		
Harvey, KS		
Sedgwick, KS		
9080 Wichita Falls, TX	0.7847	0.8470
Archer, TX		
Wichita, TX		
9140 [2] Williamsport, PA	0.8683	0.9078
Lycoming, PA		
9160 Wilmington-Newark, DE–MD	1.1894	1.1261
New Castle, DE		
Cecil, MD		
9200 Wilmington, NC	0.9364	0.9560
New Hanover, NC		
Brunswick, NC		
9260 [2] Yakima, WA	1.0512	1.0348
Yakima, WA		
9270 Yolo, CA	1.0636	1.0431
Yolo, CA		
9280 York, PA	0.9431	0.9607
York, PA		
9320 Youngstown-Warren, OH	0.9836	0.9887
Columbiana, OH		
Mahoning, OH		
Trumbull, OH		
9340 Yuba City, CA	1.0889	1.0601

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (Constituent counties)	Wage index	GAF
Sutter, CA Yuba, CA 9360 Yuma, AZ ..... Yuma, AZ	1.0080	1.0055

[1] Large Urban Area
[2] Hospitals geographically located in the area are assigned the statewide rural wage index for FY 1999.

TABLE 4B.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR RURAL AREAS

Nonurban area	Wage index	GAF
Alabama	0.7338	0.8090
Alaska	1.2456	1.1623
Arizona	0.8007	0.8588
Arkansas	0.7265	0.8035
California	0.9959	0.9972
Colorado	0.8454	0.8914
Connecticut	1.2100	1.1394
Delaware	0.8826	0.9180
Florida	0.8896	0.9230
Georgia	0.7905	0.8513
Hawaii	1.0933	1.0630
Idaho	0.8495	0.8943
Illinois	0.7942	0.8540
Indiana	0.8398	0.8873
Iowa	0.7793	0.8430
Kansas	0.7330	0.8084
Kentucky	0.7861	0.8481
Louisiana	0.7481	0.8198
Maine	0.8485	0.8936
Maryland	0.8574	0.9000
Massachusetts	1.0857	1.0579
Michigan	0.8903	0.9235
Minnesota	0.8613	0.9028
Mississippi	0.7327	0.8082
Missouri	0.7468	0.8188
Montana	0.8596	0.9016
Nebraska	0.7690	0.8354
Nevada	0.9276	0.9498
New Hampshire	1.0262	1.0179
New Jersey [1]	.....	
New Mexico	0.8136	0.8683
New York	0.8605	0.9022
North Carolina	0.8130	0.8678
North Dakota	0.7514	0.8222
Ohio	0.8537	0.8973
Oklahoma	0.7139	0.7939
Oregon	0.9933	0.9954
Pennsylvania	0.8683	0.9078
Puerto Rico	0.4089	0.5420
Rhode Island [1]	.....	
South Carolina	0.8063	0.8629
South Dakota	0.7524	0.8230
Tennessee	0.7508	0.8218
Texas	0.7441	0.8168
Utah	0.8878	0.9217
Vermont	0.9436	0.9610
Virginia	0.7863	0.8482
Washington	1.0512	1.0348
West Virginia	0.7892	0.8503
Wisconsin	0.8729	0.9111

TABLE 4B.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR RURAL AREAS—Continued

Nonurban area	Wage index	GAF
Wyoming	0.8787	0.9153

[1] All counties within the State are classified as urban.

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED

Area	Wage index	GAF
Abilene, TX	0.8083	0.8644
Albany, GA	0.7905	0.8513
Albuquerque, NM	0.8632	0.9042
Alexandria, LA	0.8544	0.8978
Allentown-Bethlehem-Easton, PA	1.0226	1.0154
Amarillo, TX	0.8509	0.8953
Anchorage, AK	1.3007	1.1973
Asheville, NC	0.8960	0.9276
Atlanta, GA	0.9936	0.9956
Augusta-Aiken, GA–SC	0.9253	0.9482
Baltimore, MD	0.9663	0.9768
Barnstable-Yarmouth, MA	1.4458	1.2872
Baton Rouge, LA	0.8891	0.9227
Benton Harbor, MI	0.8903	0.9235
Bergen-Passaic, NJ	1.1774	1.1183
Billings, MT	0.9162	0.9418
Binghamton, NY	0.9078	0.9359
Birmingham, AL	0.9092	0.9369
Bismarck, ND	0.7863	0.8482
Boise City, ID	0.9209	0.9451
Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH	1.1307	1.0878
Brazoria, TX	0.8925	0.9251
Bryan-College Station, TX	0.8084	0.8645
Buffalo-Niagara Falls, NY	0.9607	0.9729
Burlington, VT	0.9616	0.9735
Caguas, PR	0.4419	0.5716
Canton-Massillon, OH	0.8827	0.9181
Casper, WY	0.9170	0.9424
Champaign-Urbana, IL	0.8789	0.9154
Charleston-North Charleston, SC	0.9134	0.9399
Charleston, WV	0.8782	0.9149
Charlotte-Gastonia-Rock Hill, NC–SC	0.9562	0.9698
Charlottesville, VA	0.9754	0.9831
Chattanooga, TN–GA	0.8888	0.9224
Chicago, IL	1.0469	1.0319
Cincinnati, OH–KY–IN	0.9615	0.9735
Clarksville-Hopkinsville, TN–KY	0.8231	0.8752
Cleveland-Lorain-Elyria, OH	0.9907	0.9936
Columbia, MO	0.8817	0.9174
Columbus, GA–AL	0.8529	0.8968
Columbus, OH	0.9802	0.9864
Corpus Christi, TX	0.8549	0.8982
Dallas, TX	0.9364	0.9560
Danville, VA	0.8735	0.9115

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area	Wage index	GAF
Davenport-Moline-Rock Island, IA–IL	0.8431	0.8897
Dayton-Springfield, OH	0.9584	0.9713
Denver, CO	1.0059	1.0040
Des Moines, IA	0.8494	0.8942
Duluth-Superior, MN–WI	1.0031	1.0021
Dutchess County, NY	0.9904	0.9934
Elkhart-Goshen, IN	0.9388	0.9577
Eugene-Springfield, OR	1.1072	1.0722
Evansville-Henderson, IN–KY	0.8433	0.8898
Fargo-Moorhead, ND–MN	0.9264	0.9490
Fayetteville, NC	0.8407	0.8880
Flagstaff, AZ–UT	0.9543	0.9685
Flint, MI	1.1054	1.0710
Fort Collins-Loveland, CO	1.0319	1.0217
Ft. Lauderdale, FL	0.9867	0.9909
Fort Pierce-Port St. Lucie, FL	1.0263	1.0179
Fort Smith, AR–OK	0.7535	0.8238
Fort Walton Beach, FL	0.8640	0.9047
Forth Worth-Arlington, TX	0.9729	0.9814
Gadsden, AL	0.8799	0.9161
Gainesville, FL	0.9482	0.9642
Goldsboro, NC	0.8353	0.8841
Grand Forks, ND–MN	0.8918	0.9246
Grand Junction, CO	0.9099	0.9374
Grand Rapids-Muskegon-Holland, MI	0.9878	0.9916
Great Falls, MT	0.9304	0.9518
Greeley, CO	0.9376	0.9568
Green Bay, WI	0.9268	0.9493
Greenville, NC	0.9118	0.9387
Greenville-Spartanburg-Anderson, SC	0.9242	0.9475
Harrisburg-Lebanon-Carlisle, PA	1.0082	1.0056
Hartford, CT	1.1879	1.1251
Hattiesburg, MS	0.7327	0.8082
Hickory-Morganton-Lenoir, NC	0.8668	0.9067
Honolulu, HI	1.1535	1.1027
Houston, TX	0.9904	0.9934
Huntington-Ashland, WV–KY–OH	0.9295	0.9512
Huntsville, AL	0.8240	0.8758
Indianapolis, IN	0.9748	0.9827
Iowa City, IA	0.9382	0.9573
Jackson, MS	0.8310	0.8809
Jackson, TN	0.8578	0.9003
Jacksonville, FL	0.8919	0.9246
Johnson City-Kingsport-Bristol, TN–VA	0.8792	0.9156
Jonesboro, AR	0.7595	0.8283
Joplin, MO	0.7890	0.8502
Kalamazoo-Battlecreek, MI	1.1102	1.0742
Kansas City, KS–MO	0.9666	0.9770
Knoxville, TN	0.8937	0.9259
Lafayette, LA	0.8311	0.8810
Lansing-East Lansing, MI	0.9995	0.9997
Las Cruces, NM	0.8989	0.9296

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area	Wage index	GAF
Las Vegas, NV–AZ	1.1438	1.0964
Lexington, KY	0.8525	0.8965
Lima, OH	0.8787	0.9153
Lincoln, NE	0.9051	0.9340
Little Rock-North Little Rock, AR	0.8553	0.8985
Los Angeles-Long Beach, CA	1.2070	1.1375
Louisville, KY–IN	0.9113	0.9384
Macon, GA	0.8502	0.8948
Madison, WI	1.0040	1.0027
Mansfield, OH	0.8552	0.8984
Memphis, TN–AR–MS	0.8371	0.8854
Merced, CA	1.0240	1.0164
Milwaukee-Waukesha, WI	0.9135	0.9399
Minneapolis-St. Paul, MN–WI	1.0877	1.0593
Modesto, CA	1.0368	1.0251
Monroe, LA	0.8097	0.8654
Montgomery, AL	0.7877	0.8492
Myrtle Beach, SC	0.8196	0.8726
Nashville, TN	0.9322	0.9531
New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	1.2271	1.1504
New London-Norwich, CT	1.1665	1.1112
New Orleans, LA	0.9330	0.9536
New York, NY	1.4431	1.2855
Newburgh, NY–PA	1.1247	1.0838
Oakland, CA	1.5194	1.3317
Odessa-Midland, TX	0.8683	0.9078
Oklahoma City, OK	0.8727	0.9110
Omaha, NE–IA	0.9993	0.9995
Orange County, CA	1.1472	1.0986
Orlando, FL	0.9834	0.9886
Peoria-Pekin, IL	0.8081	0.8642
Philadelphia, PA–NJ	1.1382	1.0927
Pittsburgh, PA	0.9661	0.9767
Pocatello, ID (Idaho Hospital)	0.8673	0.9071
Pocatello, ID (Wyoming Hospitals)	0.8787	0.9153
Portland, ME	0.9595	0.9721
Portland-Vancouver, OR–WA	1.1202	1.0808
Provo-Orem, UT	0.9907	0.9936
Raleigh-Durham-Chapel Hill, NC	0.9833	0.9885
Rapid City, SD	0.8226	0.8748
Reno, NV	1.1118	1.0753
Rochester, MN	1.1723	1.1150
Rockford, IL	0.8634	0.9043
Sacramento, CA	1.1864	1.1242
Saginaw-Bay City-Midland, MI	0.9507	0.9660
St. Cloud, MN	0.9607	0.9729
St. Louis, MO–IL	0.9171	0.9425
Salt Lake City-Ogden, UT	0.9400	0.9585
San Diego, CA	1.2336	1.1546
Santa Fe, NM	0.9493	0.9650
Santa Rosa, CA	1.2934	1.1927
Seattle-Bellevue-Everett, WA	1.1560	1.1044

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area	Wage index	GAF
Sharon, PA	0.8866	0.9209
Sherman-Denison, TX	0.8266	0.8777
Sioux City, IA–NE	0.8499	0.8946
Sioux Falls, SD	0.8828	0.9182
South Bend, IN	0.9880	0.9918
Spokane, WA	1.0752	1.0509
Springfield, IL	0.8739	0.9118
Springfield, MO	0.8088	0.8647
State College, PA	0.8812	0.9170
Syracuse, NY	0.9420	0.9599
Tallahassee, FL	0.8518	0.8960
Tampa-St. Petersburg-Clearwater, FL	0.9203	0.9447
Texarkana, AR-Texarkana, TX	0.8542	0.8977
Toledo, OH	1.0012	1.0008
Topeka, KS	0.9609	0.9731
Tucson, AZ	0.9047	0.9337
Tulsa, OK	0.8376	0.8857
Tuscaloosa, AL	0.7658	0.8330
Tyler, TX	0.8837	0.9188
Vallejo-Fairfield-Napa, CA	1.2845	1.1870
Victoria, TX	0.8400	0.8875
Washington, DC–MD–VA–WV	1.0812	1.0549
Waterloo-Cedar Falls, IA	0.8350	0.8838
Wausau, WI	0.9442	0.9614
Wichita, KS	0.8789	0.9154
Wichita Falls, TX	0.7677	0.8344
Rural Alabama	0.7338	0.8090
Rural Illinois	0.7942	0.8540
Rural Louisiana	0.7481	0.8198
Rural Massachusetts	1.0421	1.0286
Rural Michigan	0.8903	0.9235
Rural Minnesota	0.8613	0.9028
Rural Missouri	0.7468	0.8188
Rural Nevada	0.8851	0.9198
Rural New Mexico	0.8136	0.8683
Rural Oregon	0.9933	0.9954
Rural Washington	1.0512	1.0348
Rural Wyoming	0.8787	0.9153

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS

Urban area	Average hourly wage
Abilene, TX	16.5825
Aguadilla, PR	9.8222
Akron, OH	20.5687
Albany, GA	16.5708
Albany-Schenectady-Troy, NY	17.8900
Albuquerque, NM	17.8958
Alexandria, LA	17.7146
Allentown-Bethlehem-Easton, PA	21.2002
Altoona, PA	19.3951
Amarillo, TX	17.6070
Anchorage, AK	26.6324
Ann Arbor, MI	22.9238
Anniston, AL	17.9884
Appleton-Oshkosh-Neenah, WI	18.3354
Arecibo, PR	10.1129

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Asheville, NC	18.5755
Athens, GA	18.0203
Atlanta, GA	20.6008
Atlantic-Cape May, NJ	23.9678
Augusta-Aiken, GA–SC	19.1829
Austin-San Marcos, TX	17.5021
Bakersfield, CA	19.3407
Baltimore, MD	20.0332
Bangor, ME	19.6846
Barnstable-Yarmouth, MA	31.9593
Baton Rouge, LA	18.4325
Beaumont-Port Arthur, TX	18.8069
Bellingham, WA	23.7572
Benton Harbor, MI	17.7241
Bergen-Passaic, NJ	25.3184
Billings, MT	18.9960
Biloxi-Gulfport-Pascagoula, MS	17.1946
Binghamton, NY	18.8217
Birmingham, AL	18.8506
Bismarck, ND	16.6736
Bloomington, IN	18.6271
Bloomington-Normal, IL	18.3900
Boise City, ID	19.0323
Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH	23.4028
Boulder-Longmont, CO	20.8550
Brazoria, TX	18.5041
Bremerton, WA	22.9686
Brownsville-Harlingen-San Benito, TX	17.1138
Bryan-College Station, TX	16.2473
Buffalo-Niagara Falls, NY	19.9187
Burlington, VT	19.8983
Caguas, PR	9.1414
Canton-Massillon, OH	18.3002
Casper, WY	18.0774
Cedar Rapids, IA	18.3134
Champaign-Urbana, IL	18.1242
Charleston-North Charleston, SC	18.9373
Charleston, WV	18.6776
Charlotte-Gastonia-Rock Hill, NC–SC	19.8253
Charlottesville, VA	21.3425
Chattanooga, TN–GA	18.8525
Cheyenne, WY	16.9321
Chicago, IL	21.7048
Chico-Paradise, CA	21.0787
Cincinnati, OH–KY–IN	19.9348
Clarksville-Hopkinsville, TN–KY	16.7045
Cleveland-Lorain-Elyria, OH	20.5401
Colorado Springs, CO	19.5098
Columbia, MO	18.5780
Columbia, SC	19.3016
Columbus, GA–AL	17.6831
Columbus, OH	20.3213
Corpus Christi, TX	17.6885
Cumberland, MD–WV	17.1237
Dallas, TX	19.4566
Danville, VA	18.7936
Davenport-Moline-Rock Island, IA–IL	17.4790
Dayton-Springfield, OH	19.8696
Daytona Beach, FL	18.9775
Decatur, AL	17.1056
Decatur, IL	16.6936
Denver, CO	20.8379
Des Moines, IA	17.5526
Detroit, MI	21.9074
Dothan, AL	16.3982

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Dover, DE	19.4527
Dubuque, IA	17.0836
Duluth-Superior, MN–WI	20.6977
Dutchess County, NY	21.8781
Eau Claire, WI	17.8112
El Paso, TX	19.1468
Elkhart-Goshen, IN	19.3331
Elmira, NY	17.5367
Enid, OK	16.5214
Erie, PA	19.2614
Eugene-Springfield, OR	23.2566
Evansville, Henderson, IN–KY	17.7198
Fargo-Moorhead, ND–MN	19.7733
Fayetteville, NC	17.4302
Fayetteville-Springdale-Rogers, AR	17.8965
Flagstaff, AZ–UT	19.7032
Flint, MI	22.9184
Florence, AL	15.9479
Florence, SC	17.6631
Fort Collins-Loveland, CO	21.3936
Fort Lauderdale, FL	20.3766
Fort Myers-Cape Coral, FL	18.5257
Fort Pierce-Port St. Lucie, FL	21.2784
Fort Smith, AR–OK	15.8375
Fort Walton Beach, FL	17.8995
Fort Wayne, IN	18.7962
Fort Worth-Arlington, TX	20.1487
Fresno, CA	21.5811
Gadsden, AL	18.2411
Gainesville, FL	19.6396
Galveston-Texas City, TX	22.4914
Gary, IN	19.6025
Glens Falls, NY	17.6404
Goldsboro, NC	17.7222
Grand Forks, ND–MN	18.3589
Grand Junction, CO	17.0997
Grand Rapids-Muskegon-Holland, MI	20.7161
Great Falls, MT	18.4336
Greeley, CO	19.6480
Green Bay, WI	19.0230
Greensboro-Winston-Salem-High Point, NC	19.8355
Greenville, NC	19.6007
Greenville-Spartanburg-Anderson, SC	19.1612
Hagerstown, MD	21.1564
Hamilton-Middletown, OH	19.1833
Harrisburg-Lebanon-Carlisle, PA	20.9016
Hartford, CT	24.5817
Hattiesburg, MS	15.0868
Hickory-Morganton-Lenoir, NC	18.4995
Honolulu, HI	23.9148
Houma, LA	17.0314
Houston, TX	20.5336
Huntington-Ashland, WV–KY–OH	20.0441
Huntsville, AL	17.4211
Indianapolis, IN	20.4258
Iowa City, IA	19.6992
Jackson, MI	19.1645
Jackson, MS	17.2283
Jackson, TN	17.7852
Jacksonville, FL	18.4915
Jacksonville, NC	15.6996
Jamestown, NY	15.9148
Janesville-Beloit, WI	18.8060
Jersey City, NJ	24.0964

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Johnson City-Kingsport-Bristol, TN–VA	18.2276
Johnstown, PA	17.9084
Jonesboro, AR	15.3904
Joplin, MO	16.3572
Kalamazoo-Battlecreek, MI	23.5418
Kankakee, IL	19.5674
Kansas City, KS–MO	20.0395
Kenosha, WI	18.9676
Killeen-Temple, TX	21.0041
Knoxville, TN	18.5294
Kokomo, IN	19.2700
La Crosse, WI–MN	18.5196
Lafayette, LA	17.1506
Lafayette, IN	18.3693
Lake Charles, LA	15.9437
Lakeland-Winter Haven, FL	18.5726
Lancaster, PA	19.8644
Lansing-East Lansing, MI	20.9650
Laredo, TX	15.2556
Las Cruces, NM	18.4298
Las Vegas, NV–AZ	23.7139
Lawrence, KS	17.9827
Lawton, OK	18.0698
Lewiston-Auburn, ME	19.0090
Lexington, KY	17.6740
Lima, OH	18.5932
Lincoln, NE	19.3291
Little Rock-North Little Rock, AR	17.6667
Longview-Marshall, TX	18.0723
Los Angeles-Long Beach, CA	24.9564
Louisville, KY–IN	18.8926
Lubbock, TX	17.6523
Lynchburg, VA	18.4907
Macon, GA	17.8909
Madison, WI	20.8155
Mansfield, OH	17.7305
Mayaguez, PR	8.6819
McAllen-Edinburg-Mission, TX	17.6361
Medford-Ashland, OR	20.8190
Melbourne-Titusville-Palm Bay, FL	19.1487
Memphis, TN–AR–MS	17.3552
Merced, CA	20.8449
Miami, FL	20.8119
Middlesex-Somerset-Hunterdon, NJ	23.1702
Milwaukee-Waukesha, WI	18.9231
Minneapolis-St. Paul, MN–WI	22.5517
Missoula, MT	19.0914
Mobile, AL	17.4040
Modesto, CA	21.4951
Monmouth-Ocean, NJ	23.5125
Monroe, LA	17.0762
Montgomery, AL	16.2493
Muncie, IN	19.5589
Myrtle Beach, SC	16.9930
Naples, FL	21.1457
Nashville, TN	19.6966
Nassau-Suffolk, NY	28.1530
New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	25.6149
New London-Norwich, CT	24.1351
New Orleans, LA	19.3440
New York, NY	29.9194
Newark, NJ	24.6026
Newburgh, NY–PA	23.1779
Norfolk-Virginia Beach-Newport News, VA–NC	17.0290
Oakland, CA	31.1506

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Ocala, FL	19.0159
Odessa-Midland, TX	17.9849
Oklahoma City, OK	18.0923
Olympia, WA	23.9389
Omaha, NE–IA	20.7181
Orange County, CA	23.8979
Orlando, FL	20.3876
Owensboro, KY	16.1460
Panama City, FL	17.6753
Parkersburg-Marietta, WV–OH	16.6559
Pensacola, FL	16.9466
Peoria-Pekin, IL	16.7415
Philadelphia, PA–NJ	23.5963
Phoenix-Mesa, AZ	19.9270
Pine Bluff, AR	16.4382
Pittsburgh, PA	20.3368
Pittsfield, MA	22.4781
Pocatello, ID	18.2669
Ponce, PR	9.9487
Portland, ME	19.8655
Portland-Vancouver, OR–WA	23.2244
Providence-Warwick, RI	22.4405
Provo-Orem, UT	20.5384
Pueblo, CO	18.1010
Punta Gorda, FL	18.7634
Racine, WI	18.9687
Raleigh-Durham-Chapel Hill, NC	20.3867
Rapid City, SD	17.0546
Reading, PA	19.1866
Redding, CA	24.6374
Reno, NV	23.0512
Richland-Kennewick-Pasco, WA	21.3732
Richmond-Petersburg, VA	19.1375
Riverside-San Bernardino, CA	21.4175
Roanoke, VA	17.6802
Rochester, MN	24.3054
Rochester, NY	20.0636
Rockford, IL	17.8998
Rocky Mount, NC	18.7242
Sacramento, CA	24.5905
Saginaw-Bay City-Midland, MI	19.7109
St. Cloud, MN	19.9167
St. Joseph, MO	20.5465
St. Louis, MO–IL	19.0136
Salem, OR	20.5776
Salinas, CA	31.4614
Salt Lake City-Ogden, UT	19.4382
San Angelo, TX	15.8857
San Antonio, TX	16.8290
San Diego, CA	25.4828
San Francisco, CA	28.8570
San Jose, CA	28.7281
San Juan-Bayamon, PR	9.6051
San Luis Obispo-Atascadero-Paso Robles, CA	22.2647
Santa Barbara-Santa Maria-Lompoc, CA	23.2580
Santa Cruz-Watsonville, CA	29.0487
Santa Fe, NM	19.9519
Santa Rosa, CA	28.2508
Sarasota-Bradenton, FL	19.8054
Savannah, GA	20.9009
Scranton-Wilkes Barre-Hazleton, PA	17.2431
Seattle-Bellevue-Everett, WA	23.9486
Sharon, PA	18.3824
Sheboygan, WI	17.0899
Sherman-Denison, TX	17.8053
Shreveport-Bossier City, LA	19.4893

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Sioux City, IA–NE	17.6215
Sioux Falls, SD	18.5158
South Bend, IN	20.4831
Spokane, WA	22.7055
Springfield, IL	18.1176
Springfield, MO	16.7688
Springfield, MA	22.8337
State College, PA	19.6319
Steubenville-Weirton, OH–WV	17.5119
Stockton-Lodi, CA	23.0115
Sumter, SC	16.8850
Syracuse, NY	19.5305
Tacoma, WA	21.5661
Tallahassee, FL	17.5545
Tampa-St. Petersburg-Clearwater, FL	18.9348
Terre Haute, IN	18.6798
Texarkana, AR-Texarkana, TX	17.7097
Toledo, OH	20.7579
Topeka, KS	20.3862
Trenton, NJ	21.8355
Tucson, AZ	18.7576
Tulsa, OK	17.5841
Tuscaloosa, AL	15.8762
Tyler, TX	18.3215
Utica-Rome, NY	17.4892
Vallejo-Fairfield-Napa, CA	26.6436
Ventura, CA	22.7551
Victoria, TX	17.4131
Vineland-Millville-Bridgeton, NJ	21.6923
Visalia-Tulare-Porterville, CA	20.9493
Waco, TX	17.3923
Washington, DC–MD–VA–WV	22.4162
Waterloo-Cedar Falls, IA	16.5347
Wausau, WI	20.2214
West Palm Beach-Boca Raton, FL	21.2323
Wheeling, OH–WV	15.8460
Wichita, KS	18.4872

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Wichita Falls, TX	16.2686
Williamsport, PA	17.7778
Wilmington-Newark, DE–MD	24.6591
Wilmington, NC	19.4129
Yakima, WA	21.4371
Yolo, CA	22.0507
York, PA	19.5520
Youngstown-Warren, OH	20.3921
Yuba City, CA	22.5751
Yuma, AZ	20.8977

TABLE 4E.—AVERAGE HOURLY WAGE FOR RURAL AREAS

Nonurban area	Average hourly wage
Alabama	15.1457
Alaska	25.8250
Arizona	16.5996
Arkansas	15.0624
California	20.6476
Colorado	17.5278
Connecticut	25.0854
Delaware	18.2993
Florida	18.4445
Georgia	16.3888
Hawaii	22.6670
Idaho	17.6129
Illinois	16.4463
Indiana	17.4120
Iowa	16.1574
Kansas	15.1960
Kentucky	16.2977
Louisiana	15.4880

TABLE 4E.—AVERAGE HOURLY WAGE FOR RURAL AREAS—Continued

Nonurban area	Average hourly wage
Maine	17.5914
Maryland	17.7750
Massachusetts	22.5095
Michigan	18.4407
Minnesota	17.8572
Mississippi	15.1905
Missouri	15.4837
Montana	17.4489
Nebraska	15.9437
Nevada	19.2311
New Hampshire	21.2761
New Jersey [1]	.....
New Mexico	16.8682
New York	17.8401
North Carolina	16.8551
North Dakota	15.5776
Ohio	17.6991
Oklahoma	14.8012
Oregon	20.5901
Pennsylvania	18.0013
Puerto Rico	8.4766
Rhode Island [1]	.....
South Carolina	16.7176
South Dakota	15.5989
Tennessee	15.5660
Texas	15.4273
Utah	18.4060
Vermont	19.5637
Virginia	16.3017
Washington	21.7934
West Virginia	16.3620
Wisconsin	18.0975
Wyoming	18.2168

[1] All counties within the State are classified as urban.

TABLE 4F.—PUERTO RICO WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF)

Area	Wage index	GAF	Wage index—reclass. hospitals	GAF—Reclass. hospitals
Aguadilla, PR	1.0336	1.0229	.....	.....
Arecibo, PR	1.0642	1.0435	.....	.....
Caguas, PR	0.9642	0.9753	0.9642	0.9753
Mayaguez, PR	0.9136	0.9400	.....	.....
Ponce, PR	1.0470	1.0320	.....	.....
San Juan-Bayamon, PR	1.0108	1.0074	.....	.....
Rural Puerto Rico	0.8920	0.9247	.....	.....

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TABLE 5

LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY

				RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	ARITHMETIC MEAN LOS
1	01	SURG	CRANIOTOMY AGE >17 EXCEPT FOR TRAUMA	3.0694	6.8	9.6
2	01	SURG	CRANIOTOMY FOR TRAUMA AGE >17	3.1113	7.5	10.1
3	01	SURG	* CRANIOTOMY AGE 0-17	1.9493	12.7	12.7
4	01	SURG	SPINAL PROCEDURES	2.3278	5.1	7.7
5	01	SURG	EXTRACRANIAL VASCULAR PROCEDURES	1.4851	2.7	3.6
6	01	SURG	CARPAL TUNNEL RELEASE	.7712	2.1	3.0
7	01	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC	2.3938	6.8	10.1
8	01	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC	1.2901	2.2	3.2
9	01	MED	SPINAL DISORDERS & INJURIES	1.2873	4.8	6.7
10	01	MED	NERVOUS SYSTEM NEOPLASMS W CC	1.2107	5.0	6.9
11	01	MED	NERVOUS SYSTEM NEOPLASMS W/O CC	.8245	3.1	4.2
12	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS	.9030	4.8	6.7
13	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	.7810	4.4	5.5
14	01	MED	SPECIFIC CEREBROVASCULAR DISORDERS EXCEPT TIA	1.1955	4.9	6.4
15	01	MED	TRANSIENT ISCHEMIC ATTACK & PRECEREBRAL OCCLUSIONS	.7314	3.1	3.9
16	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	1.0693	4.5	5.9
17	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	.6178	2.7	3.4
18	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W CC	.9269	4.3	5.6
19	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	.6455	3.0	3.8
20	01	MED	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	2.6102	7.9	10.5
21	01	MED	VIRAL MENINGITIS	1.4753	5.1	6.8
22	01	MED	HYPERTENSIVE ENCEPHALOPATHY	.8985	3.6	4.7
23	01	MED	NONTRAUMATIC STUPOR & COMA	.7764	3.2	4.3
24	01	MED	SEIZURE & HEADACHE AGE >17 W CC	.9577	3.8	5.1
25	01	MED	SEIZURE & HEADACHE AGE >17 W/O CC	.5893	2.7	3.4
26	01	MED	SEIZURE & HEADACHE AGE 0-17	.7277	2.5	3.3
27	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR	1.3130	3.4	5.4
28	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC	1.1700	4.2	6.0
29	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC	.6377	2.6	3.5
30	01	MED	* TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0-17	.3297	2.0	2.0
31	01	MED	CONCUSSION AGE >17 W CC	.8105	3.2	4.4
32	01	MED	CONCUSSION AGE >17 W/O CC	.5158	2.2	3.0
33	01	MED	* CONCUSSION AGE 0-17	.2072	1.6	1.6
34	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W CC	1.0091	4.1	5.5
35	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	.5907	2.7	3.6

* MEDICARE DATA HAVE BEEN SUPPLEMENTED BY DATA FROM 19 STATES FOR LOW VOLUME DRGS.
** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.
NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR TRANSFER CASES.
NOTE: ARITHMETIC MEAN IS PRESENTED FOR INFORMATIONAL PURPOSES ONLY.
NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.

TABLE 5

LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY

					RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	ARITHMETIC MEAN LOS
36	02	SURG		RETINAL PROCEDURES	.6891	1.3	1.5
37	02	SURG		ORBITAL PROCEDURES	.9637	2.5	3.7
38	02	SURG		PRIMARY IRIS PROCEDURES	.4841	1.9	2.6
39	02	SURG		LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	.5697	1.5	2.0
40	02	SURG		EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	.7895	2.1	3.2
41	02	SURG	*	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17	.3356	1.6	1.6
42	02	SURG		INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	.6030	1.6	2.1
43	02	MED		HYPHEMA	.4371	2.7	3.4
44	02	MED		ACUTE MAJOR EYE INFECTIONS	.6090	4.2	5.1
45	02	MED		NEUROLOGICAL EYE DISORDERS	.6814	2.8	3.5
46	02	MED		OTHER DISORDERS OF THE EYE AGE >17 W CC	.7521	3.6	4.7
47	02	MED		OTHER DISORDERS OF THE EYE AGE >17 W/O CC	.4617	2.5	3.3
48	02	MED	*	OTHER DISORDERS OF THE EYE AGE 0-17	.2956	2.9	2.9
49	03	SURG		MAJOR HEAD & NECK PROCEDURES	1.7567	3.7	5.0
50	03	SURG		SIALOADENECTOMY	.8283	1.6	2.0
51	03	SURG		SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	.8601	1.8	2.8
52	03	SURG		CLEFT LIP & PALATE REPAIR	.8614	1.9	2.4
53	03	SURG		SINUS & MASTOID PROCEDURES AGE >17	1.1432	2.3	3.7
54	03	SURG	*	SINUS & MASTOID PROCEDURES AGE 0-17	.4792	3.2	3.2
55	03	SURG		MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES	.8952	2.0	3.0
56	03	SURG		RHINOPLASTY	.9008	2.1	2.8
57	03	SURG		T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	.8876	2.6	3.5
58	03	SURG	*	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	.2721	1.5	1.5
59	03	SURG		TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	.6700	1.8	2.4
60	03	SURG	*	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	.2073	1.5	1.5
61	03	SURG		MYRINGOTOMY W TUBE INSERTION AGE >17	1.1586	2.7	4.6
62	03	SURG	*	MYRINGOTOMY W TUBE INSERTION AGE 0-17	.2934	1.3	1.3
63	03	SURG		OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES	1.3283	3.0	4.4
64	03	MED		EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.2177	4.4	6.7
65	03	MED		DYSEQUILIBRIUM	.5162	2.4	3.0
66	03	MED		EPISTAXIS	.5402	2.6	3.3
67	03	MED		EPIGLOTTITIS	.8230	3.0	3.8
68	03	MED		OTITIS MEDIA & URI AGE >17 W CC	.6699	3.4	4.2
69	03	MED		OTITIS MEDIA & URI AGE >17 W/O CC	.5053	2.8	3.3
70	03	MED		OTITIS MEDIA & URI AGE 0-17	.3841	2.1	2.5

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TABLE 5

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				RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	ARITHMETIC MEAN LOS
71	03	MED	LARYNGOTRACHEITIS	.7630	3.2	3.9
72	03	MED	NASAL TRAUMA & DEFORMITY	.6524	2.8	3.8
73	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17	.7504	3.3	4.4
74	03	MED	* OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0-17	.3334	2.1	2.1
75	04	SURG	MAJOR CHEST PROCEDURES	3.1811	8.1	10.2
76	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.6876	8.4	11.3
77	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	1.1565	3.4	4.9
78	04	MED	PULMONARY EMBOLISM	1.4047	6.3	7.4
79	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	1.6309	6.7	8.4
80	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC	.9147	4.7	5.9
81	04	MED	* RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0-17	1.5098	6 1	6.1
82	04	MED	RESPIRATORY NEOPLASMS	1.3606	5.3	7.1
83	04	MED	MAJOR CHEST TRAUMA W CC	.9544	4.4	5.6
84	04	MED	MAJOR CHEST TRAUMA W/O CC	.5068	2.6	3.3
85	04	MED	PLEURAL EFFUSION W CC	1.2351	5.1	6.7
86	04	MED	PLEURAL EFFUSION W/O CC	.6835	3.0	3.9
87	04	MED	PULMONARY EDEMA & RESPIRATORY FAILURE	1.3650	4.8	6.4
88	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	.9530	4.4	5.4
89	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	1.0838	5.2	6.3
90	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	.6644	3.8	4.5
91	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE 0-17	.7209	3.3	4.0
92	04	MED	INTERSTITIAL LUNG DISEASE W CC	1.2042	5.1	6.4
93	04	MED	INTERSTITIAL LUNG DISEASE W/O CC	.7711	3.5	4.4
94	04	MED	PNEUMOTHORAX W CC	1.1879	4.9	6.5
95	04	MED	PNEUMOTHORAX W/O CC	.6042	3.1	3.9
96	04	MED	BRONCHITIS & ASTHMA AGE >17 W CC	.7891	4.0	4.9
97	04	MED	BRONCHITIS & ASTHMA AGE >17 W/O CC	.5919	3.2	3.8
98	04	MED	BRONCHITIS & ASTHMA AGE 0-17	.6953	3.6	4.9
99	04	MED	RESPIRATORY SIGNS & SYMPTOMS W CC	.6738	2.3	3.0
100	04	MED	RESPIRATORY SIGNS & SYMPTOMS W/O CC	.5150	1.7	2.1
101	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	.8292	3.3	4.4
102	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	.5395	2.2	2.8
103	05	SURG	HEART TRANSPLANT	17.7902	31.6	50.5
104	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH	7.2824	9.9	12.5
105	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH	5.7099	7.9	9.8

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				RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	ARITHMETIC MEAN LOS
106	05	SURG	CORONARY BYPASS WITH PTCA	7.3690	9.1	10.9
107	05	SURG	CORONARY BYPASS W CARDIAC CATH	5.5030	9.5	10.7
108	05	SURG	OTHER CARDIOTHORACIC PROCEDURES	5.9764	8.6	11.3
109	05	SURG	CORONARY BYPASS W/O CARDIAC CATH	4.0718	7.0	8.0
110	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES W CC	4.1500	7.4	9.7
111	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES W/O CC	2.2199	5.1	5.9
112	05	SURG	PERCUTANEOUS CARDIOVASCULAR PROCEDURES	1.9893	2.8	3.9
113	05	SURG	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE	2.7389	9.8	13.0
114	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	1.5077	6.0	8.4
115	05	SURG	PERM PACE IMPLNT W AMI,HRT FAIL OR SHOCK OR AICD LEAD OR GEN PROC	3.5558	6.3	8.8
116	05	SURG	OTH PERM CARDIAC PACEMAKER IMPLANT OR PTCA W CORONARY ART STENT	2.4833	3.0	4.2
117	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT	1.2372	2.7	4.0
118	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT	1.5716	2.0	2.9
119	05	SURG	VEIN LIGATION & STRIPPING	1.3076	3.2	5.4
120	05	SURG	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	1.9630	4.9	8.2
121	05	MED	CIRCULATORY DISORDERS W AMI & MAJOR COMP DISCH ALIVE	1.6334	5.7	7.0
122	05	MED	CIRCULATORY DISORDERS W AMI W/O MAJOR COMP DISCH ALIVE	1.1286	3.6	4.4
123	05	MED	CIRCULATORY DISORDERS W AMI, EXPIRED	1.4848	2.6	4.4
124	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG	1.3793	3.4	4.5
125	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG	1.0134	2.2	2.9
126	05	MED	ACUTE & SUBACUTE ENDOCARDITIS	2.5837	9.7	12.7
127	05	MED	HEART FAILURE & SHOCK	1.0131	4.3	5.5
128	05	MED	DEEP VEIN THROMBOPHLEBITIS	.7641	5.3	6.0
129	05	MED	CARDIAC ARREST, UNEXPLAINED	1.0898	1.8	3.0
130	05	MED	PERIPHERAL VASCULAR DISORDERS W CC	.9427	4.9	6.0
131	05	MED	PERIPHERAL VASCULAR DISORDERS W/O CC	.6067	3.9	4.7
132	05	MED	ATHEROSCLEROSIS W CC	.6698	2.5	3.2
133	05	MED	ATHEROSCLEROSIS W/O CC	.5556	2.0	2.5
134	05	MED	HYPERTENSION	.5823	2.7	3.5
135	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC	.8543	3.3	4.4
136	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC	.5735	2.4	3.0
137	05	MED	* CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0-17	.8135	3.3	3.3
138	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	.7999	3.1	4.1
139	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	.4977	2.1	2.6
140	05	MED	ANGINA PECTORIS	.5957	2.4	3.0

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141	05	MED	SYNCOPE & COLLAPSE W CC	.7022	3.0	3.9
142	05	MED	SYNCOPE & COLLAPSE W/O CC	.5312	2.2	2.8
143	05	MED	CHEST PAIN	.5263	1.8	2.3
144	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	1.1122	3.8	5.3
145	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	.6316	2.2	2.9
146	06	SURG	RECTAL RESECTION W CC	2.7175	9.0	10.3
147	06	SURG	RECTAL RESECTION W/O CC	1.5890	6.1	6.7
148	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	3.4231	10.3	12.3
149	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.5692	6.3	6.9
150	06	SURG	PERITONEAL ADHESIOLYSIS W CC	2.7419	8.9	10.9
151	06	SURG	PERITONEAL ADHESIOLYSIS W/O CC	1.2808	4.8	5.9
152	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.9406	7.0	8.3
153	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.1925	5.1	5.6
154	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC	4.1847	10.3	13.4
155	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC	1.3541	3.6	4.7
156	06	SURG *	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0-17	.8378	6.0	6.0
157	06	SURG	ANAL & STOMAL PROCEDURES W CC	1.2082	3.9	5.4
158	06	SURG	ANAL & STOMAL PROCEDURES W/O CC	.6416	2.1	2.6
159	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC	1.2878	3.7	5.0
160	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC	.7411	2.2	2.7
161	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	1.0710	2.9	4.1
162	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	.6108	1.7	2.0
163	06	SURG *	HERNIA PROCEDURES AGE 0-17	.8664	2.1	2.1
164	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	2.3212	7.3	8.5
165	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	1.2269	4.3	5.0
166	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	1.4446	4.0	5.1
167	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	.8522	2.4	2.8
168	03	SURG	MOUTH PROCEDURES W CC	1.1642	3.1	4.6
169	03	SURG	MOUTH PROCEDURES W/O CC	.7219	1.9	2.6
170	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	2.8030	7.9	11.3
171	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC	1.1658	3.6	4.8
172	06	MED	DIGESTIVE MALIGNANCY W CC	1.3143	5.2	7.1
173	06	MED	DIGESTIVE MALIGNANCY W/O CC	.7320	2.8	4.0
174	06	MED	G.I. HEMORRHAGE W CC	.9933	4.0	4.9
175	06	MED	G.I. HEMORRHAGE W/O CC	.5298	2.5	3.0

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176	06	MED	COMPLICATED PEPTIC ULCER	1.1053	4.3	5.5
177	06	MED	UNCOMPLICATED PEPTIC ULCER W CC	.8614	3.7	4.6
178	06	MED	UNCOMPLICATED PEPTIC ULCER W/O CC	.6317	2.7	3.2
179	06	MED	INFLAMMATORY BOWEL DISEASE	1.1054	5.0	6.4
180	06	MED	G.I. OBSTRUCTION W CC	.9174	4.2	5.4
181	06	MED	G.I. OBSTRUCTION W/O CC	.5259	2.9	3.5
182	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC	.7690	3.4	4.4
183	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC	.5577	2.4	3.0
184	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0-17	.5457	[illegible].5	3.3
185	03	MED	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17	.8292	3.3	4.5
186	03	MED	* DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0-17	.3193	2.9	2.9
187	03	MED	DENTAL EXTRACTIONS & RESTORATIONS	.7385	3.0	4.0
188	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	1.0758	4.1	5.6
189	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	.5593	2.4	3.2
190	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17	.7519	3.9	5.4
191	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W CC	4.4345	10.8	14.6
192	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	1.7253	5.4	6.7
193	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC	3.3276	10.3	12.5
194	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC	1.6646	5.8	6.9
195	07	SURG	CHOLECYSTECTOMY W C.D.E. W CC	2.7888	8.3	9.8
196	07	SURG	CHOLECYSTECTOMY W C.D.E. W/O CC	1.6357	4.9	5.7
197	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	2.3845	7.1	8.6
198	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC	1.1996	4.0	4.6
199	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	2.3865	7.7	10.2
200	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY	3.2800	7.4	11.6
201	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES	3.6053	10.4	14.4
202	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS	1.3158	5.1	6.8
203	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	1.3000	5.1	6.9
204	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	1.2122	4.7	6.1
205	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC	1.2127	4.9	6.6
206	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC	.6947	3.1	4.1
207	07	MED	DISORDERS OF THE BILIARY TRACT W CC	1.0695	4.0	5.2
208	07	MED	DISORDERS OF THE BILIARY TRACT W/O CC	.6169	2.3	2.9
209	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF LOWER EXTREMITY	2.1803	4.9	5.5
210	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC	1.8128	6.1	7.1

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211	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC	1.2505	4.7	5.2
212	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	.8413	3.2	3.8
213	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS	1.6383	6.2	8.4
214	08	SURG	NO LONGER VALID	.0000	.0	.0
215	08	SURG	NO LONGER VALID	.0000	.0	.0
216	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	2.1275	7.0	9.9
217	08	SURG	WND DEBRID & SKN GRFT EXCEPT HAND,FOR MUSCSKELET & CONN TISS DIS	2.7944	8.7	13.0
218	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W CC	1.4641	4.2	5.3
219	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W/O CC	.9924	2.8	3.3
220	08	SURG *	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE 0-17	.5803	5.3	5.3
221	08	SURG	NO LONGER VALID	.0000	.0	.0
222	08	SURG	NO LONGER VALID	.0000	.0	.0
223	08	SURG	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC	.9255	2.0	2.6
224	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC, W/O CC	.7871	1.7	2.1
225	08	SURG	FOOT PROCEDURES	1.0122	3.0	4.4
226	08	SURG	SOFT TISSUE PROCEDURES W CC	1.4081	4.0	5.9
227	08	SURG	SOFT TISSUE PROCEDURES W/O CC	.7922	2.1	2.7
228	08	SURG	MAJOR THUMB OR JOINT PROC,OR OTH HAND OR WRIST PROC W CC	1.0038	2.3	3.4
229	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	.7058	1.8	2.4
230	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR	1.1072	3.1	4.5
231	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES EXCEPT HIP & FEMUR	1.2923	3.0	4.6
232	08	SURG	ARTHROSCOPY	1.0892	2.3	3.8
233	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	2.0628	5.3	7.6
234	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC	1.1731	2.8	3.6
235	08	MED	FRACTURES OF FEMUR	.7524	3.9	5.4
236	08	MED	FRACTURES OF HIP & PELVIS	.7243	4.1	5.3
237	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	.5384	2.9	3.7
238	08	MED	OSTEOMYELITIS	1.3409	6.7	8.9
239	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY	.9653	5.0	6.4
240	08	MED	CONNECTIVE TISSUE DISORDERS W CC	1.2252	5.0	6.7
241	08	MED	CONNECTIVE TISSUE DISORDERS W/O CC	.5903	3.1	4.0
242	08	MED	SEPTIC ARTHRITIS	1.0371	5.2	6.8
243	08	MED	MEDICAL BACK PROBLEMS	.7142	3.8	4.9
244	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	.7048	3.9	5.0
245	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	.4939	2.9	3.7

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TABLE 5

LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY

				RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	ARITHMETIC MEAN LOS
246	08	MED	NON-SPECIFIC ARTHROPATHIES	.5647	3.1	3.9
247	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE	.5534	2.6	3.5
248	08	MED	TENDONITIS, MYOSITIS & BURSITIS	.7445	3.6	4.7
249	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	.6520	2.6	3.6
250	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC	.6752	3.2	4.2
251	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC	.4621	2.3	3.0
252	08	MED	* FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0-17	.2521	1.8	1.8
253	08	MED	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W CC	.7181	3.7	4.9
254	08	MED	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W/O CC	.4309	2.7	3.4
255	08	MED	* FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE 0-17	.2935	2.9	2.9
256	08	MED	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	.7583	3.8	5.1
257	09	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W CC	.9198	2.4	3.0
258	09	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	.7228	1.9	2.1
259	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	.8837	2.0	3.1
260	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	.6241	1.4	1.5
261	09	SURG	BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION	.9131	1.7	2.2
262	09	SURG	BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY	.8729	2.9	4.2
263	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	2.0064	8.8	11.9
264	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC	1.1090	5.4	7.2
265	09	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC	1.4796	4.2	6.5
266	09	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC	.8262	2.5	3.4
267	09	SURG	PERIANAL & PILONIDAL PROCEDURES	.9293	2.9	4.6
268	09	SURG	SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES	1.0669	2.3	3.6
269	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.5798	5.6	7.9
270	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC	.7206	2.2	3.1
271	09	MED	SKIN ULCERS	1.0007	5.7	7.2
272	09	MED	MAJOR SKIN DISORDERS W CC	1.0421	4.9	6.4
273	09	MED	MAJOR SKIN DISORDERS W/O CC	.6260	3.6	4.8
274	09	MED	MALIGNANT BREAST DISORDERS W CC	1.1119	4.8	6.8
275	09	MED	MALIGNANT BREAST DISORDERS W/O CC	.5305	2.6	3.6
276	09	MED	NON-MALIGANT BREAST DISORDERS	.6407	3.6	4.5
277	09	MED	CELLULITIS AGE >17 W CC	.8342	4.8	5.9
278	09	MED	CELLULITIS AGE >17 W/O CC	.5548	3.8	4.5
279	09	MED	CELLULITIS AGE 0-17	.6657	4.3	5.0
280	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC	.6628	3.3	4.3

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				RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	ARITHMETIC MEAN LOS
281	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC	.4535	2.4	3.1
282	09	MED	* TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0-17	.2552	2.2	2.2
283	09	MED	MINOR SKIN DISORDERS W CC	.6938	3.6	4.8
284	09	MED	MINOR SKIN DISORDERS W/O CC	.4399	2.6	3.3
285	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DISORDERS	2.0425	8.1	11.0
286	10	SURG	ADRENAL & PITUITARY PROCEDURES	2.2199	5.5	7.0
287	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS	1.8591	8.0	11.2
288	10	SURG	O.R. PROCEDURES FOR OBESITY	2.0227	4.7	5.9
289	10	SURG	PARATHYROID PROCEDURES	1.0117	2.2	3.2
290	10	SURG	THYROID PROCEDURES	.9166	1.9	2.5
291	10	SURG	THYROGLOSSAL PROCEDURES	.5772	1.5	1.8
292	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	2.5980	7.5	10.8
293	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	1.2794	3.8	5.5
294	10	MED	DIABETES AGE >35	.7478	3.8	4.9
295	10	MED	DIABETES AGE 0-35	.7242	3.0	4.0
296	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	.8497	4.1	5.4
297	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC	.5202	2.9	3.7
298	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0-17	.5262	2.4	3.7
299	10	MED	INBORN ERRORS OF METABOLISM	.8800	3.9	5.4
300	10	MED	ENDOCRINE DISORDERS W CC	1.0801	4.8	6.3
301	10	MED	ENDOCRINE DISORDERS W/O CC	.6020	2.9	3.8
302	11	SURG	KIDNEY TRANSPLANT	3.6406	8.6	10.1
303	11	SURG	KIDNEY,URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM	2.6597	7.5	9.2
304	11	SURG	KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC	2.3361	6.5	9.0
305	11	SURG	KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC	1.1341	3.2	3.9
306	11	SURG	PROSTATECTOMY W CC	1.2401	3.8	5.5
307	11	SURG	PROSTATECTOMY W/O CC	.6410	2.0	2.4
308	11	SURG	MINOR BLADDER PROCEDURES W CC	1.5166	4.1	6.0
309	11	SURG	MINOR BLADDER PROCEDURES W/O CC	.9076	2.1	2.6
310	11	SURG	TRANSURETHRAL PROCEDURES W CC	1.0629	3.0	4.3
311	11	SURG	TRANSURETHRAL PROCEDURES W/O CC	.6073	1.6	2.0
312	11	SURG	URETHRAL PROCEDURES, AGE >17 W CC	.9877	2.9	4.3
313	11	SURG	URETHRAL PROCEDURES, AGE >17 W/O CC	.6286	1.8	2.4
314	11	SURG	* URETHRAL PROCEDURES, AGE 0-17	.4918	2.3	2.3
315	11	SURG	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	2.0703	4.6	8.0

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TABLE 5

LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY

				RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	ARITHMETIC MEAN LOS
316	11	MED	RENAL FAILURE	1.3315	5.0	6.9
317	11	MED	ADMIT FOR RENAL DIALYSIS	.6140	2.0	2.9
318	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W CC	1.0921	4.4	6.1
319	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W/O CC	.6150	2.2	3.0
320	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	.8665	4.5	5.6
321	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	.5808	3.4	4.0
322	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE 0-17	.5406	3.3	4.1
323	11	MED	URINARY STONES W CC, &/OR ESW LITHOTRIPSY	.7658	2.4	3.2
324	11	MED	URINARY STONES W/O CC	.4346	1.6	1.9
325	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC	.6236	3.0	4.0
326	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC	.4200	2.1	2.8
327	11	MED	* KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0-17	.3518	3.1	3.1
328	11	MED	URETHRAL STRICTURE AGE >17 W CC	.7176	2.8	3.7
329	11	MED	URETHRAL STRICTURE AGE >17 W/O CC	.4918	1.7	2.3
330	11	MED	* URETHRAL STRICTURE AGE 0-17	.3168	1.6	1.6
331	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC	.9952	4.2	5.6
332	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC	.6235	2.7	3.6
333	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0-17	.7757	3.5	4.9
334	12	SURG	MAJOR MALE PELVIC PROCEDURES W CC	1.5975	4.4	5.0
335	12	SURG	MAJOR MALE PELVIC PROCEDURES W/O CC	1.2056	3.4	3.7
336	12	SURG	TRANSURETHRAL PROSTATECTOMY W CC	.8856	2.8	3.6
337	12	SURG	TRANSURETHRAL PROSTATECTOMY W/O CC	.6176	2.0	2.3
338	12	SURG	TESTES PROCEDURES, FOR MALIGNANCY	1.0867	3.2	4.8
339	12	SURG	TESTES PROCEDURES, NON-MALIGNANCY AGE >17	.9822	2.9	4.2
340	12	SURG	* TESTES PROCEDURES, NON-MALIGNANCY AGE 0-17	.2816	2.4	2.4
341	12	SURG	PENIS PROCEDURES	1.1194	2.1	3.0
342	12	SURG	CIRCUMCISION AGE >17	.8555	2.6	3.4
343	12	SURG	* CIRCUMCISION AGE 0-17	.1530	1.7	1.7
344	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY	1.0414	1.8	2.6
345	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY	.8646	2.5	3.6
346	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC	.9494	4.3	5.8
347	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC	.5620	2.3	3.1
348	12	MED	BENIGN PROSTATIC HYPERTROPHY W CC	.6892	3.2	4.3
349	12	MED	BENIGN PROSTATIC HYPERTROPHY W/O CC	.4090	2.1	2.8
350	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	.6918	3.6	4.4

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351	12	MED	*	STERILIZATION, MALE	.2348	1.3	1.3
352	12	MED		OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	.6251	2.7	3.6
353	13	SURG		PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY	1.9235	5.6	6.9
354	13	SURG		UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	1.4953	4.8	5.8
355	13	SURG		UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC	.9322	3.2	3.5
356	13	SURG		FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	.7863	2.3	2.6
357	13	SURG		UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY	2.4429	7.3	9.0
358	13	SURG		UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	1.2111	3.7	4.4
359	13	SURG		UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	.8663	2.8	3.0
360	13	SURG		VAGINA, CERVIX & VULVA PROCEDURES	.8902	2.6	3.2
361	13	SURG		LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	1.2051	2.3	3.3
362	13	SURG	*	ENDOSCOPIC TUBAL INTERRUPTION	.3001	1.4	1.4
363	13	SURG		D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	.7498	2.5	3.3
364	13	SURG		D&C, CONIZATION EXCEPT FOR MALIGNANCY	.7280	2.6	3.6
365	13	SURG		OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	1.7421	4.6	6.9
366	13	MED		MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	1.1912	4.8	6.9
367	13	MED		MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	.5640	2.2	2.9
368	13	MED		INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	1.0544	5.0	6.4
369	13	MED		MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	.5257	2.3	3.1
370	14	SURG		CESAREAN SECTION W CC	1.0501	4.3	5.5
371	14	SURG		CESAREAN SECTION W/O CC	.7161	3.2	3.5
372	14	MED		VAGINAL DELIVERY W COMPLICATING DIAGNOSES	.5716	2.4	3.1
373	14	MED		VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	.4000	1.8	2.1
374	14	SURG		VAGINAL DELIVERY W STERILIZATION &/OR D&C	.7120	2.2	3.1
375	14	SURG	*	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	.6812	4.4	4.4
376	14	MED		POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	.4877	2.3	2.9
377	14	SURG		POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	1.4263	3.4	4.5
378	14	MED		ECTOPIC PREGNANCY	.8441	2.2	2.6
379	14	MED		THREATENED ABORTION	.4390	2.2	3.6
380	14	MED		ABORTION W/O D&C	.4168	1.7	2.2
381	14	SURG		ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	.5540	1.6	2.1
382	14	MED		FALSE LABOR	.1965	1.1	1.3
383	14	MED		OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	.4718	2.7	3.7
384	14	MED		OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	.3578	1.8	2.7
385	15		*	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	1.3671	1.8	1.8

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386	15		* EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	4.5084	17.9	17.9
387	15		* PREMATURITY W MAJOR PROBLEMS	3.0791	13.3	13.3
388	15		* PREMATURITY W/O MAJOR PROBLEMS	1.8578	8.6	8.6
389	15		FULL TERM NEONATE W MAJOR PROBLEMS	1.8279	7.6	10.2
390	15		NEONATE W OTHER SIGNIFICANT PROBLEMS	1.5908	4.2	6.0
391	15		* NORMAL NEWBORN	.1516	3.1	3.1
392	16	SURG	SPLENECTOMY AGE >17	3.2927	7.9	10.4
393	16	SURG	* SPLENECTOMY AGE 0-17	1.3392	9.1	9.1
394	16	SURG	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS	1.6195	4.1	7.0
395	16	MED	RED BLOOD CELL DISORDERS AGE >17	.8196	3.4	4.7
396	16	MED	RED BLOOD CELL DISORDERS AGE 0-17	2.1978	5.2	18.0
397	16	MED	COAGULATION DISORDERS	1.2536	4.0	5.5
398	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	1.2463	4.8	6.0
399	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC	.6908	3.0	3.7
400	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE	2.6546	6.1	9.4
401	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	2.5749	7.7	11.0
402	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC	1.0114	2.7	3.9
403	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	1.6843	5.8	8.2
404	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	.8302	3.2	4.5
405	17		* ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0-17	1.8987	4.9	4.9
406	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC	2.5688	6.9	9.5
407	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC	1.1788	3.5	4.3
408	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC	1.8204	4.6	7.5
409	17	MED	RADIOTHERAPY	1.0117	4.3	5.8
410	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	.8402	2.7	3.4
411	17	MED	HISTORY OF MALIGNANCY W/O ENDOSCOPY	.3897	2.2	3.5
412	17	MED	HISTORY OF MALIGNANCY W ENDOSCOPY	.5042	1.9	2.3
413	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	1.3473	5.4	7.5
414	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC	.7146	3.1	4.2
415	18	SURG	O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	3.5747	10.5	14.4
416	18	MED	SEPTICEMIA AGE >17	1.4883	5.7	7.4
417	18	MED	SEPTICEMIA AGE 0-17	1.3276	4.5	5.9
418	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	.9894	4.9	6.2
419	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W CC	.8764	4.0	5.0
420	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	.6331	3.2	4.0

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421	18	MED		VIRAL ILLNESS AGE >17	.6748	3.1	4.0
422	18	MED		VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0-17	.5668	2.6	3.3
423	18	MED		OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	1.6028	5.8	7.8
424	19	SURG		O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	2.3483	9.0	14.3
425	19	MED		ACUTE ADJUST REACT & DISTURBANCES OF PSYCHOSOCIAL DYSFUNCTION	.6782	3.0	4.1
426	19	MED		DEPRESSIVE NEUROSES	.5525	3.5	4.9
427	19	MED		NEUROSES EXCEPT DEPRESSIVE	.5588	3.4	4.8
428	19	MED		DISORDERS OF PERSONALITY & IMPULSE CONTROL	.7114	4.5	7.3
429	19	MED		ORGANIC DISTURBANCES & MENTAL RETARDATION	.8710	5.2	7.4
430	19	MED		PSYCHOSES	.8079	6.2	8.8
431	19	MED		CHILDHOOD MENTAL DISORDERS	.7468	4.6	7.3
432	19	MED		OTHER MENTAL DISORDER DIAGNOSES	.7085	3.4	5.3
433	20			ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	.3025	2.3	3.2
434	20			ALC/DRUG ABUSE OR DEPEND, DETOX OR OTH SYMPT TREAT W CC	.7007	3.9	5.2
435	20			ALC/DRUG ABUSE OR DEPEND, DETOX OR OTH SYMPT TREAT W/O CC	.4151	3.5	4.4
436	20			ALC/DRUG DEPENDENCE W REHABILITATION THERAPY	.8145	11.4	14.1
437	20			ALC/DRUG DEPENDENCE, COMBINED REHAB & DETOX THERAPY	.7023	7.7	9.2
438				NO LONGER VALID	.0000	.0	.0
439	21	SURG		SKIN GRAFTS FOR INJURIES	1.5800	5.0	7.7
440	21	SURG		WOUND DEBRIDEMENTS FOR INJURIES	1.7993	5.7	9.0
441	21	SURG		HAND PROCEDURES FOR INJURIES	1.0106	2.3	3.5
442	21	SURG		OTHER O.R. PROCEDURES FOR INJURIES W CC	2.2652	5.2	8.1
443	21	SURG		OTHER O.R. PROCEDURES FOR INJURIES W/O CC	.9292	2.5	3.3
444	21	MED		TRAUMATIC INJURY AGE >17 W CC	.7115	3.5	4.5
445	21	MED		TRAUMATIC INJURY AGE >17 W/O CC	.4812	2.6	3.4
446	21	MED	*	TRAUMATIC INJURY AGE 0-17	.2943	2.4	2.4
447	21	MED		ALLERGIC REACTIONS AGE >17	.4938	1.9	2.5
448	21	MED	*	ALLERGIC REACTIONS AGE 0-17	.0968	2.9	2.9
449	21	MED		POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC	.7850	2.7	3.8
450	21	MED		POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC	.4321	1.6	2.1
451	21	MED	*	POISONING & TOXIC EFFECTS OF DRUGS AGE 0-17	.2614	2.1	2.1
452	21	MED		COMPLICATIONS OF TREATMENT W CC	.9799	3.6	5.1
453	21	MED		COMPLICATIONS OF TREATMENT W/O CC	.4859	2.2	2.9
454	21	MED		OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC	.8448	3.2	4.7
455	21	MED		OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC	.4675	1.9	2.7

* MEDICARE DATA HAVE BEEN SUPPLEMENTED BY DATA FROM 19 STATES FOR LOW VOLUME DRGS.
** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.
NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR TRANSFER CASES.
NOTE: ARITHMETIC MEAN IS PRESENTED FOR INFORMATIONAL PURPOSES ONLY.
NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.

TABLE 5

LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY

				RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	ARITHMETIC MEAN LOS
456			NO LONGER VALID	.0000	.0	.0
457			NO LONGER VALID	.0000	.0	.0
458			NO LONGER VALID	.0000	.0	.0
459			NO LONGER VALID	.0000	.0	.0
460			NO LONGER VALID	.0000	.0	.0
461	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES	1.0684	2.4	4.4
462	23	MED	REHABILITATION	1.4071	10.1	12.7
463	23	MED	SIGNS & SYMPTOMS W CC	.6738	3.3	4.4
464	23	MED	SIGNS & SYMPTOMS W/O CC	.4996	2.6	3.4
465	23	MED	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	.5247	1.9	2.9
466	23	MED	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	.6121	2.3	4.0
467	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	.4941	2.3	4.4
468			EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	3.6582	9.5	13.5
469		**	PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	.0000	.0	.0
470		**	UNGROUPABLE	.0000	.0	.0
471	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY	3.3246	5.3	6.1
472			NO LONGER VALID	.0000	.0	.0
473	17		ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	3.4741	7.6	13.0
474			NO LONGER VALID	.0000	.0	.0
475	04	MED	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	3.7429	8.1	11.3
476		SURG	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	2.2182	8.9	11.9
477		SURG	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	1.7545	5.3	8.2
478	05	SURG	OTHER VASCULAR PROCEDURES W CC	2.3355	5.1	7.5
479	05	SURG	OTHER VASCULAR PROCEDURES W/O CC	1.4230	3.0	3.8
480		SURG	LIVER TRANSPLANT	10.6455	19.3	26.8
481		SURG	BONE MARROW TRANSPLANT	10.2138	24.9	27.9
482		SURG	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES	3.6031	10.0	12.8
483		SURG	TRACHEOSTOMY EXCEPT FOR FACE,MOUTH & NECK DIAGNOSES	16.3395	34.0	42.3
484	24	SURG	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	5.3380	9.5	14.8
485	24	SURG	LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TR	3.0788	7.7	9.7
486	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA	4.9966	8.4	12.5
487	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA	1.9183	5.5	7.5
488	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE	4.5766	11.9	17.2
489	25	MED	HIV W MAJOR RELATED CONDITION	1.7690	6.2	8.9
490	25	MED	HIV W OR W/O OTHER RELATED CONDITION	.9705	3.9	5.4

* MEDICARE DATA HAVE BEEN SUPPLEMENTED BY DATA FROM 19 STATES FOR LOW VOLUME DRGS.
** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.
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NOTE: ARITHMETIC MEAN IS PRESENTED FOR INFORMATIONAL PURPOSES ONLY.
NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.

TABLE 5

LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY

				RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	ARITHMETIC MEAN LOS
491	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY	1.6655	3.1	3.7
492	17	MED	CHEMOTHERAPY W ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	4.5427	11.4	17.2
493	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.7914	4.2	5.6
494	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	.9973	1.9	2.4
495		SURG	LUNG TRANSPLANT	8.9500	13.5	16.8
496	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION	5.4275	8.6	10.6
497	08	SURG	SPINAL FUSION W CC	2.7594	5.0	6.3
498	08	SURG	SPINAL FUSION W/O CC	1.6863	2.9	3.5
499	08	SURG	BACK & NECK PROCS EXCEPT SPINAL FUSION W CC	1.4677	3.8	5.0
500	08	SURG	BACK & NECK PROCS EXCEPT SPINAL FUSION W/O CC	.9714	2.4	2.9
501	08	SURG	KNEE PROC W PDX OF INFECTION W CC	2.5544	8.4	10.5
502	08	SURG	KNEE PROC W PDX OF INFECTION W/O CC	1.5539	5.4	6.6
503	08	SURG	KNEE PROCEDURES W/O PDX OF INFECTION	1.2297	3.2	4.2
504	22	SURG	EXTENSIVE 3RD DEGREE BURN W SKIN GRAFT	14.1153	23.7	31.8
505	22		EXTENSIVE 3RD DEGREE BURN W/O SKIN GRAFT	1.7875	2.3	5.8
506	22		FULL THICK BURN W SK GRAFT OR INHAL INJ W CC OR SIG TR	4.2478	12.2	16.8
507	22		FULL THICK BURN W SK GRAFT OR INHAL INJ W/O CC OR SIG TR	1.7078	6.6	9.0
508	22		FULL THICK BURN W/O SK GRAFT OR INHAL INJ W CC OR SIG TR	1.4178	5.3	7.9
509	22		FULL THICK BURN W/O SK GRAFT OR INHAL INJ W/O CC OR SIG TR	.7824	3.4	5.0
510	22		NON-EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA	1.1630	4.9	7.0
511	22		NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA	.6042	3.5	4.9

* MEDICARE DATA HAVE BEEN SUPPLEMENTED BY DATA FROM 19 STATES FOR LOW VOLUME DRGS.
** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.
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NOTE: ARITHMETIC MEAN IS PRESENTED FOR INFORMATIONAL PURPOSES ONLY.
NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.

BILLING CODE 4120–01–C

TABLE 6A.—NEW DIAGNOSIS CODES

Diagnosis code	Description	CC	MDC	DRG
337.3	Autonomic dysreflexia	N	1	18, 19
438.53	Other paralytic syndrome, bilateral	N	1	12
482.40	Pneumonia due to Staphyloccus, unspecified	Y	4	79, 80, 81
			5	121 [1]
			15	387, 389 [2]
			25	489 [3]
482.41	Pneumonia due to Staphylococcus aureus	Y	4	79, 80, 81
			5	121 [1]
			15	387, 389 [2]
			25	489 [3]
482.49	Other Staphylococcus pneumonia	Y	4	79, 80, 81
			5	121 [1]
			15	387, 389 [2]
			25	489 [3]
518.83	Chronic respiratory failure	Y	4	87
			5	121 [1]
518.84	Acute and chronic respiratory failure	Y	4	87
			5	121 [1]
			22	506, 507
519.00	Unspecified tracheostomy complication	Y	Pre	482
			4	101, 102
519.01	Infection of tracheostomy	Y	Pre	482
			4	101, 102
519.02	Mechanical complication of tracheostomy	Y	Pre	482
			4	101, 102
519.09	Other tracheostomy complication	Y	Pre	482
			4	101, 102
536.40	Unspecified gastrostomy complication	Y	6	188, 189, 190
536.41	Infection of gastrostomy	Y	6	188, 189, 190
536.42	Mechanical complication of gastrostomy	Y	6	188, 189, 190
536.49	Other gastrostomy complication	Y	6	188, 189, 190
564.81	Neurogenic bowel	N	6	182, 183, 184
564.89	Other functional disorders of intestine	N	6	182, 183, 184
569.62	Mechanical complication of colostomy and enterostomy	Y	6	188, 189, 190
659.70	Abnormality in fetal heart rate/rhythm, unspecified as to episode of care or not applicable.	N	14	370, 371, 372, 373, 374, 375
659.71	Abnormality in fetal heart rate/rhythm, delivered, with or without mention of antepartum condition.	N	14	370, 371, 372, 373, 374, 375
659.73	Abnormality in fetal heart rate/rhythm, antepartum condition or complication	N	14	383, 384
763.81	Abnormality in fetal heart rate or rhythm before the onset of labor	N	15	390
763.82	Abnormality in fetal heart rate or rhythm during labor	N	15	390
763.83	Abnormality in fetal heart rate or rhythm, unspecified as to time of onset	N	15	390
763.89	Other specified complications of labor and delivery affecting fetus and newborn.	N	15	390
780.71	Chronic fatigue syndrome	N	23	463, 464
			25	490
780.79	Other malaise and fatigue	N	23	463, 464
			25	490
786.03	Apnea	Y	4	99, 100
			25	490
786.04	Cheyne-Stokes respiration	Y	4	99, 100
			25	490
786.05	Shortness of breath	N	4	99, 100
			25	490
786.06	Tachypnea	N	4	99, 100
			25	490
786.07	Wheezing	N	4	99, 100
			25	490
965.61	Poisoning by propionic acid derivatives	N	21	449, 450, 451
965.69	Poisoning by other antirheumatics	N	21	449, 450, 451
995.86	Malignant hyperthermia	Y	21	454,455
996.55	Mechanical complications due to artificial skin graft and decellularized allodermis.	Y	21	452, 453
996.56	Mechanical complications due to peritoneal dialysis catheter	Y	21	452, 453
996.68	Infection and inflammatory reaction due to peritoneal dialysis catheter	Y	21	452, 453
V02.51	Carrier or suspected carrier of Group B streptococcus	N	23	467
V02.52	Carrier or suspected carrier of other streptococcus	N	23	467
V02.59	Carrier or suspected carrier of other specified bacterial diseases	N	23	467
V10.48	Personal history of malignant neoplasm of epididymis	N	17	411, 412
V13.61	Personal history of hypospadias	N	23	467
V13.69	Personal history other congenital malformation	N	23	467

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
V16.51	Family history of malignant neoplasm of kidney	N	23	467
V16.59	Family history of malignant neoplasm of other urinary organs	N	23	467
V18.61	Family history of polycystic kidney	N	23	467
V18.69	Family history of other kidney diseases	N	23	467
V23.81	Supervision of high-risk pregnancy of elderly primigravida	Y	14	469
V23.82	Supervision of high-risk pregnancy of elderly multigravida	Y	14	469
V23.83	Supervision of high-risk pregnancy of young primigravida	Y	14	469
V23.84	Supervision of high-risk pregnancy of young multigravida	Y	14	469
V23.89	Supervision of other high-risk pregnancy	Y	14	469
V26.51	Tubal ligation status	N	23	467
V26.52	Vasectomy status	N	23	467
V29.3	Observation for suspected genetic or metabolic condition	N	23	467
V43.83	Organ or tissue replaced by artificial skin	N	23	467
V44.50	Unspecified cystostomy status	N	23	467
V44.51	Cutaneous-vesicostomy status	N	23	467
V44.52	Appendico-vesicostomy status	N	23	467
V44.59	Other cystostomy status	N	23	467
V56.2	Fitting and adjustment of peritoneal dialysis catheter	N	11	317
V58.62	Encounter for aftercare for long- term (current) use of antibiotics	N	23	465, 466
V76.44	Special screening for malignant neoplasm of prostate	N	23	467
V76.45	Special screening for malignant neoplasm of testis	N	23	467

[1] Classified as a ''major complication'' in this DRG.
[2] Classified as a ''major problem'' in these DRGs.
[3] HIV major related condition in this DRG.

TABLE 6B.—NEW PROCEDURE CODES

Procedure code	Description	OR	MDC	DRG
36.31	Open chest transmyocardial revascularization	Y	5	108
36.32	Other transmyocardial revascularization	Y	5	108
36.39	Other heart revascularization	Y	5	108
37.67	Implantation of cardiomyostimulation system	Y	5	110, 111
75.37	Amnioinfusion	N		
86.67	Dermal regenerative graft	Y	1	7, 8
			3	63
			5	120
			6	170, 171
			8	217
			9	263, 264, 265, 266
			10	287
			21	439
			22	504, 506, 507
			24	486
92.30	Stereotactic radiosurgery, not otherwise specified	N [1]	1	7, 8
			10	292, 293
			17	401, 402, 408
92.31	Single source photon radiosurgery	N [1]	1	7, 8
			10	292, 293
			17	401, 402, 408
92.32	Multi-source photon radiosurgery	N [1]	1	7, 8
			10	292, 293
			17	401, 402, 408
92.33	Particulate radiosurgery	N [1]	1	7, 8
			10	292, 293
			17	401, 402, 408
92.39	Stereotactic radiosurgery, not elsewhere classified	N [1]	1	7, 8
			10	292, 293
			17	401, 402, 408
96.29	Reduction of intussusception of alimentary tract	N		
99.10	Injection or infusion of thrombolytic agent	N		
99.20	Injection or infusion of platelet inhibitor	N		

[1] Non-operating room procedure that affects DRG assignment.

TABLE 6C.—INVALID DIAGNOSIS CODES

Diagnosis code	Description	CC	MDC	DRG
482.4	Pneumonia due to Staphylococcus	Y	4	79, 80, 81
			5	121 [1] 1
			15	387, 389 [2]
			25	489 [3]
519.0	Tracheostomy complication	Y	PRE	482
			4	101, 102
564.8	Other specified functional disorders of intestine	N	6	182, 183, 184
763.8	Other specified complications of labor and delivery affecting fetus and newborn.	N	15	390
780.7	Malaise and fatigue	N	23	463, 464
			25	490
965.6	Poisoning by antirheumatics [antiphlogistics]	N	21	449, 450, 451
V02.5	Carrier or suspected carrier of other specified bacterial diseases	N	23	467
V13.6	Personal history of congenital malformations	N	23	467
V16.5	Family history of malignant neoplasm of urinary organs	N	23	467
V18.6	Family history of kidney diseases	N	23	467
V23.8	Supervision of other high-risk pregnancy	Y	14	469
V44.5	Cystostomy status	N	23	467

[1] Classified as a ''major complication'' in this DRG.
[2] Classified as a ''major problem'' in these DRGs.
[3] HIV major related condition in this DRG.

TABLE 6D.—INVALID PROCEDURE CODES

Procedure code	Description	OR	MDC	DRG
36.3	Other heart revascularization	Y	5	108
92.3	Stereotactic radiosurgery	N [1]	1	7,8
			10	292, 293
			17	401, 402, 408

[1] Non-operating room procedure that affects DRG assignment.

TABLE 6E.—REVISED DIAGNOSIS CODE TITLES

Diagnosis code	Description	CC	MDC	DRG
518.81	Acute respiratory failure	Y	4	87
			5	121 [1]
			22	506, 507
659.60	Elderly multigravida unspecified as to episode of care or not applicable	N	14	370, 371, 372, 373, 374, 375
659.61	Elderly multigravida delivered, with mention of antepartum condition	N	14	370, 371, 372, 373, 374, 375
659.63	Elderly multigravida with antepartum condition or complication	N	14	383, 384
V56.1	Fitting and adjustment of extracorporeal dialysis catheter	N	11	317
V82.4	Maternal postnatal screening for chromosomal anomalies	N	23	467

[1] Classified as a ''major complication'' in this DRG.

TABLE 6F.—ADDITIONS TO THE CC EXCLUSIONS LIST
PAGE 1 OF 3 PAGES

CCs that are added to the list are in Table 6F—Additions to the CC Exclusions List. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.

*01100	*01123	*01146	*01172	*01195	*01281	*11515	48249
48240	48240	48240	48240	48240	48240	48240	*48230
48241	48241	48241	48241	48241	48241	48241	48240
48249	48249	48249	48249	48249	48249	48249	48241
*01101	*01124	*01150	*01173	*01196	*01282	*11595	48249
48240	48240	48240	48240	48240	48240	48240	*48231
48241	48241	48241	48241	48241	48241	48241	48240
48249	48249	48249	48249	48249	48249	48249	48241
*01102	*01125	*01151	*01174	*01200	*01283	*1221	48249
48240	48240	48240	48240	48240	48240	48240	*48232
48241	48241	48241	48241	48241	48241	48241	48240
48249	48249	48249	48249	48249	48249	48249	48241
*01103	*01126	*01152	*01175	*01201	*01284	*1304	48249
48240	48240	48240	48240	48240	48240	48240	*48239
48241	48241	48241	48241	48241	48241	48241	48240
48249	48249	48249	48249	48249	48249	48249	48241
*01104	*01130	*01153	*01176	*01202	*01285	*1363	48249
48240	48240	48240	48240	48240	48240	48240	*48240
48241	48241	48241	48241	48241	48241	48241	01100
48249	48249	48249	48249	48249	48249	48249	01101
*01105	*01131	*01154	*01180	*01203	*01286	*3373	01102
48240	48240	48240	48240	48240	48240	3350	01103
48241	48241	48241	48241	48241	48241	33510	01104
48249	48249	48249	48249	48249	48249	33511	01105
*01106	*01132	*01155	*01181	*01204	*01790	33519	01106
48240	48240	48240	48240	48240	48240	33520	01110
48241	48241	48241	48241	48241	48241	33521	01111
48249	48249	48249	48249	48249	48249	33522	01112
*01110	*01133	*01156	*01182	*01205	*01791	33523	01113
48240	48240	48240	48240	48240	48240	33524	01114
48241	48241	48241	48241	48241	48241	33529	01115
48249	48249	48249	48249	48249	48249	3358	01116
*01111	*01134	*01160	*01183	*01206	*01792	3359	01120
48240	48240	48240	48240	48240	48240	*4800	01121
48241	48241	48241	48241	48241	48241	48240	01122
48249	48249	48249	48249	48249	48249	48241	01123
*01112	*01135	*01161	*01184	*01210	*01793	48249	01124
48240	48240	48240	48240	48240	48240	*4801	01125
48241	48241	48241	48241	48241	48241	48240	01126
48249	48249	48249	48249	48249	48249	48241	01130
*01113	*01136	*01162	*01185	*01211	*01794	48249	01131
48240	48240	48240	48240	48240	48240	*4802	01132
48241	48241	48241	48241	48241	48241	48240	01133
48249	48249	48249	48249	48249	48249	48241	01134
*01114	*01140	*01163	*01186	*01212	*01795	48249	01135
48240	48240	48240	48240	48240	48240	*4808	01136
48241	48241	48241	48241	48241	48241	48240	01140
48249	48249	48249	48249	48249	48249	48241	01141
*01115	*01141	*01164	*01190	*01213	*01796	48249	01142
48240	48240	48240	48240	48240	48240	*4809	01143
48241	48241	48241	48241	48241	48241	48240	01144
48249	48249	48249	48249	48249	48249	48241	01145
*01116	*01142	*01165	*01191	*01214	*0212	48249	01146
48240	48240	48240	48240	48240	48240	*481	01150
48241	48241	48241	48241	48241	48241	48240	01151
48249	48249	48249	48249	48249	48249	48241	01152
*01120	*01143	*01166	*01192	*01215	*0310	48249	01153
48240	48240	48240	48240	48240	48240	*4820	01154
48241	48241	48241	48241	48241	48241	48240	01155
48249	48249	48249	48249	48249	48249	48241	01156
*01121	*01144	*01170	*01193	*01216	*0391	48249	01160
48240	48240	48240	48240	48240	48240	*4821	01161
48241	48241	48241	48241	48241	48241	48240	01162
48249	48249	48249	48249	48249	48249	48241	01163
*01122	*01145	*01171	*01194	*01280	*11505	48249	01164
48240	48240	48240	48240	48240	48240	*4822	01165
48241	48241	48241	48241	48241	48241	48240	01166
48249	48249	48249	48249	48249	48249	48241	01170

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01171	4955	01183	5078	01195	48240	48241	48249
01172	4956	01184	5080	01196	48241	48249	*5061
01173	4957	01185	5081	01200	48249	*4950	48240
01174	4958	01186	5171	01201	*48283	48240	48241
01175	4959	01190	*48249	01202	48240	48241	48249
01176	5060	01191	01100	01203	48241	48249	*5062
01180	5061	01192	01101	01204	48249	*4951	48240
01181	5070	01193	01102	01205	*48284	48240	48241
01182	5071	01194	01103	01206	48240	48241	48249
01183	5078	01195	01104	01210	48241	48249	*5063
01184	5080	01196	01105	01211	48249	*4952	48240
01185	5081	01200	01106	01212	*48289	48240	48241
01186	5171	01201	01110	01213	48240	48241	48249
01190	*48241	01202	01111	01214	48241	48249	*5064
01191	01100	01203	01112	01215	48249	*4953	48240
01192	01101	01204	01113	01216	*4829	48240	48241
01193	01102	01205	01114	0310	48240	48241	48249
01194	01103	01206	01115	11505	48241	48249	*5069
01195	01104	01210	01116	11515	48249	*4954	48240
01196	01105	01211	01120	1304	*4830	48240	48241
01200	01106	01212	01121	1363	48240	48241	48249
01201	01110	01213	01122	481	48241	48249	*5070
01202	01111	01214	01123	4820	48249	*4955	48240
01203	01112	01215	01124	4821	*4831	48240	48241
01204	01113	01216	01125	4822	48240	48241	48249
01205	01114	0310	01126	48230	48241	48249	*5071
01206	01115	11505	01130	48231	48249	*4956	48240
01210	01116	11515	01131	48232	*4838	48240	48241
01211	01120	1304	01132	48239	48240	48241	48249
01212	01121	1363	01133	48240	48241	48249	*5078
01213	01122	481	01134	48241	48249	*4957	48240
01214	01123	4820	01135	48249	*4841	48240	48241
01215	01124	4821	01136	48281	48240	48241	48249
01216	01125	4822	01140	48282	48241	48249	*5080
0310	01126	48230	01141	48283	48249	*4958	48240
11505	01130	48231	01142	48284	*4843	48240	48241
11515	01131	48232	01143	48289	48240	48241	48249
1304	01132	48239	01144	4829	48241	48249	*5081
1363	01133	48240	01145	4830	48249	*4959	48240
481	01134	48241	01146	4831	*4845	48240	48241
4820	01135	48249	01150	4838	48240	48241	48249
4821	01136	48281	01151	4841	48241	48249	*5088
4822	01140	48282	01152	4843	48249	*496	48240
48230	01141	48283	01153	4845	*4846	48240	48241
48231	01142	48284	01154	4846	48240	48241	48249
48232	01143	48289	01155	4847	48241	48249	*5089
48239	01144	4829	01156	4848	48249	*500	48240
48240	01145	4830	01160	485	*4847	48240	48241
48241	01146	4831	01161	486	48240	48241	48249
48249	01150	4838	01162	4870	48241	48249	*5171
48281	01151	4841	01163	4950	48249	*501	48240
48282	01152	4843	01164	4951	*4848	48240	48241
48283	01153	4845	01165	4952	48240	48241	48249
48284	01154	4846	01166	4953	48241	48249	*5178
48289	01155	4847	01170	4954	48249	*502	48240
4829	01156	4848	01171	4955	*485	48240	48241
4830	01160	485	01172	4956	48240	48241	48249
4831	01161	486	01173	4957	48241	48249	*51881
4838	01162	4870	01174	4958	48249	*503	51883
4841	01163	4950	01175	4959	*486	48240	51884
4843	01164	4951	01176	5060	48240	48241	78603
4845	01165	4952	01180	5061	48241	48249	78604
4846	01166	4953	01181	5070	48249	*504	*51882
4847	01170	4954	01182	5071	*4870	48240	51883
4848	01171	4955	01183	5078	48240	48241	51884
485	01172	4956	01184	5080	48241	48249	78603
486	01173	4957	01185	5081	48249	*505	78604
4870	01174	4958	01186	5171	*4871	48240	*51883
4950	01175	4959	01190	*48281	48240	48241	51881
4951	01176	5060	01191	48240	48241	48249	51882
4952	01180	5061	01192	48241	48249	*5060	51883
4953	01181	5070	01193	48249	*494	48240	51884
4954	01182	5071	01194	*48282	48240	48241	78603

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TABLE 6G.—DELETIONS TO THE CC EXCLUSIONS LIST

[CCs that are deleted from the list are in Table 6G—Deletions to the CC Exclusions List. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

*01100	*01146	*01195	*11515	01143	48282	4824	4824
4824	4824	4824	4824	01144	48283	*4870	*5178
*01101	*01150	*01196	*11595	01145	48284	4824	4824
4824	4824	4824	4824	01146	48289	*4871	*51889
*01102	*01151	*01200	*1221	01150	4829	4824	4824
4824	4824	4824	4824	01151	4830	*494	*5190
*01103	*01152	*01201	*1304	01152	4831	4824	5190
4824	4824	4824	4824	01153	4838	*4950	*5191
*01104	*01153	*01202	*1363	01154	4841	4824	5190
4824	4824	4824	4824	01155	4843	*4951	*5198
*01105	*01154	*01203	*4800	01156	4845	4824	4824
4824	4824	4824	4824	01160	4846	*4952	5190
*01106	*01155	*01204	*4801	01161	4847	4824	*5199
4824	4824	4824	4824	01162	4848	*4953	4824
*01110	*01156	*01205	*4802	01163	485	4824	5190
4824	4824	4824	4824	01164	486	*4954	*74861
*01111	*01160	*01206	*4808	01165	4870	4824	4824
4824	4824	4824	4824	01166	4950	*4955	*V220
*01112	*01161	*01210	*4809	01170	4951	4824	V238
4824	4824	4824	4824	01171	4952	*4956	*V221
*01113	*01162	*01211	*481	01172	4953	4824	V238
4824	4824	4824	4824	01173	4954	*4957	*V222
*01114	*01163	*01212	*4820	01174	4955	4824	V238
4824	4824	4824	4824	01175	4956	*4958	*V230
*01115	*01164	*01213	*4821	01176	4957	4824	V238
4824	4824	4824	4824	01180	4958	*4959	*V231
*01116	*01165	*01214	*4822	01181	4959	4824	V238
4824	4824	4824	4824	01182	5060	*496	*V232
*01120	*01166	*01215	*48230	01183	5061	4824	V238
4824	4824	4824	4824	01184	5070	*500	*V233
*01121	*01170	*01216	*48231	01185	5071	4824	V238
4824	4824	4824	4824	01186	5078	*501	*V234
*01122	*01171	*01280	*48232	01190	5080	4824	V238
4824	4824	4824	4824	01191	5081	*502	*V235
*01123	*01172	*01281	*48239	01192	5171	4824	V238
4824	4824	4824	4824	01193	*48281	*503	*V237
*01124	*01173	*01282	*4824	01194	4824	4824	V238
4824	4824	4824	01100	01195	*48282	*504	*V238
*01125	*01174	*01283	01101	01196	4824	4824	V237
4824	4824	4824	01102	01200	*48283	*505	V238
*01126	*01175	*01284	01103	01201	4824	4824	V239
4824	4824	4824	01104	01202	*48284	*5060	*V239
*01130	*01176	*01285	01105	01203	4824	4824	V238
4824	4824	4824	01106	01204	*48289	*5061	
*01131	*01180	*01286	01110	01205	4824	4824	
4824	4824	4824	01111	01206	*4829	*5062	
*01132	*01181	*01790	01112	01210	4824	4824	
4824	4824	4824	01113	01211	*4830	*5063	
*01133	*01182	*01791	01114	01212	4824	4824	
4824	4824	4824	01115	01213	*4831	*5064	
*01134	*01183	*01792	01116	01214	4824	4824	
4824	4824	4824	01120	01215	*4838	*5069	
*01135	*01184	*01793	01121	01216	4824	4824	
4824	4824	4824	01122	0310	*4841	*5070	
*01136	*01185	*01794	01123	11505	4824	4824	
4824	4824	4824	01124	11515	*4843	*5071	
*01140	*01186	*01795	01125	1304	4824	4824	
4824	4824	4824	01126	1363	*4845	*5078	
*01141	*01190	*01796	01130	481	4824	4824	
4824	4824	4824	01131	4820	*4846	*5080	
*01142	*01191	*0212	01132	4821	4824	4824	
4824	4824	4824	01133	4822	*4847	*5081	
*01143	*01192	*0310	01134	48230	4824	4824	
4824	4824	4824	01135	48231	*4848	*5088	
*01144	*01193	*0391	01136	48232	4824	4824	
4824	4824	4824	01140	48239	*485	*5089	
*01145	*01194	*11505	01141	4824	4824	4824	
4824	4824	4824	01142	48281	*486	*5171	

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY

[FY97 MEDPAR Update 03/98 Grouper V15.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
1	36863	9.6140	2	4	7	12	20
2	7073	10.0431	3	5	8	13	20
3	3	9.3333	7	7	9	12	12
4	6387	7.7417	1	3	5	9	17
5	101629	3.6388	1	2	2	4	8
6	359	3.0306	1	1	2	4	7
7	12693	10.1052	2	4	7	12	20
8	3051	3.1786	1	1	2	4	7
9	1712	6.5724	1	3	5	8	13
10	19898	6.8603	2	3	5	8	14
11	2976	4.1398	1	2	3	5	8
12	38546	6.6802	2	3	5	8	12
13	6395	5.4835	2	3	4	6	9
14	374285	6.2936	2	3	5	8	12
15	146334	3.8586	1	2	3	5	7
16	13990	5.9277	2	3	4	7	11
17	3228	3.4291	1	2	3	4	7
18	27696	5.5756	2	3	4	7	10
19	7354	3.8089	1	2	3	5	7
20	6638	10.1788	2	5	8	13	19
21	1386	6.8283	2	3	5	8	14
22	2803	4.6522	2	2	4	6	9
23	6933	4.2573	1	2	3	5	8
24	58307	5.0648	1	2	4	6	10
25	22886	3.4256	1	2	3	4	7
26	35	3.2857	1	1	3	4	7
27	4246	5.4788	1	1	3	7	12
28	14087	5.9295	1	2	4	7	12
29	4349	3.5220	1	1	3	4	7
31	3135	4.4287	1	2	3	5	8
32	1378	2.9594	1	1	2	3	5
34	20202	5.4414	1	3	4	7	11
35	4292	3.5517	1	2	3	4	7
36	5421	1.5379	1	1	1	1	2
37	1697	3.7183	1	1	2	4	8
38	116	2.5948	1	1	2	3	5
39	1908	2.0383	1	1	1	2	4
40	2300	3.1822	1	1	2	4	7
42	4052	2.0908	1	1	1	2	4
43	120	3.4250	1	2	3	5	7
44	1346	5.0498	2	3	4	6	9
45	2428	3.4773	1	2	3	4	6
46	3177	4.6396	1	2	4	6	9
47	1232	3.2873	1	1	3	4	7
48	2	4.5000	4	4	5	5	5
49	2297	5.0004	1	2	4	6	9
50	3026	1.9752	1	1	2	2	3
51	308	2.8182	1	1	1	3	6
52	89	2.7528	1	1	2	3	7
53	3012	3.6597	1	1	2	4	8
54	2	6.0000	5	5	7	7	7
55	1704	2.9607	1	1	2	3	6
56	695	2.8374	1	1	2	3	6
57	611	3.6759	1	1	3	4	7
59	121	2.4215	1	1	2	3	5
60	1	4.0000	4	4	4	4	4
61	280	4.6464	1	1	2	5	10
62	4	1.2500	1	1	1	1	2
63	3733	4.4466	1	2	3	5	9
64	3432	6.6973	1	2	5	8	14
65	29238	2.9721	1	2	2	4	5
66	6848	3.2604	1	2	3	4	6
67	494	3.7854	1	2	3	4	7
68	11573	4.1497	1	2	3	5	7
69	3471	3.3244	1	2	3	4	6
70	37	2.5405	1	1	2	3	4
71	100	3.9300	1	2	3	6	7
72	829	3.7853	1	2	3	5	7
73	6323	4.4058	1	2	3	6	8
74	2	2.5000	2	2	3	3	3

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY97 MEDPAR Update 03/98 Grouper V15.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
75	41135	10.2396	4	5	8	13	20
76	41950	11.3136	3	5	9	14	21
77	2041	4.8863	1	2	4	7	10
78	31059	7.3075	3	5	7	9	12
79	248239	8.4083	3	4	7	10	15
80	8319	5.8721	2	3	5	7	10
81	7	11.2857	2	3	6	7	8
82	71558	7.1252	2	3	6	9	14
83	7419	5.5741	2	3	4	7	10
84	1322	3.3162	1	2	3	4	6
85	22565	6.6618	2	3	5	8	13
86	1510	3.8801	1	2	3	5	7
87	73527	6.3192	1	3	5	8	12
88	390502	5.4117	2	3	4	7	10
89	471124	6.2766	2	4	5	8	11
90	39143	4.4608	2	3	4	6	8
91	48	3.9375	1	2	3	5	7
92	14606	6.3852	2	3	5	8	12
93	1323	4.3583	1	2	4	6	8
94	13510	6.4760	2	3	5	8	12
95	1408	3.8544	1	2	3	5	7
96	62085	4.8491	2	3	4	6	9
97	25768	3.8219	1	2	3	5	7
98	28	4.9286	1	2	3	5	13
99	26603	3.0405	1	1	2	4	6
100	10353	2.1232	1	1	2	3	4
101	20349	4.4392	1	2	3	5	9
102	4579	2.7917	1	1	2	3	5
103	515	50.5320	9	14	32	71	124
104	29432	12.4392	4	7	10	16	23
105	25718	9.6492	4	6	8	11	17
106	107341	10.6962	6	7	9	12	17
107	69437	7.9517	4	5	7	9	13
108	8142	11.7677	4	6	9	14	22
110	62676	9.6167	2	5	8	12	18
111	5616	5.8063	2	4	6	7	9
112	119137	3.9263	1	1	3	5	8
113	46975	12.2664	4	6	9	15	24
114	8543	8.4041	2	4	7	11	16
115	15131	8.7469	2	4	7	11	17
116	210530	4.1764	1	2	3	5	8
117	3747	3.9861	1	1	2	5	9
118	6529	2.9326	1	1	2	3	6
119	1640	5.3829	1	1	3	7	13
120	38162	8.1769	1	2	5	10	18
121	170973	6.6427	2	4	6	8	12
122	83711	4.1990	1	2	4	6	7
123	43626	4.3987	1	1	2	5	10
124	155144	4.4560	1	2	4	6	9
125	63029	2.8712	1	1	2	4	6
126	5445	12.4382	4	6	9	15	25
127	723327	5.5118	2	3	4	7	10
128	16139	6.0284	3	4	5	7	9
129	4482	2.9514	1	1	1	3	7
130	98650	5.9904	2	3	5	7	10
131	24713	4.6719	1	3	4	6	8
132	175262	3.1519	1	2	3	4	6
133	6682	2.4811	1	1	2	3	5
134	30563	3.4498	1	2	3	4	6
135	8271	4.3344	1	2	3	5	8
136	1117	2.9687	1	1	2	4	5
138	210196	4.0456	1	2	3	5	8
139	67634	2.5762	1	1	2	3	5
140	108283	2.9686	1	1	2	4	5
141	82219	3.8511	1	2	3	5	7
142	36801	2.7878	1	1	2	3	5
143	144774	2.2571	1	1	2	3	4
144	79437	5.2262	1	2	4	7	10
145	6398	2.8678	1	1	2	4	6
146	10433	10.2667	5	7	9	12	17

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY97 MEDPAR Update 03/98 Grouper V15.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
147	1790	6.7374	4	5	7	8	10
148	147867	12.2636	5	7	10	15	22
149	14480	6.8502	4	5	6	8	10
150	23924	10.8759	4	6	9	13	19
151	4176	5.8829	2	3	5	8	10
152	4736	8.3328	4	5	7	10	14
153	1616	5.6293	3	4	5	7	8
154	34592	13.3723	4	7	11	16	25
155	4766	4.6897	1	2	4	6	9
156	2	18.0000	6	6	30	30	30
157	9351	5.4102	1	2	4	7	11
158	4141	2.6218	1	1	2	3	5
159	18453	4.9685	1	2	4	6	10
160	9823	2.6793	1	1	2	3	5
161	14694	4.0874	1	2	3	5	9
162	7099	2.0338	1	1	1	2	4
163	6	10.0000	1	4	9	13	13
164	5319	8.5336	4	5	7	10	15
165	1658	4.9566	2	3	5	6	8
166	3561	5.1106	2	3	4	6	9
167	2350	2.8400	1	2	2	4	5
168	1732	4.5704	1	2	3	6	9
169	853	2.5768	1	1	2	3	5
170	12888	11.2453	2	5	8	14	23
171	1013	4.8164	1	2	4	6	9
172	33258	7.1141	2	3	5	9	14
173	2164	3.9750	1	1	3	5	8
174	250195	4.9246	2	3	4	6	9
175	21767	3.0099	1	2	3	4	5
176	18457	5.4888	2	3	4	7	10
177	11202	4.5540	2	2	4	6	8
178	3523	3.2109	1	2	3	4	6
179	12572	6.4144	2	3	5	8	12
180	93855	5.4295	2	3	4	7	10
181	21459	3.5079	1	2	3	4	6
182	236477	4.3554	1	2	3	5	8
183	70321	3.0159	1	1	2	4	6
184	91	3.2857	1	2	2	4	7
185	4110	4.4822	1	2	3	6	9
187	892	3.9608	1	2	3	5	8
188	75769	5.5554	1	2	4	7	11
189	8683	3.2034	1	1	2	4	6
190	62	5.2903	1	2	4	7	11
191	10738	14.5968	4	7	11	18	29
192	839	6.7247	2	4	6	8	12
193	7407	12.4918	5	7	10	15	22
194	774	6.9225	3	4	6	9	12
195	7134	9.8004	4	6	8	12	17
196	1274	5.7245	2	4	5	7	10
197	25188	8.6282	3	5	7	10	15
198	6401	4.5894	2	3	4	6	8
199	2067	10.1751	3	5	8	14	20
200	1357	11.4952	2	4	8	14	24
201	1670	14.3072	4	6	11	18	29
202	28883	6.7510	2	3	5	8	13
203	29715	6.8468	2	3	5	9	14
204	53504	6.0856	2	3	5	7	11
205	23103	6.5500	2	3	5	8	13
206	1630	4.0865	1	2	3	5	8
207	35726	5.1383	1	2	4	6	10
208	9541	2.9005	1	1	2	4	6
209	364469	5.4343	3	4	5	6	8
210	142415	7.0179	3	4	6	8	12
211	26144	5.1433	3	4	5	6	8
212	13	3.7692	1	2	4	5	6
213	7546	8.4157	2	4	6	11	16
216	6154	9.8351	2	4	7	12	19
217	20823	12.9944	3	5	9	16	27
218	24004	5.3243	2	3	4	6	10
219	18448	3.2888	1	2	3	4	5

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY97 MEDPAR Update 03/98 Grouper V15.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
220	5	3.2000	1	1	3	4	7
223	18683	2.6174	1	1	2	3	5
224	7760	2.0628	1	1	2	3	4
225	5697	4.3498	1	2	3	5	9
226	5583	5.9226	1	2	4	7	12
227	4638	2.7288	1	1	2	3	5
228	2773	3.4241	1	1	2	4	8
229	1114	2.3887	1	1	2	3	5
230	2399	4.5302	1	2	3	5	9
231	10765	4.5644	1	2	3	5	9
232	498	3.8273	1	1	2	4	9
233	4948	7.6326	2	3	5	9	16
234	2286	3.6374	1	2	3	5	7
235	5378	5.3103	1	3	4	6	10
236	39661	5.1485	1	3	4	6	9
237	1608	3.6486	1	2	3	5	7
238	7892	8.8692	3	4	7	11	17
239	59978	6.4285	2	3	5	8	12
240	13753	6.6862	2	3	5	8	13
241	2925	4.0021	1	2	3	5	7
242	2652	6.7266	2	3	5	8	13
243	82323	4.8596	2	3	4	6	9
244	12497	5.0070	2	3	4	6	9
245	4392	3.7368	1	2	3	5	7
246	1280	3.9313	1	2	3	5	7
247	12331	3.4951	1	2	3	4	7
248	8162	4.6837	1	2	4	6	9
249	10919	3.6445	1	1	3	4	7
250	3586	4.2284	1	2	3	5	8
251	2229	2.9484	1	1	2	4	5
252	1	1.0000	1	1	1	1	1
253	19548	4.8593	1	3	4	6	9
254	9373	3.3465	1	2	3	4	6
255	2	3.5000	1	1	6	6	6
256	5566	5.1175	1	2	4	6	10
257	21299	2.9851	1	2	2	3	5
258	16484	2.1352	1	1	2	3	3
259	3797	3.0830	1	1	2	3	7
260	4492	1.5410	1	1	1	2	2
261	2003	2.2476	1	1	2	3	4
262	665	4.2391	1	1	3	6	9
263	27639	11.4184	3	5	8	14	22
264	3332	7.0624	2	3	5	8	14
265	4341	6.5312	1	2	4	8	13
266	2480	3.4161	1	1	2	4	7
267	254	4.5984	1	2	3	5	9
268	888	3.5676	1	1	2	4	7
269	9483	7.8891	2	3	6	10	16
270	2696	3.1439	1	1	2	4	7
271	23100	7.1558	3	4	6	9	13
272	5981	6.4233	2	3	5	8	12
273	1315	4.8008	1	2	4	6	8
274	2440	6.7398	1	3	5	8	14
275	215	3.5163	1	1	3	4	7
276	944	4.4492	1	2	4	6	8
277	82207	5.9080	2	3	5	7	10
278	24763	4.4937	2	3	4	6	8
279	12	5.0000	2	2	4	7	9
280	14318	4.3117	1	2	3	5	8
281	6028	3.1443	1	1	3	4	6
282	2	2.0000	2	2	2	2	2
283	5236	4.8010	1	2	4	6	9
284	1668	3.3171	1	2	3	4	6
285	5567	11.0223	3	5	8	13	21
286	2153	6.9833	3	4	5	8	13
287	6222	11.2252	3	5	8	13	22
288	1521	5.9382	3	3	5	6	9
289	5499	3.2366	1	1	2	3	7
290	8981	2.5171	1	1	2	3	4
291	67	1.7612	1	1	1	2	3

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY97 MEDPAR Update 03/98 Grouper V15.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
292	5072	10.7744	2	4	8	14	21
293	351	5.4672	1	2	4	7	12
294	82620	4.9159	1	2	4	6	9
295	3630	3.9573	1	2	3	5	7
296	236933	5.3935	2	3	4	7	10
297	32857	3.6526	1	2	3	4	7
298	95	3.6526	1	1	2	4	8
299	979	5.3463	1	2	4	7	10
300	16904	6.2827	2	3	5	8	12
301	2411	3.8075	1	2	3	5	7
302	8040	10.1373	5	6	8	12	18
303	19774	9.2208	4	5	7	10	16
304	12948	8.9874	2	4	7	11	18
305	2570	3.8911	1	2	3	5	7
306	10714	5.5080	1	2	3	7	12
307	2368	2.4041	1	1	2	3	4
308	9227	6.0016	1	2	4	8	13
309	3565	2.5910	1	1	2	3	5
310	26862	4.3113	1	2	3	5	9
311	7848	1.9509	1	1	1	2	4
312	1744	4.3354	1	1	3	6	9
313	589	2.3820	1	1	2	3	5
314	1	10.0000	10	10	10	10	10
315	28603	8.0449	1	2	5	10	18
316	93772	6.7982	2	3	5	9	14
317	803	2.8543	1	1	2	3	6
318	6238	6.0928	1	3	4	8	12
319	412	2.9879	1	1	2	4	6
320	178400	5.5722	2	3	4	7	10
321	23782	4.0371	2	2	3	5	7
322	85	4.0588	2	2	3	4	7
323	17085	3.2128	1	1	2	4	6
324	7560	1.9376	1	1	1	2	4
325	7442	3.9614	1	2	3	5	8
326	2205	2.7728	1	1	2	3	5
327	9	2.8889	1	1	2	3	4
328	767	3.7171	1	2	3	5	7
329	88	2.2500	1	1	1	3	4
331	44022	5.5767	1	3	4	7	11
332	4566	3.5572	1	1	3	5	7
333	320	4.9219	1	2	4	6	11
334	18718	4.9703	3	3	4	6	8
335	10403	3.7142	2	3	3	4	5
336	54368	3.6034	1	2	3	4	7
337	31918	2.2865	1	1	2	3	4
338	2785	4.7885	1	2	3	6	10
339	2000	4.1895	1	1	3	5	9
340	2	1.0000	1	1	1	1	1
341	4945	2.9521	1	1	2	3	6
342	1013	3.4423	1	2	2	4	7
344	3904	2.6360	1	1	1	3	5
345	1349	3.6338	1	1	2	4	8
346	4889	5.8151	1	3	4	7	11
347	368	3.1141	1	1	2	4	6
348	3216	4.2463	1	2	3	5	8
349	636	2.7453	1	1	2	3	5
350	6146	4.4007	2	2	4	5	8
352	640	3.6078	1	1	3	4	7
353	2831	6.9347	3	4	5	8	12
354	10001	5.7745	3	3	4	6	10
355	5668	3.4622	2	3	3	4	5
356	29070	2.6484	1	2	2	3	4
357	6365	9.0207	3	5	7	11	17
358	27581	4.3699	2	3	3	5	7
359	28195	2.9766	2	2	3	3	4
360	17946	3.1562	1	2	3	4	5
361	543	3.3204	1	1	2	3	7
363	3976	3.3154	1	2	2	3	6
364	1838	3.5620	1	1	2	5	8
365	2315	6.8877	1	2	5	9	14

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY97 MEDPAR Update 03/98 Grouper V15.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
366	4395	6.8066	1	3	5	8	14
367	510	2.8863	1	1	2	3	6
368	2907	6.3509	2	3	5	8	12
369	2621	3.0626	1	1	2	4	6
370	1207	5.4905	2	3	4	5	9
371	1184	3.4611	2	3	3	4	5
372	1004	3.1464	1	2	2	3	5
373	3985	2.1154	1	1	2	2	3
374	159	3.0629	1	2	2	3	4
375	9	5.1111	2	2	3	9	10
376	222	2.9144	1	2	2	3	6
377	53	4.4528	1	2	3	6	9
378	171	2.5906	1	2	2	3	4
379	338	3.5562	1	1	2	3	7
380	90	2.1556	1	1	2	3	4
381	192	2.1198	1	1	1	2	4
382	42	1.2619	1	1	1	1	2
383	1490	3.7302	1	2	3	4	8
384	129	2.6512	1	1	1	3	6
385	1	2.0000	2	2	2	2	2
389	10	10.2000	1	7	7	15	19
390	13	6.0000	2	2	4	5	17
392	2546	10.3987	4	5	7	12	21
394	1820	7.0368	1	2	4	8	16
395	71452	4.7241	1	2	3	6	9
396	16	17.3750	1	1	4	11	13
397	18933	5.5143	1	2	4	7	11
398	18263	6.0488	2	3	5	7	11
399	1325	3.7170	1	2	3	5	7
400	7291	9.3665	2	3	6	12	20
401	6715	11.0067	2	4	8	14	23
402	1465	3.8826	1	1	3	5	8
403	39249	8.1435	2	3	6	10	17
404	3823	4.4499	1	2	3	6	9
406	3326	9.5391	2	4	7	12	20
407	636	4.3270	1	2	4	5	8
408	2692	7.5137	1	2	5	9	16
409	4682	5.8317	2	3	4	6	11
410	59539	3.4172	1	2	3	4	6
411	19	3.5263	1	1	2	2	7
412	25	2.2800	1	1	2	3	4
413	7854	7.4318	2	3	6	9	15
414	677	4.1905	1	2	3	5	8
415	45551	14.3639	4	7	11	18	28
416	231746	7.3984	2	4	6	9	14
417	43	5.8837	2	3	5	7	11
418	21340	6.1925	2	3	5	8	11
419	15355	5.0178	2	3	4	6	9
420	2697	3.9459	1	2	3	5	7
421	12186	3.9568	1	2	3	5	7
422	89	3.3258	1	2	2	4	7
423	10830	7.7667	2	3	6	9	15
424	1640	14.2976	2	5	10	18	29
425	15541	4.1344	1	2	3	5	8
426	4507	4.9022	1	2	3	6	10
427	1656	4.7977	1	2	3	6	10
428	963	7.2887	1	2	5	8	15
429	32953	7.1813	2	3	5	8	14
430	57380	8.7114	2	4	7	11	17
431	220	7.2409	1	3	5	8	13
432	414	5.3116	1	2	3	6	12
433	6874	3.2098	1	1	2	4	7
434	21742	5.1845	2	3	4	6	9
435	14706	4.4104	1	2	4	5	8
436	3357	13.9896	4	7	13	21	27
437	12879	9.2165	3	5	8	12	16
439	1149	7.7346	1	3	5	9	16
440	5199	8.9683	2	3	6	10	19
441	578	3.4810	1	1	2	4	7
442	16431	8.1169	1	3	6	10	17

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY97 MEDPAR Update 03/98 Grouper V15.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
443	3185	3.3215	1	1	2	4	7
444	3471	4.4967	1	2	3	5	8
445	1261	3.3672	1	2	3	4	6
446	1	2.0000	2	2	2	2	2
447	4291	2.5101	1	1	2	3	5
449	28174	3.7816	1	1	3	5	8
450	6226	2.0830	1	1	1	2	4
451	9	2.7778	1	1	1	4	5
452	23072	5.0396	1	2	4	6	10
453	3826	2.9260	1	1	2	4	6
454	3900	4.6767	1	2	3	6	9
455	772	2.7176	1	1	2	3	5
456	197	8.4721	1	1	3	9	20
457	128	3.5781	1	1	1	3	9
458	1543	15.0194	3	7	12	19	31
459	487	8.9548	2	3	6	11	19
460	2357	6.0793	1	3	4	7	12
461	3071	4.4435	1	1	2	4	11
462	10468	12.4882	4	6	10	16	23
463	14079	4.4165	1	2	3	5	8
464	3582	3.3707	1	2	3	4	6
465	207	2.9179	1	1	1	3	5
466	1765	4.0436	1	1	2	4	8
467	1331	4.4132	1	1	2	4	7
468	62314	13.4808	3	6	10	17	27
471	12993	6.0741	3	4	5	7	10
472	181	27.2983	1	8	19	38	55
473	8512	12.7849	2	3	7	18	33
475	110026	11.1951	2	5	9	15	22
476	5974	11.9093	3	6	10	15	22
477	28969	8.1503	1	3	6	11	17
478	124086	7.4574	1	3	5	9	15
479	18459	3.8438	1	2	3	5	7
480	415	26.7590	8	11	20	32	55
481	263	27.8213	16	20	24	33	44
482	6659	12.7485	4	7	10	15	23
483	42214	40.2055	14	21	33	50	74
484	411	14.7591	2	6	11	18	28
485	3536	9.6649	4	5	7	11	18
486	2380	12.4319	1	5	10	16	25
487	4381	7.4170	1	3	6	9	14
488	874	17.1201	4	7	12	22	35
489	15056	8.9267	2	4	6	11	19
490	4923	5.4148	1	2	4	7	11
491	11099	3.6559	2	2	3	4	6
492	2359	17.1768	4	5	12	27	36
493	56592	5.6275	1	2	5	7	11
494	25335	2.4293	1	1	2	3	5
495	130	16.7538	7	9	13	19	30
496	904	10.5564	4	6	8	13	20
497	22184	6.2841	2	3	5	7	11
498	12634	3.5001	1	2	3	5	6
499	36447	4.9602	2	2	4	6	9
500	36672	2.8703	1	2	2	4	5
501	1910	10.4806	4	6	8	12	19
502	471	6.5669	3	4	6	8	10
503	6366	4.2147	1	2	3	5	8
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TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY

[FY97 MEDPAR Update 03/98 Grouper V16.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
1	36863	9.6140	2	4	7	12	20
2	7073	10.0431	3	5	8	13	20
3	3	9.3333	7	7	9	12	12

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY97 MEDPAR Update 03/98 Grouper V16.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
4	6387	7.7417	1	3	5	9	17
5	101629	3.6388	1	2	2	4	8
6	359	3.0306	1	1	2	4	7
7	12693	10.1052	2	4	7	12	20
8	3051	3.1786	1	1	2	4	7
9	1712	6.5724	1	3	5	8	13
10	19898	6.8603	2	3	5	8	14
11	2976	4.1398	1	2	3	5	8
12	38546	6.6802	2	3	5	8	12
13	6395	5.4835	2	3	4	6	9
14	374285	6.2936	2	3	5	8	12
15	146334	3.8586	1	2	3	5	7
16	13990	5.9277	2	3	4	7	11
17	3228	3.4291	1	2	3	4	7
18	27696	5.5756	2	3	4	7	10
19	7354	3.8089	1	2	3	5	7
20	6638	10.1788	2	5	8	13	19
21	1386	6.8283	2	3	5	8	14
22	2803	4.6522	2	2	4	6	9
23	6933	4.2573	1	2	3	5	8
24	58307	5.0648	1	2	4	6	10
25	22886	3.4256	1	2	3	4	7
26	35	3.2857	1	1	3	4	7
27	4246	5.4788	1	1	3	7	12
28	14087	5.9295	1	2	4	7	12
29	4349	3.5220	1	1	3	4	7
31	3135	4.4287	1	2	3	5	8
32	1378	2.9594	1	1	2	3	5
34	20202	5.4414	1	3	4	7	11
35	4292	3.5517	1	2	3	4	7
36	5421	1.5379	1	1	1	1	2
37	1697	3.7183	1	1	2	4	8
38	116	2.5948	1	1	2	3	5
39	1908	2.0383	1	1	1	2	4
40	2300	3.1822	1	1	2	4	7
42	4052	2.0908	1	1	1	2	4
43	120	3.4250	1	2	3	5	7
44	1346	5.0498	2	3	4	6	9
45	2428	3.4773	1	2	3	4	6
46	3177	4.6396	1	2	4	6	9
47	1232	3.2873	1	1	3	4	7
48	2	4.5000	4	4	5	5	5
49	2297	5.0004	1	2	4	6	9
50	3026	1.9752	1	1	2	2	3
51	308	2.8182	1	1	1	3	6
52	80	2.4125	1	1	2	3	5
53	3021	3.6660	1	1	2	4	8
54	2	6.0000	5	5	7	7	7
55	1704	2.9607	1	1	2	3	6
56	695	2.8374	1	1	2	3	6
57	523	3.5488	1	1	3	4	7
59	121	2.4215	1	1	2	3	5
60	1	4.0000	4	4	4	4	4
61	280	4.6464	1	1	2	5	10
62	4	1.2500	1	1	1	1	2
63	3733	4.4466	1	2	3	5	9
64	3432	6.6973	1	2	5	8	14
65	29238	2.9721	1	2	2	4	5
66	6848	3.2604	1	2	3	4	6
67	494	3.7854	1	2	3	4	7
68	11573	4.1497	1	2	3	5	7
69	3471	3.3244	1	2	3	4	6
70	37	2.5405	1	1	2	3	4
71	100	3.9300	1	2	3	6	7
72	829	3.7853	1	2	3	5	7
73	6323	4.4058	1	2	3	6	8
74	2	2.5000	2	2	3	3	3
75	41135	10.2396	4	5	8	13	20
76	41950	11.3136	3	5	9	14	21
77	2041	4.8863	1	2	4	7	10

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY97 MEDPAR Update 03/98 Grouper V16.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
78	31059	7.3075	3	5	7	9	12
79	248239	8.4083	3	4	7	10	15
80	8319	5.8721	2	3	5	7	10
81	7	11.2857	2	3	6	7	8
82	71558	7.1252	2	3	6	9	14
83	7419	5.5741	2	3	4	7	10
84	1322	3.3162	1	2	3	4	6
85	22565	6.6618	2	3	5	8	13
86	1510	3.8801	1	2	3	5	7
87	73527	6.3192	1	3	5	8	12
88	390502	5.4117	2	3	4	7	10
89	471124	6.2766	2	4	5	8	11
90	39143	4.4608	2	3	4	6	8
91	48	3.9375	1	2	3	5	7
92	14606	6.3852	2	3	5	8	12
93	1323	4.3583	1	2	4	6	8
94	13510	6.4760	2	3	5	8	12
95	1408	3.8544	1	2	3	5	7
96	62085	4.8491	2	3	4	6	9
97	25768	3.8219	1	2	3	5	7
98	28	4.9286	1	2	3	5	13
99	26603	3.0405	1	1	2	4	6
100	10353	2.1232	1	1	2	3	4
101	20349	4.4392	1	2	3	5	9
102	4579	2.7917	1	1	2	3	5
103	515	50.5320	9	14	32	71	124
104	30204	12.5198	4	7	10	16	23
105	26990	9.7535	4	6	8	11	17
106	4691	10.8874	5	7	9	13	19
107	102650	10.6875	6	7	9	12	17
108	6098	11.2642	4	6	9	14	21
109	69437	7.9517	4	5	7	9	13
110	62676	9.6167	2	5	8	12	18
111	5616	5.8063	2	4	6	7	9
112	119137	3.9263	1	1	3	5	8
113	46975	12.2664	4	6	9	15	24
114	8543	8.4041	2	4	7	11	16
115	15131	8.7469	2	4	7	11	17
116	210530	4.1764	1	2	3	5	8
117	3747	3.9861	1	1	2	5	9
118	6529	2.9326	1	1	2	3	6
119	1640	5.3829	1	1	3	7	13
120	38162	8.1769	1	2	5	10	18
121	170973	6.6427	2	4	6	8	12
122	83711	4.1990	1	2	4	6	7
123	43626	4.3987	1	1	2	5	10
124	155144	4.4560	1	2	4	6	9
125	63029	2.8712	1	1	2	4	6
126	5445	12.4382	4	6	9	15	25
127	723327	5.5118	2	3	4	7	10
128	16139	6.0284	3	4	5	7	9
129	4482	2.9514	1	1	1	3	7
130	98650	5.9904	2	3	5	7	10
131	24713	4.6719	1	3	4	6	8
132	175262	3.1519	1	2	3	4	6
133	6682	2.4811	1	1	2	3	5
134	30563	3.4498	1	2	3	4	6
135	8271	4.3344	1	2	3	5	8
136	1117	2.9687	1	1	2	4	5
138	210196	4.0456	1	2	3	5	8
139	67634	2.5762	1	1	2	3	5
140	108283	2.9686	1	1	2	4	5
141	82219	3.8511	1	2	3	5	7
142	36801	2.7878	1	1	2	3	5
143	144774	2.2571	1	1	2	3	4
144	79437	5.2262	1	2	4	7	10
145	6398	2.8678	1	1	2	4	6
146	10433	10.2667	5	7	9	12	17
147	1790	6.7374	4	5	7	8	10
148	147867	12.2636	5	7	10	15	22

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY97 MEDPAR Update 03/98 Grouper V16.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
149	14480	6.8502	4	5	6	8	10
150	23924	10.8759	4	6	9	13	19
151	4176	5.8829	2	3	5	8	10
152	4736	8.3328	4	5	7	10	14
153	1616	5.6293	3	4	5	7	8
154	34592	13.3723	4	7	11	16	25
155	4766	4.6897	1	2	4	6	9
156	2	18.0000	6	6	30	30	30
157	9351	5.4102	1	2	4	7	11
158	4141	2.6218	1	1	2	3	5
159	18453	4.9685	1	2	4	6	10
160	9823	2.6793	1	1	2	3	5
161	14694	4.0874	1	2	3	5	9
162	7099	2.0338	1	1	1	2	4
163	6	10.0000	1	4	9	13	13
164	5319	8.5336	4	5	7	10	15
165	1658	4.9566	2	3	5	6	8
166	3561	5.1106	2	3	4	6	9
167	2350	2.8400	1	2	2	4	5
168	1790	4.5961	1	2	3	6	9
169	883	2.5787	1	1	2	3	5
170	12888	11.2453	2	5	8	14	23
171	1013	4.8164	1	2	4	6	9
172	33258	7.1141	2	3	5	9	14
173	2164	3.9750	1	1	3	5	8
174	250195	4.9246	2	3	4	6	9
175	21767	3.0099	1	2	3	4	5
176	18457	5.4888	2	3	4	7	10
177	11202	4.5540	2	2	4	6	8
178	3523	3.2109	1	2	3	4	6
179	12572	6.4144	2	3	5	8	12
180	93855	5.4295	2	3	4	7	10
181	21459	3.5079	1	2	3	4	6
182	236477	4.3554	1	2	3	5	8
183	70321	3.0159	1	1	2	4	6
184	91	3.2857	1	2	2	4	7
185	4110	4.4822	1	2	3	6	9
187	892	3.9608	1	2	3	5	8
188	75769	5.5554	1	2	4	7	11
189	8683	3.2034	1	1	2	4	6
190	62	5.2903	1	2	4	7	11
191	10738	14.5968	4	7	11	18	29
192	839	6.7247	2	4	6	8	12
193	7407	12.4918	5	7	10	15	22
194	774	6.9225	3	4	6	9	12
195	7134	9.8004	4	6	8	12	17
196	1274	5.7245	2	4	5	7	10
197	25188	8.6282	3	5	7	10	15
198	6401	4.5894	2	3	4	6	8
199	2067	10.1751	3	5	8	14	20
200	1357	11.4952	2	4	8	14	24
201	1670	14.3072	4	6	11	18	29
202	28883	6.7510	2	3	5	8	13
203	29715	6.8468	2	3	5	9	14
204	53504	6.0856	2	3	5	7	11
205	23103	6.5500	2	3	5	8	13
206	1630	4.0865	1	2	3	5	8
207	35726	5.1383	1	2	4	6	10
208	9541	2.9005	1	1	2	4	6
209	364469	5.4343	3	4	5	6	8
210	142415	7.0179	3	4	6	8	12
211	26144	5.1433	3	4	5	6	8
212	13	3.7692	1	2	4	5	6
213	7546	8.4157	2	4	6	11	16
216	6154	9.8351	2	4	7	12	19
217	20823	12.9944	3	5	9	16	27
218	24004	5.3243	2	3	4	6	10
219	18448	3.2888	1	2	3	4	5
220	5	3.2000	1	1	3	4	7
223	18683	2.6174	1	1	2	3	5

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY97 MEDPAR Update 03/98 Grouper V16.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
224	7760	2.0628	1	1	2	3	4
225	5697	4.3498	1	2	3	5	9
226	5583	5.9226	1	2	4	7	12
227	4638	2.7288	1	1	2	3	5
228	2773	3.4241	1	1	2	4	8
229	1114	2.3887	1	1	2	3	5
230	2399	4.5302	1	2	3	5	9
231	10765	4.5644	1	2	3	5	9
232	498	3.8273	1	1	2	4	9
233	4948	7.6326	2	3	5	9	16
234	2286	3.6374	1	2	3	5	7
235	5378	5.3103	1	3	4	6	10
236	39661	5.1485	1	3	4	6	9
237	1608	3.6486	1	2	3	5	7
238	7892	8.8692	3	4	7	11	17
239	59978	6.4285	2	3	5	8	12
240	13753	6.6862	2	3	5	8	13
241	2925	4.0021	1	2	3	5	7
242	2652	6.7266	2	3	5	8	13
243	82323	4.8596	2	3	4	6	9
244	12497	5.0070	2	3	4	6	9
245	4392	3.7368	1	2	3	5	7
246	1280	3.9313	1	2	3	5	7
247	12331	3.4951	1	2	3	4	7
248	8162	4.6837	1	2	4	6	9
249	10919	3.6445	1	1	3	4	7
250	3586	4.2284	1	2	3	5	8
251	2229	2.9484	1	1	2	4	5
252	1	1.0000	1	1	1	1	1
253	19548	4.8593	1	3	4	6	9
254	9373	3.3465	1	2	3	4	6
255	2	3.5000	1	1	6	6	6
256	5566	5.1175	1	2	4	6	10
257	21299	2.9851	1	2	2	3	5
258	16484	2.1352	1	1	2	3	3
259	3797	3.0830	1	1	2	3	7
260	4492	1.5410	1	1	1	2	2
261	2003	2.2476	1	1	2	3	4
262	665	4.2391	1	1	3	6	9
263	27639	11.4184	3	5	8	14	22
264	3332	7.0624	2	3	5	8	14
265	4341	6.5312	1	2	4	8	13
266	2480	3.4161	1	1	2	4	7
267	254	4.5984	1	2	3	5	9
268	888	3.5676	1	1	2	4	7
269	9483	7.8891	2	3	6	10	16
270	2696	3.1439	1	1	2	4	7
271	23100	7.1558	3	4	6	9	13
272	5981	6.4233	2	3	5	8	12
273	1315	4.8008	1	2	4	6	8
274	2440	6.7398	1	3	5	8	14
275	215	3.5163	1	1	3	4	7
276	944	4.4492	1	2	4	6	8
277	82207	5.9080	2	3	5	7	10
278	24763	4.4937	2	3	4	6	8
279	12	5.0000	2	2	4	7	9
280	14318	4.3117	1	2	3	5	8
281	6028	3.1443	1	1	3	4	6
282	2	2.0000	2	2	2	2	2
283	5236	4.8010	1	2	4	6	9
284	1668	3.3171	1	2	3	4	6
285	5567	11.0223	3	5	8	13	21
286	2153	6.9833	3	4	5	8	13
287	6222	11.2252	3	5	8	13	22
288	1521	5.9382	3	3	5	6	9
289	5499	3.2366	1	1	2	3	7
290	8981	2.5171	1	1	2	3	4
291	67	1.7612	1	1	1	2	3
292	5072	10.7744	2	4	8	14	21
293	351	5.4672	1	2	4	7	12

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY97 MEDPAR Update 03/98 Grouper V16.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
294	82620	4.9159	1	2	4	6	9
295	3630	3.9573	1	2	3	5	7
296	236933	5.3935	2	3	4	7	10
297	32857	3.6526	1	2	3	4	7
298	95	3.6526	1	1	2	4	8
299	979	5.3463	1	2	4	7	10
300	16904	6.2827	2	3	5	8	12
301	2411	3.8075	1	2	3	5	7
302	8040	10.1373	5	6	8	12	18
303	19774	9.2208	4	5	7	10	16
304	12948	8.9874	2	4	7	11	18
305	2570	3.8911	1	2	3	5	7
306	10714	5.5080	1	2	3	7	12
307	2368	2.4041	1	1	2	3	4
308	9227	6.0016	1	2	4	8	13
309	3565	2.5910	1	1	2	3	5
310	26862	4.3113	1	2	3	5	9
311	7848	1.9509	1	1	1	2	4
312	1744	4.3354	1	1	3	6	9
313	589	2.3820	1	1	2	3	5
314	1	10.0000	10	10	10	10	10
315	28603	8.0449	1	2	5	10	18
316	93772	6.7982	2	3	5	9	14
317	803	2.8543	1	1	2	3	6
318	6238	6.0928	1	3	4	8	12
319	412	2.9879	1	1	2	4	6
320	178400	5.5722	2	3	4	7	10
321	23782	4.0371	2	2	3	5	7
322	85	4.0588	2	2	3	4	7
323	17085	3.2128	1	1	2	4	6
324	7560	1.9376	1	1	1	2	4
325	7442	3.9614	1	2	3	5	8
326	2205	2.7728	1	1	2	3	5
327	9	2.8889	1	1	2	3	4
328	767	3.7171	1	2	3	5	7
329	88	2.2500	1	1	1	3	4
331	44022	5.5767	1	3	4	7	11
332	4566	3.5572	1	1	3	5	7
333	320	4.9219	1	2	4	6	11
334	18718	4.9703	3	3	4	6	8
335	10403	3.7142	2	3	3	4	5
336	54368	3.6034	1	2	3	4	7
337	31918	2.2865	1	1	2	3	4
338	2785	4.7885	1	2	3	6	10
339	2000	4.1895	1	1	3	5	9
340	2	1.0000	1	1	1	1	1
341	4945	2.9521	1	1	2	3	6
342	1013	3.4423	1	2	2	4	7
344	3904	2.6360	1	1	1	3	5
345	1349	3.6338	1	1	2	4	8
346	4889	5.8151	1	3	4	7	11
347	368	3.1141	1	1	2	4	6
348	3216	4.2463	1	2	3	5	8
349	636	2.7453	1	1	2	3	5
350	6146	4.4007	2	2	4	5	8
352	640	3.6078	1	1	3	4	7
353	2831	6.9347	3	4	5	8	12
354	10001	5.7745	3	3	4	6	10
355	5668	3.4622	2	3	3	4	5
356	29070	2.6484	1	2	2	3	4
357	6365	9.0207	3	5	7	11	17
358	27581	4.3699	2	3	3	5	7
359	28195	2.9766	2	2	3	3	4
360	17946	3.1562	1	2	3	4	5
361	543	3.3204	1	1	2	3	7
363	3976	3.3154	1	2	2	3	6
364	1838	3.5620	1	1	2	5	8
365	2315	6.8877	1	2	5	9	14
366	4395	6.8066	1	3	5	8	14
367	510	2.8863	1	1	2	3	6

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY97 MEDPAR Update 03/98 Grouper V16.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
368	2907	6.3509	2	3	5	8	12
369	2621	3.0626	1	1	2	4	6
370	1207	5.4905	2	3	4	5	9
371	1184	3.4611	2	3	3	4	5
372	1004	3.1464	1	2	2	3	5
373	3985	2.1154	1	1	2	2	3
374	159	3.0629	1	2	2	3	4
375	9	5.1111	2	2	3	9	10
376	222	2.9144	1	2	2	3	6
377	53	4.4528	1	2	3	6	9
378	171	2.5906	1	2	2	3	4
379	338	3.5562	1	1	2	3	7
380	90	2.1556	1	1	2	3	4
381	192	2.1198	1	1	1	2	4
382	42	1.2619	1	1	1	1	2
383	1490	3.7302	1	2	3	4	8
384	129	2.6512	1	1	1	3	6
385	1	2.0000	2	2	2	2	2
389	10	10.2000	1	7	7	15	19
390	13	6.0000	2	2	4	5	17
392	2546	10.3987	4	5	7	12	21
394	1820	7.0368	1	2	4	8	16
395	71452	4.7241	1	2	3	6	9
396	16	17.3750	1	1	4	11	13
397	18933	5.5143	1	2	4	7	11
398	18263	6.0488	2	3	5	7	11
399	1325	3.7170	1	2	3	5	7
400	7291	9.3665	2	3	6	12	20
401	6715	11.0067	2	4	8	14	23
402	1465	3.8826	1	1	3	5	8
403	39249	8.1435	2	3	6	10	17
404	3823	4.4499	1	2	3	6	9
406	3326	9.5391	2	4	7	12	20
407	636	4.3270	1	2	4	5	8
408	2692	7.5137	1	2	5	9	16
409	4682	5.8317	2	3	4	6	11
410	59539	3.4172	1	2	3	4	6
411	19	3.5263	1	1	2	2	7
412	25	2.2800	1	1	2	3	4
413	7854	7.4318	2	3	6	9	15
414	677	4.1905	1	2	3	5	8
415	45551	14.3639	4	7	11	18	28
416	231746	7.3984	2	4	6	9	14
417	43	5.8837	2	3	5	7	11
418	21340	6.1925	2	3	5	8	11
419	15355	5.0178	2	3	4	6	9
420	2697	3.9459	1	2	3	5	7
421	12186	3.9568	1	2	3	5	7
422	89	3.3258	1	2	2	4	7
423	10830	7.7667	2	3	6	9	15
424	1640	14.2976	2	5	10	18	29
425	15541	4.1344	1	2	3	5	8
426	4507	4.9022	1	2	3	6	10
427	1656	4.7977	1	2	3	6	10
428	963	7.2887	1	2	5	8	15
429	32953	7.1813	2	3	5	8	14
430	57380	8.7114	2	4	7	11	17
431	220	7.2409	1	3	5	8	13
432	414	5.3116	1	2	3	6	12
433	6874	3.2098	1	1	2	4	7
434	21742	5.1845	2	3	4	6	9
435	14706	4.4104	1	2	4	5	8
436	3357	13.9896	4	7	13	21	27
437	12879	9.2165	3	5	8	12	16
439	1149	7.7346	1	3	5	9	16
440	5199	8.9683	2	3	6	10	19
441	578	3.4810	1	1	2	4	7
442	16431	8.1169	1	3	6	10	17
443	3185	3.3215	1	1	2	4	7
444	3471	4.4967	1	2	3	5	8

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY97 MEDPAR Update 03/98 Grouper V16.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
445	1261	3.3672	1	2	3	4	6
446	1	2.0000	2	2	2	2	2
447	4291	2.5101	1	1	2	3	5
449	28174	3.7816	1	1	3	5	8
450	6226	2.0830	1	1	1	2	4
451	9	2.7778	1	1	1	4	5
452	23072	5.0396	1	2	4	6	10
453	3826	2.9260	1	1	2	4	6
454	3900	4.6767	1	2	3	6	9
455	772	2.7176	1	1	2	3	5
461	3071	4.4435	1	1	2	4	11
462	10468	12.4882	4	6	10	16	23
463	14079	4.4165	1	2	3	5	8
464	3582	3.3707	1	2	3	4	6
465	207	2.9179	1	1	1	3	5
466	1765	4.0436	1	1	2	4	8
467	1331	4.4132	1	1	2	4	7
468	62290	13.4801	3	6	10	17	27
471	12993	6.0741	3	4	5	7	10
473	8512	12.7849	2	3	7	18	33
475	110026	11.1951	2	5	9	15	22
476	5972	11.9089	3	6	10	15	22
477	28961	8.1501	1	3	6	11	17
478	124086	7.4574	1	3	5	9	15
479	18459	3.8438	1	2	3	5	7
480	415	26.7590	8	11	20	32	55
481	263	27.8213	16	20	24	33	44
482	6659	12.7485	4	7	10	15	23
483	42214	40.2055	14	21	33	50	74
484	411	14.7591	2	6	11	18	28
485	3536	9.6649	4	5	7	11	18
486	2380	12.4319	1	5	10	16	25
487	4381	7.4170	1	3	6	9	14
488	874	17.1201	4	7	12	22	35
489	15056	8.9267	2	4	6	11	19
490	4923	5.4148	1	2	4	7	11
491	11099	3.6559	2	2	3	4	6
492	2359	17.1768	4	5	12	27	36
493	56592	5.6275	1	2	5	7	11
494	25335	2.4293	1	1	2	3	5
495	130	16.7538	7	9	13	19	30
496	904	10.5564	4	6	8	13	20
497	22184	6.2841	2	3	5	7	11
498	12634	3.5001	1	2	3	5	6
499	36447	4.9602	2	2	4	6	9
500	36672	2.8703	1	2	2	4	5
501	1910	10.4806	4	6	8	12	19
502	471	6.5669	3	4	6	8	10
503	6366	4.2147	1	2	3	5	8
504	158	31.8481	9	14	26	39	57
505	174	5.8218	1	1	1	5	11
506	1138	16.7926	4	8	13	22	34
507	395	8.9747	2	4	7	12	17
508	1227	7.8240	2	3	5	10	16
509	483	4.9896	1	2	3	6	10
510	1024	6.9355	2	3	5	8	14
511	328	4.8323	1	2	3	6	9
	11317977						

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) JULY 1998

State	Urban	Rural
ALABAMA	0.387	0.442
ALASKA	0.503	0.733
ARIZONA	0.374	0.542
ARKANSAS	0.516	0.458
CALIFORNIA	0.365	0.480
COLORADO	0.467	0.566
CONNECTICUT	0.546	0.532
DELAWARE	0.506	0.487
DISTRICT OF COLUMBIA	0.521	.....
FLORIDA	0.384	0.394
GEORGIA	0.498	0.498
HAWAII	0.434	0.558
IDAHO	0.563	0.585
ILLINOIS	0.445	0.547
INDIANA	0.559	0.597
IOWA	0.514	0.641
KANSAS	0.415	0.641
KENTUCKY	0.496	0.520
LOUISIANA	0.442	0.495
MAINE	0.620	0.576
MARYLAND	0.764	0.818
MASSACHUSETTS	0.541	0.571
MICHIGAN	0.468	0.580
MINNESOTA	0.532	0.603
MISSISSIPPI	0.478	0.499
MISSOURI	0.442	0.519
MONTANA	0.529	0.574
NEBRASKA	0.483	0.640
NEVADA	0.322	0.585
NEW HAMPSHIRE	0.574	0.584
NEW JERSEY	0.437	.....
NEW MEXICO	0.467	0.511
NEW YORK	0.551	0.623
NORTH CAROLINA	0.522	0.464
NORTH DAKOTA	0.617	0.666
OHIO	0.534	0.569
OKLAHOMA	0.460	0.530
OREGON	0.554	0.620

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) JULY 1998—Continued

State	Urban	Rural
PENNSYLVANIA	0.406	0.528
PUERTO RICO	0.479	0.561
RHODE ISLAND	0.571	.....
SOUTH CAROLINA	0.472	0.478
SOUTH DAKOTA	0.537	0.620
TENNESSEE	0.482	0.507
TEXAS	0.428	0.536
UTAH	0.535	0.632
VERMONT	0.615	0.576
VIRGINIA	0.476	0.499
WASHINGTON	0.600	0.661
WEST VIRGINIA	0.591	0.573
WISCONSIN	0.569	0.641
WYOMING	0.495	0.698

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED) JULY 1998

State	Ratio
ALABAMA	0.050
ALASKA	0.066
ARIZONA	0.043
ARKANSAS	0.054
CALIFORNIA	0.039
COLORADO	0.053
CONNECTICUT	0.041
DELAWARE	0.057
DISTRICT OF COLUMBIA	0.040
FLORIDA	0.046
GEORGIA	0.049
HAWAII	0.045
IDAHO	0.054
ILLINOIS	0.043
INDIANA	0.059
IOWA	0.054

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED) JULY 1998—Continued

State	Ratio
KANSAS	0.051
KENTUCKY	0.051
LOUISIANA	0.055
MAINE	0.040
MARYLAND	0.013
MASSACHUSETTS	0.056
MICHIGAN	0.046
MINNESOTA	0.055
MISSISSIPPI	0.048
MISSOURI	0.048
MONTANA	0.052
NEBRASKA	0.057
NEVADA	0.066
NEW HAMPSHIRE	0.066
NEW JERSEY	0.039
NEW MEXICO	0.047
NEW YORK	0.053
NORTH CAROLINA	0.047
NORTH DAKOTA	0.075
OHIO	0.053
OKLAHOMA	0.055
OREGON	0.055
PENNSYLVANIA	0.043
PUERTO RICO	0.054
RHODE ISLAND	0.033
SOUTH CAROLINA	0.052
SOUTH DAKOTA	0.061
TENNESSEE	0.056
TEXAS	0.051
UTAH	0.056
VERMONT	0.047
VIRGINIA	0.058
WASHINGTON	0.066
WEST VIRGINIA	0.056
WISCONSIN	0.052
WYOMING	0.056

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TABLE 10--Percentage Difference in Wage Indexes for Areas That Qualify for a Wage Index Exception for Excluded Hospitals and Units

Area	1982-1995 Difference	1984-1995 Difference	1988-1995 Difference	1990-1995 Difference	1991-1995 Difference	1992-1995 Difference	1993-1995 Difference	1994-1995 Difference
Connecticut	16.5655	18.8796						
Florida		9.1690						
Hawaii	8.4648	23.6425	13.5348		14.7989	10.9983		
Illinois				8.0893				
Indiana				9.2802				
Mississippi				9.9025	10.2333	8.3901		
Nebraska			9.8129					
New Hampshire	11.7660	15.6335						
New Mexico				9.0290				
Oregon				8.0893				
South Carolina		11.4321						
South Dakota				8.1668	8.2913			
Vermont		12.2976						
Washington			8.9589	12.7105	8.9476			
Wyoming				12.1413	10.8268	9.7342		
Aguadilla, PR							11.8688	13.2044
Anniston, AL		13.0457	9.2719	8.3437	8.9835		8.1007	
Arecibo, PR		11.5789	23.2247	31.4995	28.3834	8.4037	10.8686	15.5998
Athens, GA		12.5664						
Atlantic-Cape May, NJ	10.2557	17.3419	9.8992	9.0901				
Bellingham, WA			9.0329					
Bergen-Passaic, NJ	14.4894	16.4441	18.4668					
Bremerton, WA	13.7531	15.6900	16.0415	16.1145	14.5176			
Cedar Rapids, IA				8.0122				
Charleston-North Charleston, SC			9.4975					
Charlotte-Gastonia-Rock Hill, NC-SC		13.8899						
Charlottesville, VA	11.0020	16.3482		8.4748	9.9466	12.1146	12.3962	13.7001
Cheyenne, WY				8.1898	9.1736			8.0609
Clarksville-Hopkinsville, TN-KY		10.8130	9.9509	17.9011				
Columbia, SC		10.2203						

TABLE 10--Percentage Difference in Wage Indexes for Areas That Qualify for a Wage Index Exception for Excluded Hospitals and Units

Area	1982-1995 Difference	1984-1995 Difference	1988-1995 Difference	1990-1995 Difference	1991-1995 Difference	1992-1995 Difference	1993-1995 Difference	1994-1995 Difference
Columbus, GA-AL	8.3895	16.0610	13.8603	12.9554	9.8557	9.9407	9.6015	
Danville, VA	12.9503	18.7836	20.6176	14.8688	11.9733			11.2448
Decatur, AL		11.5197	10.0761					
Duluth-Superior, MN-WI				8.7738	8.0203			
Dutchess County, NY		8.4396						
Elkhart-Goshen, IN				8.7875				
Eugene-Springfield , OR		9.9520	10.2330	18.1665				
Fargo-Moorhead, ND-MN								8.0118
Fayetteville-Springdale-Rogers, AR		16.8766		12.2691	21.1768	17.2897	14.8390	12.9598
Florence, AL		8.4626						
Florence, SC	11.6984	10.5530						
Gadsden, AL				13.5554	8.8344			
Gainesville, FL		8.5014						
Galveston-Texas City, TX			14.8956	9.8228				
Greeley, CO				12.2550				
Greensboro-Winston-Salem-High Point, NC	11.7551							
Hagerstown, MD		17.0376	11.2917	15.4090	14.0159	12.4201	11.1704	
Hickory-Morganton-Lenoir, NC		8.6083						
Houma, LA		9.7128	14.3096			8.1095		
Jackson, MS				11.0265	11.1899	10.1286		
Jackson, TN	9.2067	13.4392	8.3239					
Jacksonville, NC						9.2983		8.5616
Jersey City, NJ		8.2146	10.2790					
Kankakee, IL			11.0523	11.4458				9.0373
Knoxville, TN		8.9490						
Kokomo, IN							8.1597	10.4087
Lakeland-Winter Haven, FL		9.3540	9.5011					
Laredo, TX				12.0487		8.9778		
Las Cruse, NM			12.2663					
Lima, OH			11.0905					

TABLE 10--Percentage Difference in Wage Indexes for Areas That Qualify for a Wage Index Exception for Excluded Hospitals and Units

Area	1982-1995 Difference	1984-1995 Difference	1988-1995 Difference	1990-1995 Difference	1991-1995 Difference	1992-1995 Difference	1993-1995 Difference	1994-1995 Difference
Lynchburg, VA							9.8165	
Macon, GA		15.2890						
McAllen-Edinburg-Mission, TX		10.7436	10.1269					
Middlesex-Somerset-Hunterdon, NJ	8.8146	12.5189						
Mobile, AL					8.7328			
Monmouth-Ocean, NJ	15.1432	20.7734	14.4111	10.2928				
Muncie, IN			16.7926	10.2396				
Nassau-Suffolk, NY		12.1748						
New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	10.4049	14.7010						
New London-Norwich, CT		9.0824						
New York, NY		9.6791						
Newark, NJ		9.2656						
Newburgh, NY-PA	21.1491	25.5730	15.6816	9.1833	9.6331			
Ocala, FL		12.5998						
Olympia, WA		9.5161		11.6668				
Omaha, NE-IA			11.0370					
Panama City, FL					13.0671			
Providence-Warwick-Pawtucket, RI		11.1659						
Pueblo, CO					8.9094			
Redding, CA		19.9879	12.5701					
Richland-Kennewick-Pasco, WA			9.5218	11.7427				
Rochester, MN	14.8682	11.2060		16.1776	11.4492	11.1427	123789	11.5978
St. Joseph, MO		13.9915		12.3243	15.1709	17.1456	15.8442	18.4198
Salinas, CA	21.6325	20.5691	16.2274	14.9242	10.3273		9.8877	
Santa Cruz-Watsonville, CA	13.5641	13.6471	9.4639	9.8071				
Santa Rosa, CA							9.0807	
Savannah, GA	13.9143	19.7623	20.9118	16.0525		12.3773		16.6705
Springfield, MA	10.3096	9.6614						
Terre Haute, IN		9.6009						
Waco, TX				8.1227				8.9657

TABLE 10--Percentage Difference in Wage Indexes for Areas That Qualify for a Wage Index Exception for Excluded Hospitals and Units

Area	1982-1995 Difference	1984-1995 Difference	1988-1995 Difference	1990-1995 Difference	1991-1995 Difference	1992-1995 Difference	1993-1995 Difference	1994-1995 Difference
Wast Palm Beach-Boca Raton, FL		8.0870						
Wilmington-Newark, DE-MD	13.1950	15.6727	9.2931	12.4882	11.4966			
Wilmington, NC		14.5250						
Yakima, WA				9.6066	8.3429			
Yuma, AZ			13.3138	16.1614				

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Appendix A—Regulatory Impact Analysis

I. Introduction

Section 804(2) of Title 5, United States Code (as added by section 251 of Public Law 104–121), specifies that a ''major rule'' is any rule that the Office of Management and Budget finds is likely to result in—

- An annual effect on the economy of $100 million or more;
- A major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or
- Significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic and export markets.

We estimate that the impact of this final rule will be to decrease payments to hospitals by approximately $530 million in FY 1999. Therefore, this rule is a major rule as defined in Title 5, United States Code, section 804(2).

We have examined the impacts of this final rule as required by Executive Order 12866 and the Regulatory Flexibility Act (RFA) (Public Law 96–354). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects; distributive impacts; and equity). The RFA requires agencies to analyze options for regulatory relief for small businesses. For purposes of the RFA, most hospitals, and most other providers, physicians, and health care suppliers are small entities, either by nonprofit status or by having revenues of $5 million or less annually.

Also, section 1102(b) of the Social Security Act requires us to prepare a regulatory impact analysis for any final rule that may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA). Section 601(g) of the Social Security Amendments of 1983 (Public Law 98–21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the prospective payment system, we classify these hospitals as urban hospitals.

It is clear that the changes being made in this document will affect both a substantial number of small rural hospitals as well as other classes of hospitals, and the effects on some may be significant. Therefore, the discussion below, in combination with the rest of this final rule, constitutes a combined regulatory impact analysis and regulatory flexibility analysis.

In accordance with the provisions of Executive Order 12866, this final rule was reviewed by the Office of Management and Budget.

II. Changes in the Final Rule

Since we published the proposed rule, the market basket estimates for hospitals subject to the prospective payment system and hospitals and units excluded from the system have both fallen by 0.2 percentage points. As a result, the updates are 0.2 percent lower than the updates reflected in the impact analysis for the proposed rule.

Also, in the proposed rule, we included discharges to swing beds under the expanded transfer definition. In this final rule we are not including swing beds from the definition of a postacute care setting. The overall payment impact of this change is relatively very small (an increase of approximately $4 million).

With the exception of these two changes, we are generally implementing the policy and statutory changes discussed in the proposed rule.

III. Limitations of Our Analysis

As has been the case in previously published regulatory impact analyses, the following quantitative analysis presents the projected effects of our policy changes, as well as statutory changes effective for FY 1999, on various hospital groups. We estimate the effects of individual policy changes by estimating payments per case while holding all other payment policies constant. We use the best data available, but we do not attempt to predict behavioral responses to our policy changes, and we do not make adjustments for future changes in such variables as admissions, lengths of stay, or case mix.

We received no comments on the methodology used for the impact analysis in the proposed rule.

IV. GME Payment to Nonhospital Providers

In the past, Medicare only paid hospitals for GME costs. Therefore, FQHCs, RHCs, and Medicare+Choice organizations may have been reluctant to train large numbers of residents since Medicare would not reimburse their incurred training costs. This final rule specifies that Medicare will reimburse the qualified nonhospital provider for Medicare's share of the reasonable costs of the training where the qualified nonhospital provider incurs all or substantially all of the costs of the training at that site. This final rule may facilitate more training of residents in settings where many of those residents will ultimately practice after their training is completed. Additionally, this could result in an increase in the number of physicians practicing in underserved areas.

In addition, hospitals are currently allowed to count residents working in nonhospital sites in their FTE count of residents for determining indirect and direct graduate medical education payments, if the hospital incurs ''all or substantially all of the costs'' of the training at the non-hospital site. The regulation defined the statutory requirement of ''all or substantially all'' to mean at least the residents' salaries and fringe benefits. In this final rule, we are defining ''all or substantially all'' of the costs of training in the nonhospital site to mean residents' salaries and fringe benefits as well as the portion of teaching physicians' salaries and fringe benefits that can be allocated to direct GME. We believe that this definition will not discourage training in nonhospital settings.

Section 4625 of the Balanced Budget Act, which provides for direct graduate medical education payments to nonhospital providers, would have minimal impact in the context of total graduate medical education costs. We believe that the most significant impact resulting from making payment directly to qualified nonhospital providers and the redefinition of ''all or substantially all'' will be that additional nonhospital sites may participate in training residents. We expect that such an impact will result in little if any additional cost to Medicare.

V. Hospitals Included in and Excluded From the Prospective Payment System

The prospective payment systems for hospital inpatient operating and capital-related costs encompass nearly all general, short-term, acute care hospitals that participate in the Medicare program. There were 45 Indian Health Service hospitals in our database, which we excluded from the analysis due to the special characteristics of the prospective payment method for these hospitals. Among other short-term, acute care hospitals, only the 50 such hospitals in Maryland remain excluded from the prospective payment system under the waiver at section 1814(b)(3) of the Act. Thus, as of July 1998, we have included 4,975 hospitals in our analysis. This represents about 82 percent of all Medicare-participating hospitals. The majority of this impact analysis focuses on this set of hospitals.

The remaining 18 percent are specialty hospitals that are excluded from the prospective payment system and continue to be paid on the basis of their reasonable costs (subject to a rate-of-increase ceiling on their inpatient operating costs per discharge). These hospitals include psychiatric, rehabilitation, long-term care, children's, and cancer hospitals. The impacts of our final policy changes on these hospitals are discussed below.

VI. Impact on Excluded Hospitals and Units

As of July 1998, there were 1,077 specialty hospitals excluded from the prospective payment system and instead paid on a reasonable cost basis subject to the rate-of-increase ceiling under § 413.40. In addition, there were 2,408 psychiatric and rehabilitation units in hospitals otherwise subject to the prospective payment system. These excluded units are also paid in accordance with § 413.40.

As required by section 1886(b)(3)(B) of the Act, the update factor applicable to the rate-of-increase limit for excluded hospitals and units for FY 1999 would be between 0 and 2.4 percent, depending on the hospital's costs in relation to its limit.

The impact on excluded hospitals and units of the update in the rate-of-increase limit depends on the cumulative cost increases experienced by each excluded hospital or unit since its applicable base period. For excluded hospitals and units that have maintained their cost increases at a

level below the percentage increases in the rate-of-increase limits since their base period, the major effect will be on the level of incentive payments these hospitals and units receive. Conversely, for excluded hospitals and units with per-case cost increases above the cumulative update in their rate-of-increase limits, the major effect will be the amount of excess costs that would not be reimbursed.

We note that, under § 413.40(d)(3), an excluded hospital or unit whose costs exceed 110 percent of its rate-of-increase limit receives its rate-of-increase limit plus 50 percent of the difference between its reasonable costs and 110 percent of the limit, not to exceed 110 percent of its limit. In addition, under the various provisions set forth in § 413.40, certain excluded hospitals and units can obtain payment adjustments for justifiable increases in operating costs that exceed the limit. At the same time, however, by generally limiting payment increases, we continue to provide an incentive for excluded hospitals and units to restrain the growth in their spending for patient services.

VII. Quantitative Impact Analysis of the Final Policy Changes Under the Prospective Payment System for Operating Costs

A. Basis and Methodology of Estimates

In this final rule, we are announcing policy changes and payment rate updates for the prospective payment systems for operating and capital-related costs. We have prepared separate impact analyses of the changes to each system. This section deals with changes to the operating prospective payment system.

The data used in developing the quantitative analyses presented below are taken from the FY 1997 MedPAR file and the most current provider-specific file that is used for payment purposes. Although the analyses of the changes to the operating prospective payment system do not incorporate cost data, the most recently available hospital cost report data were used to categorize hospitals. Our analysis has several qualifications. First, we do not make adjustments for behavioral changes that hospitals may adopt in response to these final policy changes. Second, due to the interdependent nature of the prospective payment system, it is very difficult to precisely quantify the impact associated with each change. Third, we draw upon various sources for the data used to categorize hospitals in the tables. In some cases, particularly the number of beds, there is a fair degree of variation in the data from different sources. We have attempted to construct these variables with the best available source overall. For individual hospitals, however, some miscategorizations are possible.

Using cases in the FY 1997 MedPAR file, we simulated payments under the operating prospective payment system given various combinations of payment parameters. Any short-term, acute care hospitals not paid under the general prospective payment systems (Indian Health Service hospitals and hospitals in Maryland) are excluded from the simulations. Payments under the capital prospective payment system, or payments for costs other than inpatient operating costs, are not analyzed here. Estimated payment impacts of final FY 1999 changes to the capital prospective payment system are discussed below in section VIII of this Appendix.

The final changes discussed separately below are the following:

- The effects of implementing the expanded transfer definition enacted by section 4407 of the BBA, which counts as a transfer any discharge from one of 10 DRGs if upon discharge the patient is admitted to an excluded hospital or distinct part unit or a skilled nursing facility, or is provided home health care that is related to the hospitalization within 3 days of the date of discharge.
- The effects of the annual reclassification of diagnoses and procedures and the recalibration of the DRG relative weights required by section 1886(d)(4)(C) of the Act.
- The effects of changes in hospitals' wage index values reflecting the wage index update (FY 1995 data).
- The effects of two changes to the wage index for FY 1999: (1) Including the Part A costs associated with physicians under contract; and (2) removing the overhead costs related to departments excluded from the wage data used to calculate the wage index (for example, skilled nursing facilities and distinct part units).
- The effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB) that will be effective in FY 1999.
- The total change in payments based on FY 1999 policies relative to payments based on FY 1998 policies.

To illustrate the impacts of the FY 1999 changes, our analysis begins with a FY 1999 baseline simulation model using: the FY 1998 GROUPER (version 15.0); the FY 1998 wage index; the transfer definition prior to implementation of section 4407 of the BBA; and no MGCRB reclassifications. Outlier payments are set at 5.1 percent of total DRG payments.

Each final and statutory policy change is then added incrementally to this baseline model, finally arriving at an FY 1999 model incorporating all of the changes. This allows us to isolate the effects of each change.

Our final comparison illustrates the percent change in payments per case from FY 1998 to FY 1999. Four factors have significant impacts here. First is the update to the standardized amounts. In accordance with section 1886(d)(3)(A)(iv) of the Act, we are updating the large urban and the other areas average standardized amounts for FY 1999 by the most recently forecasted hospital market basket increase for FY 1999 of 2.4 percent minus 1.9 percentage points. Similarly, section 1886(b)(3)(C)(ii) of the Act provides that the update factor applicable to the hospital-specific rates for sole community hospitals (SCHs) and Medicare-dependent, small rural hospitals (MDHs) is equal to the market basket increase of 2.4 percent minus 1.9 percentage points (for an update of 0.5 percent).

A second significant factor impacting changes in hospitals' payments per case from FY 1998 to FY 1999 is a change in MGCRB reclassification status from one year to the next. That is, hospitals reclassified in FY 1998 that are no longer reclassified in FY 1999 may have a negative payment impact going from FY 1998 to FY 1999; conversely, hospitals not reclassified in FY 1998 that are reclassified in FY 1999 may have a positive impact. In some cases, these impacts can be quite substantial, so if a relatively small number of hospitals in a particular category lose their reclassification status, the percentage increase in payments for the category may be below the national mean.

A third significant factor is that we currently estimate that actual outlier payments during FY 1998 will be 5.4 percent of actual total DRG payments. When the FY 1998 final rule was published, we projected FY 1998 outlier payments would be 5.1 percent of total DRG payments, and the standardized amounts were reduced correspondingly. The effects of the slightly higher than expected outlier payments during FY 1998 (as discussed in the Addendum to this final rule) are reflected in the analyses below comparing our current estimates of FY 1998 payments per case to estimated FY 1999 payments per case.

Fourth, payments per case in FY 1999 are reduced from FY 1998 for hospitals that receive the indirect medical education (IME) or the disproportionate share (DSH) adjustments. Section 1886(d)(5)(B)(ii) of the Act provides that the IME adjustment is reduced from approximately a 7.0 percent increase for every 10 percent increase in a hospital's resident-to-bed ratio in FY 1998, to a 6.5 percent increase in FY 1999. Similarly, in accordance with section 1886(d)(5)(F)(ix) of the Act, the DSH adjustment for FY 1999 is reduced by 2 percent from what would otherwise have been paid, compared to a 1 percent reduction for FY 1998.

Table I demonstrates the results of our analysis. The table categorizes hospitals by various geographic and special payment consideration groups to illustrate the varying impacts on different types of hospitals. The top row of the table shows the overall impact on the 4,975 hospitals included in the analysis. This is 113 fewer hospitals than were included in the impact analysis in the FY 1998 final rule with comment period (62 FR 46119).

The next four rows of Table I contain hospitals categorized according to their geographic location (all urban, which is further divided into large urban and other urban, or rural). There are 2,810 hospitals located in urban areas (MSAs or NECMAs) included in our analysis. Among these, there are 1,611 hospitals located in large urban areas (populations over 1 million), and 1,199 hospitals in other urban areas (populations of 1 million or fewer). In addition, there are 2,165 hospitals in rural areas. The next two groupings are by bed-size categories, shown separately for urban and rural hospitals. The final groupings by geographic location are by census divisions, also shown separately for urban and rural hospitals.

The second part of Table I shows hospital groups based on hospitals' FY 1999 payment classifications, including any reclassifications under section 1886(d)(10) of the Act. For example, the rows labeled urban,

large urban, other urban, and rural show the numbers of hospitals paid based on these categorizations (after consideration of geographic reclassifications) are 2,894, 1,698, 1,196, and 2,081, respectively.

The next three groupings examine the impacts of the final changes on hospitals grouped by whether or not they have residency programs (teaching hospitals that receive an IME adjustment), receive DSH payments, or some combination of these two adjustments. There are 3,880 nonteaching hospitals in our analysis, 854 teaching hospitals with fewer than 100 residents, and 241 teaching hospitals with 100 or more residents.

In the DSH categories, hospitals are grouped according to their DSH payment status, and whether they are considered urban or rural after MGCRB reclassifications. Hospitals in the rural DSH categories, therefore, represent hospitals that were not reclassified for purposes of the standardized amount or for purposes of the DSH adjustment. (They may, however, have been reclassified for purposes of the wage index.) The next category groups hospitals considered urban after geographic reclassification, in terms of whether they receive the IME adjustment, the DSH adjustment, both, or neither.

The next row separately examines hospitals that available data show may qualify under section 4401(b) of the BBA for the special temporary relief provision, which grants an additional 0.3 percent update to the standardized amounts (in addition to the 0.5 percent update other hospitals receive during FY 1999), resulting in a 0.8 percent update for this category of hospitals. To be eligible, a hospital must not be an MDH, nor may it receive either IME or DSH payments. It must also experience a negative margin on its operating prospective payments during FY 1999. We estimated eligible hospitals based on whether they had a negative operating margin on their FY 1995 cost report (latest available data). Finally, to qualify, a hospital must be located in a State where the aggregate FY 1995 operating prospective payments were less than the aggregate associated costs for all of the non-IME, non-DSH, non-MDH hospitals in the State. There are 344 hospitals in this row.

The next four rows examine the impacts of the final changes on rural hospitals by special payment groups (SCHs, rural referral centers (RRCs), and MDHs), as well as rural hospitals not receiving a special payment designation. The RRCs (145), SCHs (637), MDHs (352), and SCH and RRCs (59) shown here were not reclassified for purposes of the standardized amount. There are six SCHs that will be reclassified for the standardized amount in FY 1999 that, therefore, are not included in these rows. There are seven hospitals that continue to be paid under the same rules as SCHs, by virtue of their prior designation as essential access community hospitals (EACH). These hospitals are categorized in our analysis as SCHs (there are also three EACH/RRCs).

The next two groupings are based on type of ownership and the hospital's Medicare utilization expressed as a percent of total patient days. These data are taken primarily from the FY 1995 Medicare cost report files, if available (otherwise FY 1994 data are used). Data needed to determine ownership status or Medicare utilization percentages were unavailable for 115 hospitals. For the most part, these are new hospitals.

The next series of groupings concern the geographic reclassification status of hospitals. The first three groupings display hospitals that were reclassified by the MGCRB for both FY 1998 and FY 1999, or for either of those 2 years, by urban/rural status. The next rows illustrate the overall number of FY 1999 reclassifications, as well as the numbers of reclassified hospitals grouped by urban and rural location. The final row in Table I contains hospitals located in rural counties but deemed to be urban under section 1886(d)(8)(B) of the Act.

TABLE I.—IMPACT ANALYSIS OF CHANGES FOR FY 1999 OPERATING PROSPECTIVE PAYMENT SYSTEM

[Percent Changes in Payments Per Case]

	Num. of hosps.[1]	Pac tran. provision[2]	DRG recalib.[3]	New wage Data[4]	Contract phys. pt A Costs[5]	Allocated overhead costs[6]	DRG & WI changes[7]	MGCRB reclassification[8]	All FY 99 changes[9]
	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
(BY GEOGRAPHIC LOCATION):									
ALL HOSPITALS	4,975	−0.6	0.1	0.0	0.0	0.0	0.0	0.0	−1.0
URBAN HOSPITALS	2,810	−0.7	0.2	−0.1	0.0	−0.1	−0.2	−0.4	−1.3
LARGE URBAN	1,611	−0.7	0.2	−0.4	0.0	−0.1	−0.5	−0.5	−1.7
OTHER URBAN	1,199	−0.6	0.1	0.4	0.0	−0.1	0.3	−0.4	−0.7
RURAL HOSPITALS	2,165	−0.4	0.1	0.7	0.0	0.4	1.0	2.7	1.3
BED SIZE (URBAN):									
0–99 BEDS	704	−0.8	0.1	−0.2	0.0	0.0	−0.2	−0.6	−0.9
100–199 BEDS	937	−0.9	0.2	−0.2	0.0	−0.1	−0.2	−0.5	−1.2
200–299 BEDS	568	−0.7	0.2	−0.2	0.0	−0.1	−0.2	−0.4	−1.2
300–499 BEDS	449	−0.6	0.1	−0.1	0.0	−0.1	−0.2	−0.5	−1.4
500 OR MORE BEDS	152	−0.5	0.1	0.1	0.0	−0.2	0.0	−0.3	−1.6
BED SIZE (RURAL):									
0–49 BEDS	1,137	−0.2	0.0	0.7	0.0	0.5	1.0	0.0	1.0
50–99 BEDS	634	−0.3	0.0	0.6	0.0	0.4	0.8	1.1	0.8
100–149 BEDS	229	−0.5	0.1	0.6	−0.1	0.5	1.0	3.6	1.1
	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
150–199 BEDS	91	−0.5	0.1	0.8	0.0	0.4	1.1	4.5	2.5
200 OR MORE BEDS	74	−0.4	0.1	0.8	0.0	0.3	1.1	5.3	1.7
URBAN BY CENSUS DIVISION:									
NEW ENGLAND	152	−0.7	0.1	−1.1	0.2	−0.3	−1.2	−0.2	−2.6
MIDDLE ATLANTIC	425	−0.4	0.2	0.2	0.2	−0.1	0.3	−0.4	−0.9
SOUTH ATLANTIC	414	−0.6	0.2	0.7	−0.2	−0.1	0.5	−0.5	−0.4
EAST NORTH CENTRAL	476	−0.8	0.1	−0.4	−0.2	−0.3	−0.9	−0.4	−2.2
EAST SOUTH CENTRAL	162	−0.5	0.2	0.7	−0.2	−0.3	0.2	−0.5	−0.7
WEST NORTH CENTRAL	189	−0.7	0.1	0.6	0.2	0.2	1.0	−0.5	−0.1
WEST SOUTH CENTRAL	354	−1.0	0.2	−0.7	0.3	−0.1	−0.4	−0.5	−1.6
MOUNTAIN	129	−0.9	0.1	−0.1	0.1	−0.1	−0.2	−0.5	−1.1
PACIFIC	461	−0.8	0.2	−0.9	−0.2	0.1	−0.9	−0.4	−2.0
PUERTO RICO	48	−0.8	0.3	0.9	−0.2	−0.3	0.5	−0.6	−0.3
RURAL BY CENSUS DIVISION:									
NEW ENGLAND	53	−0.4	0.0	1.0	0.0	0.0	0.9	1.4	−0.3
MIDDLE ATLANTIC	80	−0.2	0.0	0.7	0.4	0.2	1.2	1.7	1.3
SOUTH ATLANTIC	286	−0.4	0.1	0.6	−0.2	0.3	0.7	3.8	1.8
EAST NORTH CENTRAL	285	−0.4	0.1	0.8	−0.1	0.3	1.0	2.1	1.3
EAST SOUTH CENTRAL	269	−0.3	0.1	1.3	−0.2	0.4	1.5	2.7	1.7
WEST NORTH CENTRAL	500	−0.3	−0.1	0.9	0.0	0.7	1.5	2.3	1.4
WEST SOUTH CENTRAL	342	−0.5	0.1	0.1	0.1	0.5	0.6	3.5	0.7

TABLE I.—IMPACT ANALYSIS OF CHANGES FOR FY 1999 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Percent Changes in Payments Per Case]

	Num. of hosps.[1]	Pac tran. provision[2]	DRG recalib.[3]	New wage Data[4]	Contract phys. pt A Costs[5]	Allocated overhead costs[6]	DRG & WI changes[7]	MGCRB reclassification[8]	All FY 99 changes[9]
	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
MOUNTAIN	204	−0.2	0.0	0.2	−0.1	0.5	0.5	1.8	0.6
PACIFIC	141	−0.5	0.1	0.3	−0.2	0.5	0.6	2.4	0.7
PUERTO RICO	5	−0.5	0.0	2.3	−0.2	−0.2	1.8	1.7	−0.2
(BY PAYMENT CATEGORIES):									
URBAN HOSPITALS	2,894	−0.7	0.2	−0.1	0.0	−0.1	−0.2	−0.4	−1.3
LARGE URBAN	1,698	−0.7	0.2	−0.4	0.0	−0.1	−0.4	−0.3	−1.6
OTHER URBAN	1,196	−0.6	0.1	0.4	0.0	−0.1	0.3	−0.4	−0.6
RURAL HOSPITALS	2,081	−0.4	0.1	0.7	0.0	0.4	1.0	2.4	1.1
TEACHING STATUS:									
NON-TEACHING	3,880	−0.7	0.1	0.1	−0.1	0.1	0.2	0.3	−0.3
LESS THAN 100 RES	854	−0.7	0.1	−0.1	0.0	−0.1	−0.2	−0.3	−1.1
100+ RESIDENTS	241	−0.5	0.2	−0.1	0.1	−0.2	−0.1	−0.3	−2.0
DISPROPORTIONATE SHARE HOSPITALS (DSH):									
NON-DSH	3,089	−0.6	0.1	0.1	0.0	0.0	0.0	0.3	−0.6
URBAN DSH:									
100 BEDS OR MORE	1,404	−0.7	0.2	−0.1	0.0	−0.1	−0.1	−0.4	−1.4
FEWER THAN 100 BEDS	88	−0.6	0.2	−0.6	−0.1	0.0	−0.7	−0.4	−1.2
RURAL DSH:									
SOLE COMMUNITY (SCH)	162	−0.2	0.0	0.7	−0.1	0.3	0.8	0.0	1.0
REFERRAL CENTERS (RRC)	53	−0.5	0.2	1.1	−0.1	0.4	1.4	5.6	2.5
	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
OTHER RURAL DSH HOSP:									
100 BEDS OR MORE	60	−0.6	0.2	0.9	−0.2	0.5	1.3	1.1	0.7
FEWER THAN 100 BEDS	119	−0.2	0.0	1.1	−0.1	0.5	1.4	−0.2	1.3
URBAN TEACHING AND DSH:									
BOTH TEACHING AND DSH	709	−0.7	0.2	−0.1	0.0	−0.1	−0.2	−0.5	−1.6
TEACHING AND NO DSH	331	−0.6	0.1	−0.1	0.0	−0.2	−0.3	−0.1	−1.3
NO TEACHING AND DSH	783	−0.8	0.2	0.0	−0.1	0.0	0.0	−0.2	−0.7
NO TEACHING AND NO DSH	1,071	−0.7	0.1	−0.1	0.0	−0.1	−0.2	−0.4	−0.9
SPECIAL UPDATE HOSPITALS (UNDER SEC. 4401(b) OF PUBLIC LAW 105–33)	344	−0.6	0.1	0.0	−0.1	−0.1	−0.1	−0.2	−0.8
RURAL HOSPITAL TYPES:									
NONSPECIAL STATUS HOSPITALS	888	−0.4	0.1	0.9	−0.1	0.6	1.3	1.2	0.7
RRC	145	−0.6	0.2	0.9	0.0	0.4	1.4	6.4	2.2
SCH	637	−0.1	−0.1	0.3	0.0	0.2	0.4	0.1	0.4
MDH	352	−0.2	0.0	0.8	0.0	0.5	1.2	0.5	1.0
SCH AND RRC	59	−0.2	0.0	0.3	−0.1	0.2	0.3	2.0	1.2
TYPE OF OWNERSHIP:									
VOLUNTARY	2,858	−0.6	0.1	0.0	0.0	−0.1	−0.1	−0.1	−1.0
PROPRIETARY	671	−0.9	0.2	0.1	−0.1	0.0	0.0	0.2	−1.0
GOVERNMENT	1,331	−0.5	0.2	0.1	0.0	0.1	0.2	0.3	−0.5
	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
UNKNOWN	115	−0.8	0.2	0.3	−0.2	0.1	0.4	−0.5	−1.0
MEDICARE UTILIZATION AS A PERCENT OF INPATIENT DAYS:									
0–25	247	−0.6	0.2	−1.0	0.0	0.0	−0.8	−0.2	−2.0
25–50	1,264	−0.7	0.2	−0.2	0.0	−0.1	−0.2	−0.3	−1.5
50–65	1,978	−0.6	0.1	0.2	0.0	−0.1	0.1	0.2	−0.6
OVER 65	1,371	−0.6	0.1	0.2	0.0	0.0	0.3	0.1	−0.2
UNKNOWN	115	−0.8	0.2	0.3	−0.2	0.1	0.4	−0.5	−1.0
HOSPITALS RECLASSIFIED BY THE MEDICARE GEOGRAPHIC REVIEW BOARD:									
RECLASSIFICATION STATUS DURING FY 98 AND FY 99:									
RECLASSIFIED DURING BOTH FY98 AND FY99	315	−0.5	0.1	0.6	−0.1	0.2	0.7	6.8	−0.5
URBAN	72	−0.4	0.2	0.4	−0.1	−0.2	0.1	4.9	−1.0
RURAL	243	−0.5	0.1	0.7	−0.1	0.4	1.1	8.3	−0.1
RECLASSIFIED DURING FY 99 ONLY	170	−0.5	0.1	0.5	0.0	0.3	0.8	5.0	5.4
URBAN	15	−0.7	0.1	−0.1	0.1	0.1	0.1	4.6	2.3
RURAL	155	−0.5	0.1	0.7	0.0	0.3	1.0	5.1	6.3
RECLASSIFIED DURING FY 98 ONLY	126	−0.7	0.1	0.3	−0.1	−0.1	0.1	−0.6	−3.6
URBAN	53	−0.8	0.1	0.2	−0.1	−0.3	−0.1	−0.7	−2.9
	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
RURAL	73	−0.3	0.1	0.6	−0.1	0.4	1.0	−0.5	−5.9
FY 99 RECLASSIFICATIONS:									
ALL RECLASSIFIED HOSP	485	−0.5	0.1	0.6	−0.1	0.2	0.7	6.2	1.4
STAND. AMOUNT ONLY	94	−0.6	0.1	0.5	0.0	−0.2	0.3	1.0	−0.7
WAGE INDEX ONLY	281	−0.5	0.1	0.4	−0.1	0.3	0.6	6.9	−1.2
BOTH	47	−0.6	0.2	0.9	−0.2	−0.3	0.5	3.7	−2.2
NONRECLASSIFIED	4,526	−0.7	0.1	0.0	0.0	−0.1	−0.1	−0.4	−0.9
ALL URBAN RECLASS	87	−0.5	0.2	0.3	−0.1	−0.2	0.1	4.8	−0.3
STAND. AMOUNT ONLY	26	−0.4	0.2	1.3	−0.1	−0.3	0.9	0.8	0.1

TABLE I.—IMPACT ANALYSIS OF CHANGES FOR FY 1999 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Percent Changes in Payments Per Case]

	Num. of hosps.[1]	Pac tran. provision[2]	DRG recalib.[3]	New wage Data[4]	Contract phys. pt A Costs[5]	Allocated overhead costs[6]	DRG & WI changes[7]	MGCRB reclassification[8]	All FY 99 changes[9]
	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
NONRECLASSIFIED	2,696	−0.7	0.2	−0.1	0.0	−0.1	−0.2	−0.6	1.3
ALL RURAL RECLASS	398	−0.5	0.1	0.7	−0.1	0.4	1.1	7.0	2.4
STAND. AMOUNT ONLY	55	−0.4	0.1	0.9	−0.1	0.4	1.1	4.8	2.7
WAGE INDEX ONLY	314	−0.5	0.1	0.7	0.0	0.4	1.1	6.9	2.2
BOTH	29	−0.5	0.1	0.8	−0.1	0.3	1.1	10.0	3.8
NONRECLASSIFIED	1,767	−0.3	0.0	0.7	0.0	0.4	0.9	−0.4	0.4
OTHER RECLASSIFIED HOSPITALS (SECTION 1886(d)(8)(B))	27	−0.5	0.1	−0.4	0.0	−0.3	−0.6	1.0	1.1

[1] Because data necessary to classify some hospitals by category are missing, the total number of hospitals in each category may not equal the national total. Discharge data are from FY 1997, and hospital cost report data are from reporting periods beginning in FY 1994 and FY 1995.

[2] This column displays the impact of the change enacted by section 4407 of the BBA, which defines discharges from 1 of 10 DRGs to postacute care as transfers. Under our final policy, 3 of the 10 DRGs will be paid under an alternative methodology where they will receive 50 percent of the full DRG amount on the first day and 50 percent of the current per diem transfer payment amount for each day of the stay. The remaining seven DRGs would be paid using our current transfer payment methodology.

[3] This column displays the payment impact of the recalibration of the DRG weights based on FY 1997 MedPAR data and the DRG classification changes, in accordance with section 1886(d)(4)(C) of the Act.

[4] This column shows the payment effects of updating the data used to calculate the wage index with data from the FY 1995 cost reports.

[5] This column displays the impact of adding contract Part A physician costs to the wage data.

[6] This column illustrates the payment impact of removing the overhead costs allocated to departments where the directly assigned costs are already excluded from the wage index calculation (for example, SNFs and distinct part units).

[7] This column displays the combined impact of the reclassification and recalibration of the DRGs, the updated and revised wage data used to calculate the wage index, and the budget neutrality adjustment factor for these two changes, in accordance with sections 1886(d)(4)(C)(iii) and 1886(d)(3)(E) of the Act. Thus, it represents the combined impacts shown in columns 2, 3, 4, and 5, and the FY 1999 budget neutrality factor of 0.999006.

[8] Shown here are the effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB). The effects shown here demonstrate the FY 1999 payment impact of going from no reclassifications to the reclassifications scheduled to be in effect for FY 1999. Reclassification for prior years has no bearing on the payment impacts shown here.

[9] This column shows changes in payments from FY 1998 to FY 1999. It incorporates all of the changes displayed in columns 1, 6, and 7 (the changes displayed in columns 2, 3, 4 and 5 are included in column 6). It also displays the impact of the FY 1999 update, changes in hospitals' reclassification status in FY 1999 compared to FY 1998, the difference in outlier payments from FY 1998 to FY 1999, and the reductions to payments through the IME and DSH adjustments taking effect during FY 1999. The sum of these columns may be different from the percentage changes shown here due to rounding and interactive effects.

B. Impact of the Implementation of the Expanded Transfer Definition (Column 1)

Section 1886(d)(5)(J) of the Act (added by section 4407 of the BBA) requires the Secretary to select 10 DRGs for which discharges (from any one of these DRGs) to a postacute care provider will be treated as a transfer beginning with discharges on or after October 1, 1998. Column 1 shows the impact of this provision.

Although the expanded definition encompasses only 10 DRGs, they were selected, in accordance with the statute, based upon their large and disproportionate volume of cases receiving postacute care. Therefore, the overall payment impact of this change is significant (a 0.6 percent decrease in payments per case).

The 10 DRGs that we are including under this provision are identified in section IV.A. of the preamble to this final rule. In addition to selecting 10 DRGs, the statute authorizes the Secretary to develop an alternative transfer payment methodology for DRGs where a substantial portion of the costs of the cases occur very early in the stay. This is particularly likely to happen in some surgical DRGs because of the high cost of the surgical procedure. Based on our analysis comparing the costs per case for these cases with payments under our current transfer payment methodology, we will pay the current transfer per diem for all DRGs except DRGs 209, 210, and 211. For those three DRGs, the alternative payment methodology is 50 percent of the full DRG payment amount, plus 50 percent of the current per diem transfer payment for each day of the stay, up to the full DRG payment.

To simulate the impact of these final policies, we adjusted hospitals' transfer-adjusted discharges and case-mix index values (using version 15 of the GROUPER) to reflect the impact of this expansion in the transfer definition. The transfer-adjusted discharge fraction is calculated one of two ways, depending on the transfer payment methodology. Under our current transfer payment methodology, and for all but the three DRGs receiving special payment consideration, this adjustment is made simply by adding one to the length of stay and dividing that amount by the geometric mean length of stay for the DRG (with the resulting fraction not to exceed 1.0). For example, a transfer after 3 days from a DRG with a geometric mean length of stay of 6 days would have a transfer-adjusted discharge fraction of 0.667 ((3+1)/6).

For transfers from any one of the three DRGs receiving the alternative payment methodology, the transfer-adjusted discharge fraction is 0.5 (to reflect that these cases receive half the full DRG amount the first day), plus one-half of the result of dividing one plus the length of stay prior to transfer by the geometric mean length of stay for the DRG. As with the above adjustment, the result is equal to the lesser of the transfer-adjusted discharge fraction or 1.

The transfer-adjusted case-mix index values are calculated by summing the transfer-adjusted DRG weights and dividing by the transfer-adjusted discharges. The transfer-adjusted DRG weights are calculated by multiplying the DRG weight by the lesser of 1 or the transfer-adjusted discharge fraction for the case, divided by the geometric mean length of stay for the DRG. In this way, simulated payments per case can be compared before and after the change to the transfer policy.

This change has the greatest impact among urban hospitals (0.7 percent decrease). Among urban hospitals, hospitals with up to 99 beds and those with between 100 and 199 beds are most affected, with 0.8 percent and 0.9 percent reductions in payments, respectively. For urban hospitals grouped by census division, the Middle Atlantic division has the smallest negative impact, a 0.4 percent decrease. The Middle Atlantic division has traditionally had the longest average lengths of stay, therefore, it is reasonable that the impact is smallest here. Transfer cases with a length of stay more than the (geometric) mean length of stay minus one day do not experience any payment impact under this provision. (Full payment is reached one day prior to the mean length of stay due to the double per diem paid for the first day under our current transfer payment methodology.)

Rural hospitals experience a smaller payment impact overall, especially the smallest rural hospitals: those with fewer than 50 beds (a 0.2 percent decrease). The smallest impacts among rural census divisions are in the Middle Atlantic and the Mountain. The largest rural impacts are in the West South Central and the Pacific divisions, and Puerto Rico, all with 0.5 percent decreases. This change is consistent with the shorter lengths of stay in these geographic regions.

The largest negative impact is a 1.0 percent decrease in payments observed among urban West South Central hospitals. The smallest negative impact occurs in SCHs (0.1 percent decrease). Those SCHs paid based on their hospital-specific amount would see no impact related to this change, since there is no transfer adjustment made to the hospital-specific amount.

C. Impact of the Changes to the DRG Classifications and Relative Weights (Column 2)

In column 2 of Table I, we present the combined effects of the DRG reclassifications and recalibration, as discussed in section II of the preamble to this final rule. Section 1886(d)(4)(C)(i) of the Act requires us to annually make appropriate classification changes and to recalibrate the DRG weights in order to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources.

We compared aggregate payments using the FY 1998 DRG relative weights (GROUPER version 15) to aggregate payments using the final FY 1999 DRG relative weights (GROUPER version 16). Overall, payments increase by 0.1 percent due to the DRG changes, although this is prior to applying the budget neutrality factor for DRG and wage index changes (see column 6). Consistent with the minor changes reflected in the FY 1999 GROUPER, the redistributional impacts of DRG reclassifications and recalibration across hospital groups are very small (a 0.2 percent increase for large urban hospitals, and a 0.1 percent increase for other urban hospitals as well as for rural hospitals). Within hospital categories, the net effects for urban hospitals are small positive changes for all hospitals (a 0.2 percent increase for hospitals with between 100 and 299 beds, and a 0.1 percent increase for smaller or larger urban hospitals). Rural hospitals with 100 or more beds experience an increase of 0.1 percent, for smaller rural hospitals, there is no impact (0.0 percent change).

The breakdowns by urban census division show that the increase among urban hospitals is spread across all census categories, with the largest increase (0.3 percent) for hospitals in Puerto Rico. For rural hospitals, there is no impact (that is, a 0.0 percent change) for hospitals in the New England, Middle Atlantic, and Mountain census divisions. The West North Central division experiences a 0.1 percent decrease. All other rural census divisions experience a 0.1 percent increase. The only other hospital category experiencing a negative impact is SCHs, with a 0.1 percent decrease.

This pattern of small increases or no change applies to all other hospital categories. Overall, we attribute this change to the increasing severity of illness of hospital inpatients. That is, as greater numbers of less acutely ill patients are treated outside the inpatient setting, the acuity of the remaining hospital inpatients increases. Although, in the past, this effect was seen more clearly in large urban and very large rural hospitals, which often had more outpatient settings available for patient treatment, hospitals in all areas now appear to be able to take advantage of this practice. Of course, in general, these positive impacts are very minor, with virtually no hospital group experiencing more than a 0.2 percent increase.

D. Impact of Updating the Wage Data (Column 3)

Section 1886(d)(3)(E) of the Act requires that, beginning October 1, 1993, we annually update the wage data used to calculate the wage index. In accordance with this requirement, the wage index for FY 1999 is based on data submitted for hospital cost reporting periods beginning on or after October 1, 1994 and before October 1, 1995. As with the previous column, the impact of the new data on hospital payments is isolated by holding the other payment parameters constant in the two simulations. That is, column 3 shows the percentage changes in payments when going from a model using the FY 1998 wage index based on FY 1994 wage data before geographic reclassifications to a model using the FY 1999 prereclassification wage index based on FY 1995 wage data.

The wage data collected on the FY 1995 cost reports includes, for the first time, contract labor costs and hours for top management positions as allowable in the wage index calculation. In addition, the changes to wage-related costs associated with hospital and home office salaries that were discussed in the September 1, 1994 final rule (59 FR 45355) are reflected in the FY 1995 data. These changes are reflected in column 3, as well as other year-to-year changes in hospitals' labor costs.

The results indicate that the new wage data have no overall impact in hospital payments. Rural hospitals as a category, however, benefit from the update. Their payments increase by 0.7 percent. These increases are attributable to increases above 5 percent in the wage index values for the rural areas of several States.

Urban hospitals as a group are not significantly affected by the updated wage data (a 0.1 percent decrease). The gains of hospitals in other urban areas (0.4 percent increase) are offset by decreases among hospitals in large urban areas (0.4 percent decrease). The negative impact among large urban areas appears to be largely due to three large urban MSAs with decreases of greater than 6 percent in their wage index values due to the FY 1995 data.

Among urban census divisions, New England experiences the largest decline, 1.1 percent. This is primarily attributable to a 2.0 percent decline in the Boston MSA's wage index. The negative impact in the Pacific division is associated with three MSAs that have a 7 percent decline in their wage index. On the other hand, in urban Puerto Rico, two MSAs had increases of more than 10 percent.

The largest increases are in the rural census divisions. Rural Puerto Rico experiences the greatest positive impact, 2.3 percent. Hospitals in two other census divisions receive positive increases of at least 1.0 percent; East South Central at 1.3 percent, and New England at 1.0 percent. We believe these positive impacts of the new wage data for rural hospitals stem from the expansion of the contract labor definition, specifically the inclusion certain management categories. On average, the hourly cost of contract labor increased for rural hospitals by 5.9 percent. Among urban hospitals, the increase was 4.2 percent.

E. Impact of Including Contract Physician Part A Costs (Column 4)

As discussed in section III.C.1 of the preamble, we began collecting separate wage data for both direct and contract physician Part A services on the FY 1995 cost report. This change was made in order to address any potential inequity of including only salaried Part A physician costs in the wage index while some States had laws prohibiting their hospitals from employing physicians directly (forcing hospitals to contract with physicians for administrative services). We are including contract physician Part A costs in the wage index calculation.

Column 4 shows the payment impacts of including these data. Although only two States currently maintain the prohibition against hospitals directly employing physicians (Texas and California), many hospitals in other States reported these costs as well. Thus, the impacts of this final change extend well beyond Texas and California.

In general, most hospital categories experience either no changes due to this final policy, or small (0.1 percent) increases or decreases. Urban hospitals in the West South Central census division (which includes Texas) have a 0.3 percent increase. Hospitals in the Pacific division (which includes California) have a decrease of 0.2 percent overall in their wage index.

The MSA with the greatest increase due to this change is Galveston-Texas City, TX. Although hospitals in this MSA experience a drop in their wage index due to the use of FY 1995 data, much of that decrease is recovered by a 12 percent increase resulting from the inclusion of contract physician Part A costs. Two California MSAs experience increases in their wage indexes of at least 1.0 percent: Stockton-Lodi and Fresno.

F. Impact of Removing Overhead Costs of Excluded Areas (Column 5)

Prior years' wage index calculations have removed the direct wages and hours associated with certain subprovider components excluded from the prospective payment system; however, the overhead costs associated with these excluded components have not been removed. We revised the FY 1995 cost report to allow hospitals to report separately overhead salaries and hours, and for the FY 1999 wage index we are removing the overhead costs and hours allocated to areas of the hospital excluded from the wage index calculation.

Column 5 displays the impacts on FY 1999 payments per case of implementing this change. The overall payment impact is 0.0 percent; however, the impact diverges along urban and rural lines. Urban hospitals lose 0.1 percent as a result of removing these overhead costs, while rural hospitals gain 0.4 percent.

Hospitals in the rural West North Central census division experience the largest percentage increase (0.7 percent). All the rural Statewide wage indexes increased in this census division, led by Minnesota (3.2 percent) and South Dakota (2.4 percent).

The combined wage index changes in Table I are determined by summing the individual impacts in columns 3, 4, and 5. For example, the rural West North Central census division gains 0.9 percent from the new wage data, and 0.7 percent from removing the overhead costs allocated to

excluded areas. Therefore, the combined impact of the FY 1999 wage index for these hospitals is a 1.6 percent increase.

The following chart compares the shifts in wage index values for labor market areas for FY 1999 relative to FY 1998. This chart demonstrates the impact of the changes for the FY 1999 wage index relative to the FY 1998 wage index. The majority of labor market areas (305) experience less than a 5 percent change. A total of 38 labor market areas experience an increase of more than 5 percent, with 9 having an increase greater than 10 percent. A total of 28 areas (all urban) experience decreases of more than 5 percent, although, of those, all decline by less than 10 percent.

Percentage change in area wage index values	Number of labor market areas	
	FY 1998	FY 1999
Increase more than 10 percent	2	9
Increase more than 5 percent and less than 10 percent	24	29
Increase or decrease less than 5 percent	334	305
Decrease more than 5 percent and less than 10 percent	9	28
Decrease more than 10 percent	1	0

Among urban hospitals, 129 would experience an increase of more than 5 percent and 23 more than 10 percent. More rural hospitals have increases greater than 5 percent (355), but none greater than 10 percent. On the negative side, 186 urban hospitals but no rural hospitals have decreases in their wage index values of at least 5 percent (none have decreases greater than 10 percent). The following chart shows the impact for urban and rural hospitals.

Percentage change in area wage index values	Number of hospitals	
	Urban	Rural
Increase more than 10 percent	23	0
Increase more than 5 percent and less than 10 percent	129	355
Increase or decrease less than 5 percent	2472	1810
Decrease more than 5 percent and less than 10 percent	186	0
Decrease more than 10 percent	0	0

G. Combined Impact of DRG and Wage Index Changes—Including Budget Neutrality Adjustment (Column 6)

The impact of DRG reclassifications and recalibration on aggregate payments is required by section 1886(d)(4)(C)(iii) of the Act to be budget neutral. In addition, section 1886(d)(3)(E) of the Act specifies that any updates or adjustments to the wage index are to be budget neutral. As noted in the Addendum to this final rule, we compared aggregate payments using the FY 1998 DRG relative weights and wage index to aggregate payments using the FY 1999 DRG relative weights and wage index. Based on this comparison, we computed a wage and recalibration budget neutrality factor of 0.999006. In Table I, the combined overall impacts of the effects of both the DRG reclassifications and recalibration and the updated wage index are shown in column 6. The 0.0 percent impact for All Hospitals demonstrates that these changes, in combination with the budget neutrality factor, are budget neutral.

For the most part, the changes in this column are the sum of the changes in columns 2, 3, 4, and 5, minus approximately 0.1 percent attributable to the budget neutrality factor. There may, of course, be some variation of plus or minus 0.1 percent due to rounding.

H. Impact of MGCRB Reclassifications (Column 7)

Our impact analysis to this point has assumed hospitals are paid on the basis of their actual geographic location (with the exception of ongoing policies that provide that certain hospitals receive payments on bases other than where they are geographically located, such as hospitals in rural counties that are deemed urban under section 1886(d)(8)(B) of the Act). The changes in column 7 reflect the per case payment impact of moving from this baseline to a simulation incorporating the MGCRB decisions for FY 1999. As noted below, these decisions affect hospitals' standardized amount and area wage index assignments. In addition, rural hospitals may be reclassified for purposes of receiving a higher DSH adjustment.

Beginning in 1998, by February 28 of each year, the MGCRB makes reclassification determinations that will be effective for the next fiscal year, which begins on October 1. (In previous years, these determinations were made by March 30.) The MGCRB may approve a hospital's reclassification request for the purpose of using the other area's standardized amount, wage index value, or both. For FYs 1999 through 2001, a hospital may reclassify for purposes of qualifying for a DSH adjustment or to receive a higher DSH payment.

The FY 1999 final wage index values incorporate all of the MGCRB's reclassification decisions for FY 1999. The wage index values also reflect all decisions made by the HCFA Administrator through the appeals and review process. The overall effect of geographic reclassification is required by section 1886(d)(8)(D) of the Act to be budget neutral. Therefore, we applied an adjustment of 0.993433 to ensure that the effects of reclassification are budget neutral. (See section II.A.4 of the Addendum to this final rule.)

As a group, rural hospitals benefit from geographic reclassification. Their payments rise 2.7 percent, while payments to urban hospitals decline 0.4 percent. Hospitals in other urban areas see a decrease in payments of 0.4 percent, while large urban hospitals lose 0.5 percent. Among urban hospital groups (that is, bed size, census division, and special payment status), payments generally decline.

A positive impact is evident among all rural hospital groups except the smallest hospitals (under 50 beds), which experience no payment impact overall. The smallest increase among the rural census divisions is 1.4 percent for New England. The largest increase is in rural South Atlantic, with an increase of 3.8 percent.

Among rural hospitals designated as RRCs, 116 hospitals are reclassified for purposes of the wage index only, leading to the 6.4 percent increase in payments among RRCs overall. This positive impact on RRCs is also reflected in the category of rural hospitals with 200 or more beds, which has a 5.3 percent increase in payments.

Rural hospitals reclassified for FY 1998 and FY 1999 experience a 8.3 percent increase in payments. This may be due to the fact that these hospitals have the most to gain from reclassification and have been reclassified for a period of years. Rural hospitals reclassified for FY 1999 only experience a 5.1 percent increase in payments, while rural hospitals reclassified for FY 1998 only experience a 0.5 percent decrease in payments. Urban hospitals reclassified for FY 1998 but not FY 1999 experience a 0.7 percent decline in payments overall. Urban hospitals reclassified for FY 1999 but not for FY 1998 experience a 4.6 percent increase in payments.

The FY 1999 Reclassification rows of Table I show the changes in payments per case for all FY 1999 reclassified and nonreclassified hospitals in urban and rural locations for each of the three reclassification categories (standardized amount only, wage index only, or both). The table illustrates that the largest impact for reclassified rural hospitals is for those hospitals reclassified for both the standardized amount and the wage index. These hospitals receive a 10.0 percent increase in payments. In addition, rural hospitals reclassified just for the wage index receive a 6.9 percent payment increase. The overall impact on reclassified hospitals is to increase their payments per case by an average of 6.2 percent for FY 1999.

Among the 27 rural hospitals deemed to be urban under section 1886(d)(8)(B) of the Act, payments increase 1.0 percent due to MGCRB reclassification. This is because, although these hospitals are treated as being attached to an urban area in our baseline (their redesignation is ongoing, rather than annual like the MGCRB reclassifications), they are eligible for MGCRB reclassification. For FY 1999, one hospital in this category reclassified to a large urban area.

The reclassification of hospitals primarily affects payment to nonreclassified hospitals through changes in the wage index and the geographic reclassification budget neutrality adjustment required by section 1886(d)(8)(D) of the Act. Among hospitals that are not reclassified, the overall impact of hospital reclassifications is an average decrease in payments per case of about 0.4 percent. Urban nonreclassified hospitals decrease slightly more, experiencing a 0.6 percent decrease (roughly the amount of the budget neutrality offset).

The number of reclassifications for purposes of the standardized amount, or for

both the standardized amount and the wage index, has decreased from 149 in FY 1998 to 141 in FY 1999. The number of wage index only reclassifications decreased from 284 in FY 1998 to 281 in FY 1999.

I. All Changes (Column 8)

Column 8 compares our estimate of payments per case, incorporating all changes reflected in this final rule for FY 1999 (including statutory changes), to our estimate of payments per case in FY 1998. It includes the effects of the 0.5 percent update to the standardized amounts and the hospital-specific rates for SCHs and MDHs. It also reflects the 0.3 percentage point difference between the projected outlier payments in FY 1999 (5.1 percent of total DRG payments) and the current estimate of the percentage of actual outlier payments in FY 1998 (5.4 percent), as described in the introduction to this Appendix and the Addendum to this final rule.

Additional changes affecting the difference between FY 1998 and FY 1999 payments are the reductions to the IME and DSH adjustments enacted by the BBA. These changes initially went into effect during FY 1998 and include additional decreases in payment for each of several succeeding years. As noted in the introduction to this impact analysis, for FY 1999, IME is reduced to approximately a 6.5 percent rate of increase, and DSH is reduced by 2 percent from what hospitals otherwise would receive. We estimate the overall effect of these statutory changes to be a 0.5 percent reduction in FY 1999 payments relative to FY 1998. For hospitals receiving both IME and DSH, the impact is estimated to be a 0.9 percent reduction in payments per case.

Column 8 also includes the impacts of FY 1999 MGCRB reclassifications compared to the payment impacts of FY 1998 reclassifications. Therefore, when comparing FY 1999 payments to FY 1998, the percent changes due to FY 1999 reclassifications shown in column 7 need to be offset by the effects of reclassification on hospitals' FY 1998 payments (column 7 of Table 1, August 29, 1997 final rule with comment period; 62 FR 46119). For example, the impact of MGCRB reclassifications on rural hospitals' FY 1998 payments was approximately a 2.2 percent increase, offsetting much of the 2.7 percent increase in column 7 for FY 1999. Therefore, the net change in FY 1999 payments due to reclassification for rural hospitals is actually closer to an increase of 0.5 percent relative to FY 1998. However, last year's analysis contained a somewhat different set of hospitals, so this might affect the numbers slightly.

There might also be interactive effects among the various factors comprising the payment system that we are not able to isolate. For these reasons, the values in column 8 may not equal the sum of the changes in columns 1, 6, and 7, plus the other impacts that we are able to identify.

The overall payment change from FY 1998 to FY 1999 for all hospitals is a 1.0 percent decrease. This reflects the 0.6 percent net change in total payments due to the postacute transfer change for FY 1999 shown in column 1; the 0.5 percent update for FY 1999, the 0.3 percent lower outlier payments in FY 1999 compared to FY 1998 (5.1 percent compared to 5.4 percent); and the 0.5 percent reduction due to lower IME and DSH payments.

Hospitals in urban areas experience a 1.3 percent drop in payments per case compared to FY 1998. Urban hospitals lose 0.9 percent due to the combined effects of the expanded transfer definition and the DRG and wage index changes. The 0.4 percent negative impact due to reclassification is offset by an identical negative impact for FY 1998. The impact of reducing IME and DSH is a 0.5 percent reduction in FY 1999 payments per case. Most of this negative impact is incurred by hospitals in large urban areas, where payments are expected to fall 1.7 percent per case compared to 0.7 percent per case for hospitals in other urban areas.

Hospitals in rural areas, meanwhile, experience a 1.3 percent payment increase. As discussed previously, this is primarily due to a smaller negative impact due to the expanded transfer definition (0.4 percent decrease compared to 0.6 percent nationally) and the positive effect due to the wage index and DRG changes (1.0 percent increase).

Among census divisions, urban New England displays the largest negative impact, 2.6 percent. This outcome is primarily related to the 1.1 percent decrease due to the new wage data. Similarly, urban East North Central experiences a 2.2 percent drop in payments per case, due to a 0.9 percent drop due to the combined wage index and DRG changes. The urban Pacific and the urban West South Central also experience overall larger payment declines, with 2.0 and 1.6 percent decreases, respectively. The urban West North Central has the smallest negative change among urban census divisions (0.1 percent), stemming primarily from a 1.0 percent increase due to the DRG and wage index changes. Hospitals in this census division also are less reliant on IME and DSH funding, and are, therefore, impacted less by these reductions.

The only rural census division to experience a negative payment impact is New England (0.3 percent decrease). This appears to result from a much smaller reclassification effect for rural New England hospitals in FY 1999. For FY 1998, the impact of MGCRB reclassification for these hospitals was a 2.1 percent increase (see 62 FR 46119). For FY 1999, the increase is only 1.4 percent. The largest increases by a rural census division are in the South Atlantic and the East South Central, with 1.8 and 1.7 percent increases, respectively. In the South Atlantic, this is primarily due to a larger FY 1999 benefit from MGCRB reclassifications. For the East South Central, it is largely due to a 1.3 percent increase from the FY 1995 wage data.

Among special categories of rural hospitals, RRCs have the largest increase, 2.2 percent. This carries over to other categories as well: rural hospitals with between 150 and 200 beds have a 2.5 percent rise in payments (there are 37 RRCs in this category); and RRCs receiving DSH see a 2.5 percent increase.

The largest negative payment impacts from FY 1998 to FY 1999 are among hospitals that were reclassified for FY 1998 and are not reclassified for FY 1999. Overall, these hospitals lose 3.6 percent. The urban hospitals in this category lose 2.9 percent, while the rural hospitals lose 5.9 percent. On the other hand, hospitals reclassified for FY 1999 that were not reclassified for FY 1998 would experience the greatest payment increases: 5.4 percent overall; 6.3 percent for 155 rural hospitals; and 2.3 percent for 15 urban hospitals.

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 1999 OPERATING PROSPECTIVE PAYMENT SYSTEM

[Payments per case]

	Number of hospitals (1)	Average FY 1998 payment per case (2) [1]	Average FY 1999 payment per case (3) [1]	All changes (4)
(BY GEOGRAPHIC LOCATION):				
ALL HOSPITALS	4,975	6,773	6,707	−1.0
URBAN HOSPITALS	2,810	7,342	7,246	−1.3
LARGE URBAN AREAS	1,611	7,891	7,758	−1.7
OTHER URBAN AREAS	1,199	6,589	6,544	−0.7
RURAL AREAS	2,165	4,460	4,517	1.3
BED SIZE (URBAN):				
0–99 BEDS	704	4,931	4,889	−0.9
100–199 BEDS	937	6,128	6,056	−1.2
200–299 BEDS	568	6,934	6,851	−1.2

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 1999 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Payments per case]

	Number of hospitals	Average FY 1998 payment per case	Average FY 1999 payment per case	All changes
	(1)	(2) [1]	(3) [1]	(4)
300–499 BEDS	449	7,846	7,738	−1.4
500 OR MORE BEDS	152	9,743	9,592	−1.6
BED SIZE (RURAL):				
0–49 BEDS	1,137	3,665	3,701	1.0
50–99 BEDS	634	4,176	4,207	0.8
100–149 BEDS	229	4,613	4,662	1.1
150–199 BEDS	91	4,776	4,895	2.5
200 OR MORE BEDS	74	5,610	5,704	1.7
URBAN BY CENSUS DIV:				
NEW ENGLAND	152	7,887	7,682	−2.6
MIDDLE ATLANTIC	425	8,181	8,107	−0.9
SOUTH ATLANTIC	414	6,978	6,948	−0.4
EAST NORTH CENTRAL	476	7,029	6,873	−2.2
EAST SOUTH CENTRAL	162	6,569	6,524	−0.7
	(1)	(2) [1]	(3) [1]	(4)
WEST NORTH CENTRAL	189	7,001	6,996	−0.1
WEST SOUTH CENTRAL	354	6,830	6,720	−1.6
MOUNTAIN	129	7,046	6,971	−1.1
PACIFIC	461	8,409	8,245	−2.0
PUERTO RICO	48	3,065	3,056	−0.3
RURAL BY CENSUS DIV:				
NEW ENGLAND	53	5,305	5,287	−0.3
MIDDLE ATLANTIC	80	4,818	4,881	1.3
SOUTH ATLANTIC	286	4,610	4,694	1.8
EAST NORTH CENTRAL	285	4,496	4,553	1.3
EAST SOUTH CENTRAL	269	4,162	4,235	1.7
WEST NORTH CENTRAL	500	4,178	4,236	1.4
WEST SOUTH CENTRAL	342	3,991	4,017	0.7
MOUNTAIN	204	4,750	4,779	0.6
PACIFIC	141	5,608	5,647	0.7
PUERTO RICO	5	2,374	2,370	−0.2
(BY PAYMENT CATEGORIES):				
URBAN HOSPITALS	2,894	7,299	7,207	−1.3
LARGE URBAN AREAS	1,698	7,798	7,670	−1.6
OTHER URBAN AREAS	1,196	6,570	6,530	−0.6
RURAL AREAS	2,081	4,444	4,494	1.1
TEACHING STATUS:				
NON-TEACHING	3,880	5,468	5,450	−0.3
FEWER THAN 100 RESIDENTS	854	7,228	7,145	−1.1
100 OR MORE RESIDENTS	241	10,974	10,755	−2.0
DISPROPORTIONATE SHARE HOSPITALS (DSH):				
NON-DSH	3,089	5,837	5,799	−0.6
URBAN DSH:				
100 BEDS OR MORE	1,404	7,951	7,843	−1.4
FEWER THAN 100 BEDS	88	5,068	5,007	−1.2
	(1)	(2) [1]	(3) [1]	(4)
RURAL DSH:				
SOLE COMMUNITY (SCH)	162	4,211	4,251	1.0
REFERRAL CENTERS (RRC)	53	5,294	5,428	2.5
OTHER RURAL DSH HOSP:				
100 BEDS OR MORE	60	4,134	4,162	0.7
FEWER THAN 100 BEDS	119	3,553	3,600	1.3
URBAN TEACHING AND DSH:				
BOTH TEACHING AND DSH	709	8,975	8,828	−1.6
TEACHING AND NO DSH	331	7,384	7,291	−1.3
NO TEACHING AND DSH	783	6,318	6,271	−0.7
NO TEACHING AND NO DSH	1,071	5,664	5,612	−0.9
SPECIAL UPDATE HOSPITALS (UNDER SEC. 4401(b) OF PUBLIC LAW 105–33	344	5,276	5,236	−0.8
RURAL HOSPITAL TYPES:				
NONSPECIAL STATUS HOSPITALS	888	3,920	3,947	0.7
RRC	145	5,170	5,286	2.2
SCH	637	4,484	4,502	0.4

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 1999 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Payments per case]

	Number of hospitals	Average FY 1998 payment per case	Average FY 1999 payment per case	All changes
	(1)	(2) [1]	(3) [1]	(4)
MDH	352	3,715	3,753	1.0
SCH AND RRC	59	5,339	5,402	1.2
TYPE OF OWNERSHIP:				
VOLUNTARY	2,858	6,956	6,884	−1.0
PROPRIETARY	671	6,160	6,096	−1.0
GOVERNMENT	1,331	6,243	6,209	−0.5
UNKNOWN	115	7,894	7,811	−1.0
MEDICARE UTILIZATION AS A PERCENT OF INPATIENT DAYS:				
0–25	247	8,931	8,755	−2.0
25–50	1,264	8,254	8,127	−1.5
50–65	1,978	6,170	6,134	−0.6
OVER 65	1,371	5,253	5,241	−0.2
UNKNOWN	115	7,894	7,811	−1.0
HOSPITALS RECLASSIFIED BY THE MEDICARE GEOGRAPHIC REVIEW BOARD:				
RECLASSIFICATION STATUS DURING FY98 AND FY99:				
RECLASSIFIED DURING BOTH FY98 AND FY99	315	5,971	5,944	−0.5
URBAN	72	7,376	7,302	−1.0
RURAL	243	5,258	5,254	−0.1
RECLASSIFIED DURING FY99 ONLY	170	5,149	5,427	5.4
URBAN	15	8,019	8,207	2.3
RURAL	155	4,668	4,960	6.3
RECLASSIFIED DURING FY98 ONLY	126	6,310	6,084	−3.6
URBAN	53	7,218	7,011	−2.9
RURAL	73	4,453	4,188	−5.9
FY 99 RECLASSIFICATIONS:				
ALL RECLASSIFIED HOSP	485	5,683	5,763	1.4
STAND. AMT. ONLY	94	5,940	5,899	−0.7
WAGE INDEX ONLY	281	6,007	5,935	−1.2
BOTH	47	6,407	6,264	−2.2
NONRECLASS	4,526	6,851	6,786	−0.9
ALL URBAN RECLASS	87	7,497	7,472	−0.3
STAND. AMT. ONLY	26	5,630	5,635	0.1
WAGE INDEX ONLY	40	8,874	8,872	0.0
BOTH	21	6,810	6,725	−1.3
NONRECLASS	2,696	7,348	7,249	−1.3
ALL RURAL RECLASS	398	5,016	5,134	2.4
STAND. AMT. ONLY	55	4,374	4,494	2.7
WAGE INDEX ONLY	314	5,083	5,194	2.2
BOTH	29	5,039	5,231	3.8
NONRECLASS	1,767	4,109	4,127	0.4
OTHER RECLASSIFIED HOSPITALS (SECTION 1886(d)(8)(B))	27	4,765	4,714	−1.1

[1] These payment amounts per case do not reflect any estimates of annual case-mix increase.

Table II presents the projected impact on payments per case of the final changes for FY 1999 for urban and rural hospitals and for the different categories of hospitals shown in Table I. It compares the projected payments per case for FY 1999 with the average estimated per case payments for FY 1998, as calculated under our models. Thus, this table presents, in terms of the average dollar amounts paid per discharge, the combined effects of the changes presented in Table I. The percentage changes shown in the last column of Table II equal the percentage changes in average payments from column 8 of Table I.

VIII. Impact of Changes in the Capital Prospective Payment System

A. General Considerations

We now have data that were unavailable in previous impact analyses for the capital prospective payment system. Specifically, we have cost report data available for the fourth year of the capital prospective payment system (cost reports beginning in FY 1995) available through the March 1998 update of the Health Care Provider Cost Report Information System (HCRIS). We also have updated information on the projected aggregate amount of obligated capital approved by the fiscal intermediaries. However, our impact analysis of payment changes for capital-related costs is still limited by the lack of hospital-specific data on several items. These are the hospital's projected new capital costs for each year, its projected old capital costs for each year, and the actual amounts of obligated capital that will be put in use for patient care and recognized as Medicare old capital costs in each year. The lack of this information affects our impact analysis in the following ways:

- Major investment in hospital capital assets (for example in building and major fixed equipment) occurs at irregular intervals. As a result, there can be significant variation in the growth rates of Medicare capital-related costs per case among hospitals. We do not have the necessary hospital-specific budget data to project the hospital capital growth rate for individual hospitals.
- Moreover, our policy of recognizing certain obligated capital as old capital makes it difficult to project future capital-related costs for individual hospitals. Under § 412.302(c), a hospital is required to notify

its intermediary that it has obligated capital by the later of October 1, 1992, or 90 days after the beginning of the hospital's first cost reporting period under the capital prospective payment system. The intermediary must then notify the hospital of its determination whether the criteria for recognition of obligated capital have been met by the later of the end of the hospital's first cost reporting period subject to the capital prospective payment system or 9 months after the receipt of the hospital's notification. The amount that is recognized as old capital is limited to the lesser of the actual allowable costs when the asset is put in use for patient care or the estimated costs of the capital expenditure at the time it was obligated. We have substantial information regarding intermediary determinations of projected aggregate obligated capital amounts. However, we still do not know when these projects will actually be put into use for patient care, the actual amount that will be recognized as obligated capital when the project is put into use, or the Medicare share of the recognized costs. Therefore, we do not know actual obligated capital commitments for purposes of the FY 1999 capital cost projections. In Appendix B of this final rule, we discuss the assumptions and computations that we employ to generate the amount of obligated capital commitments for use in the FY 1999 capital cost projections.

In Table III of this section, we present the redistributive effects that are expected to occur between ''hold-harmless'' hospitals and ''fully prospective'' hospitals in FY 1999. In addition, we have integrated sufficient hospital-specific information into our actuarial model to project the impact of the final FY 1999 capital payment policies by the standard prospective payment system hospital groupings. While we now have actual information on the effects of the transition payment methodology and interim payments under the capital prospective payment system and cost report data for most hospitals, we still need to randomly generate numbers for the change in old capital costs, new capital costs for each year, and obligated amounts that will be put in use for patient care services and recognized as old capital each year. We continue to be unable to predict accurately FY 1999 capital costs for individual hospitals, but with the most recent data hospitals' experience under the capital prospective payment system, there is adequate information to estimate the aggregate impact on most hospital groupings.

B. Projected Impact Based on the Final FY 1999 Actuarial Model

1. Assumptions

In this impact analysis, we model dynamically the impact of the capital prospective payment system from FY 1998 to FY 1999 using a capital cost model. The FY 1999 model, as described in Appendix B of this final rule, integrates actual data from individual hospitals with randomly generated capital cost amounts. We have capital cost data from cost reports beginning in FY 1989 through FY 1995 as reported on the March 1998 update of HCRIS, interim payment data for hospitals already receiving capital prospective payments through PRICER, and data reported by the intermediaries that include the hospital-specific rate determinations that have been made through April 1, 1998 in the provider-specific file. We used these data to determine the final FY 1999 capital rates. However, we do not have individual hospital data on old capital changes, new capital formation, and actual obligated capital costs. We have data on costs for capital in use in FY 1995, and we age that capital by a formula described in Appendix B. Therefore, we need to randomly generate only new capital acquisitions for any year after FY 1995. All Federal rate payment parameters are assigned to the applicable hospital.

For purposes of this impact analysis, the FY 1999 actuarial model includes the following assumptions:

- Medicare inpatient capital costs per discharge will change at the following rates during these periods:

AVERAGE PERCENTAGE CHANGE IN CAPITAL COSTS PER DISCHARGE

Fiscal year	Percentage change
1997	−3.02
1998	−0.46
1999	0.61

We have reduced our estimate of the growth in Medicare costs per discharge from the August 29, 1997 final rule with comment period to this final rule based on later cost data. We are now estimating a much smaller increase in costs per discharge.

- The Medicare case-mix index will increase by 1.0 percent in FY 1998 and FY 1999.
- The Federal capital rate and hospital-specific rate were updated in FY 1996 by an analytical framework that considers changes in the prices associated with capital-related costs, and adjustments to account for forecast error, changes in the case-mix index, allowable changes in intensity, and other factors. The final FY 1999 update for inflation is 0.10 percent (see section IV of the Addendum).

2. Results

We have used the actuarial model to estimate the change in payment for capital-related costs from FY 1998 to FY 1999. Table III shows the effect of the capital prospective payment system on low capital cost hospitals and high capital cost hospitals. We consider a hospital to be a low capital cost hospital if, based on a comparison of its initial hospital-specific rate and the applicable Federal rate, it will be paid under the fully prospective payment methodology. A high capital cost hospital is a hospital that, based on its initial hospital-specific rate and the applicable Federal rate, will be paid under the hold-harmless payment methodology. Based on our actuarial model, the breakdown of hospitals is as follows:

CAPITAL TRANSITION PAYMENT METHODOLOGY FOR FY 1999

Type of hospital	Percent of hospitals	Percent of discharges	Percent of capital costs	Percent of capital payments
Low Cost Hospital	66	62	53	58
High Cost Hospital	34	38	47	42

A low capital cost hospital may request to have its hospital-specific rate redetermined based on old capital costs in the current year, through the later of the hospital's cost reporting period beginning in FY 1994 or the first cost reporting period beginning after obligated capital comes into use (within the limits established in § 412.302(e) for putting obligated capital in to use for patient care). If the redetermined hospital-specific rate is greater than the adjusted Federal rate, these hospitals will be paid under the hold-harmless payment methodology. Regardless of whether the hospital became a hold-harmless payment hospital as a result of a redetermination, we continue to show these hospitals as low capital cost hospitals in Table III.

Assuming no behavioral changes in capital expenditures, Table III displays the percentage change in payments from FY 1998 to FY 1999 using the above described actuarial model. With the final Federal rate, we estimate aggregate Medicare capital payments will increase by 2.78 percent in FY 1999.

TABLE III.—IMPACT OF PROPOSED CHANGES FOR FY 1999 ON PAYMENTS PER DISCHARGE

	Number of hospitals	Discharges	Adjusted Federal payment	Average Federal percent	Hospital specific payment	Hold harmless payment	Exceptions payment	Total payment	Percent change over FY 1998
FY 1998 Payments per Discharge:									
Low Cost Hospitals	3,258	6,777,970	$458.00	72.42	$86.30	$3.85	$8.89	$557.04	.....
Fully Prospective	3,024	6,149,617	441.23	70.00	95.12	.....	7.61	543.95	.....
100% Federal Rate	204	554,222	650.05	100.00	.....	17.77	667.82	.....	
Hold Harmless	30	74,130	413.10	61.17	.....	351.63	49.36	814.09	.....
High Cost Hospitals	1,643	4,203,327	635.31	95.72	.....	37.11	15.30	687.72	.....
100% Federal Rate	1,415	3,748,353	660.94	100.00	.....	.....	10.62	671.56	.....
Hold Harmless	228	454,974	424.09	61.78	.....	342.86	53.86	820.81	.....
Total Hospitals	4,901	10,981,297	525.87	81.61	53.27	16.58	11.35	607.06	.....
FY 1999 Payments per Discharge:									
Low Cost Hospitals	3,258	6,626,732	527.01	81.53	58.33	3.13	9.57	598.04	7.36
Fully Prospective	3,024	6,012,484	515.37	80.00	64.29	.....	8.28	587.94	8.09
100% Federal Rate	207	545,059	663.77	100.00	.....	.....	17.97	681.75	2.09
Hold Harmless	27	69,188	460.62	66.21	.....	300.02	55.73	816.37	0.28
High Cost Hospitals	1,643	4,107,081	656.33	96.98	.....	26.89	20.02	703.24	2.26
100% Federal Rate	1,438	3,730,929	674.49	100.00	.....	.....	14.16	688.65	2.54
Hold Harmless	205	376,151	476.26	68.09	.....	293.59	78.14	847.99	3.31
Total Hospitals	4,901	10,733,812	576.49	87.61	36.01	12.22	13.57	638.29	5.15

We project that low capital cost hospitals paid under the fully prospective payment methodology will experience an average increase in payments per case of 7.36 percent, and high capital cost hospitals will experience an average increase of 2.26 percent.

For hospitals paid under the fully prospective payment methodology, the Federal rate payment percentage will increase from 70 percent to 80 percent and the hospital-specific rate payment percentage will decrease from 30 to 20 percent in FY 1999. The Federal rate payment percentage for hospitals paid under the hold-harmless payment methodology is based on the hospital's ratio of new capital costs to total capital costs. The average Federal rate payment percentage for high cost hospitals receiving a hold-harmless payment for old capital will increase from 61.78 percent to 68.09 percent. We estimate the percentage of hold-harmless hospitals paid based on 100 percent of the Federal rate will increase from 86.3 percent to 87.6 percent. We estimate that high cost hold-harmless hospitals will experience an increase in payments of 3.31 per cent from FY 1998 to FY 1999. This is different from our projection in the proposed rule, which projected a decrease in payments. This change is a result of lower projected capital costs, which means some hospitals who otherwise would have been paid hold-harmless will now receive 100 percent of the federal rate. Since these are the lowest cost hospitals in the hold-harmless grouping, removing these hospitals from the mix increased the average projected hold-harmless payment and, consequently, the average projected total payment.

We expect that the average hospital-specific rate payment per discharge will decrease from $53.27 in FY 1998 to $36.01 in FY 1999. This is partly due to the decrease in the hospital-specific rate payment percentage from 30 percent in FY 1998 to 20 percent in FY 1999.

We are making no changes in our exceptions policies for FY 1999. As a result, the minimum payment levels would be:

- 90 percent for sole community hospitals;
- 80 percent for urban hospitals with 100 or more beds and a disproportionate share patient percentage of 20.2 percent or more; or
- 70 percent for all other hospitals.

We estimate that exceptions payments will be 2.13 percent of the total capital payments in FY 1999. Since the August 29, 1997 final rule with comment period, we have reduced our estimates of capital cost per case based on more recent data. Although we still estimate that more hospitals will receive exceptions payment in FY 1999 than in FY 1998 fewer hospitals will have costs over the exceptions threshold then we previously estimated. The projected distribution of the eligible hospitals and exception payments is shown in the table below:

ESTIMATED FY 1999 EXCEPTIONS PAYMENTS

Type of hospital	Number of hospitals	Percent of exceptions payments
Low Capital Cost	185	44
High Capital Cost	215	56
Total	400	100

C. Cross-Sectional Comparison of Capital Prospective Payment Methodologies

Table IV presents a cross-sectional summary of hospital groupings by capital prospective payment methodology. This distribution is generated by our actuarial model.

TABLE IV.—DISTRIBUTION BY METHOD OF PAYMENT (HOLD-HARMLESS/FULLY PROSPECTIVE) OF HOSPITALS RECEIVING CAPITAL PAYMENTS

	(1) Total No. of Hospitals	(2) Hold-harmless		(3) Percentage paid fully prospective rate
		Percentage paid hold-harmless (A)	Percentage paid fully federal (B)	
By Geographic Location:				
All hospitals	4,901	4.7	33.6	61.7
Large urban areas (populations over 1 million)	1,574	5.4	41.1	53.5
Other urban areas (populations of 1 million of fewer)	1,178	5.4	41.6	53.0

TABLE IV.—DISTRIBUTION BY METHOD OF PAYMENT (HOLD-HARMLESS/FULLY PROSPECTIVE) OF HOSPITALS RECEIVING CAPITAL PAYMENTS—Continued

	(1) Total No. of Hospitals	(2) Hold-harmless		(3) Percentage paid fully prospective rate
		Percentage paid hold-harmless (A)	Percentage paid fully federal (B)	
Rural areas	2,149	3.9	23.6	72.5
Urban hospitals	2,752	5.4	41.3	53.3
0–99 beds	656	5.3	34.8	59.9
100–199 beds	929	7.3	47.0	45.6
200–299 beds	567	5.5	41.4	53.1
300–499 beds	448	1.8	40.8	57.4
500 or more beds	152	4.6	35.5	59.9
Rural hospitals	2,149	3.9	23.6	72.5
0–49 beds	1,124	3.6	15.7	80.6
50–99 beds	632	4.6	28.5	66.9
100–149 beds	229	3.1	39.7	57.2
150–199 beds	90	5.6	26.7	67.8
200 or more beds	74	1.4	48.6	50.0
By Region:				
Urban by Region	2,752	5.4	41.3	53.3
New England	151	0.0	27.8	72.2
Middle Atlantic	421	5.0	33.3	61.8
South Atlantic	409	5.1	53.8	41.1
East North Central	472	4.7	31.4	64.0
East South Central	157	7.0	52.2	40.8
West North Central	183	6.6	36.1	57.4
West South Central	334	12.0	57.2	30.8
Mountain	125	4.8	52.0	43.2
Pacific	452	3.3	37.6	59.1
Puerto Rico	48	2.1	27.1	70.8
Rural by Region	2,149	3.9	23.6	72.5
New England	53	0.0	22.6	77.4
Middle Atlantic	79	5.1	24.1	70.9
South Atlantic	282	2.5	33.0	64.5
East North Central	283	3.2	19.1	77.7
East South Central	267	0.7	35.2	64.0
West North Central	498	3.4	16.3	80.3
West South Central	339	3.5	28.0	68.4
Mountain	203	11.3	14.3	74.4
Pacific	140	6.4	22.1	71.4
Large urban areas (populations over 1 million)	1,661	5.5	40.9	53.6
Other urban areas (populations of 1 million of fewer)	1,175	5.1	41.8	53.1
Rural areas	2,065	3.9	23.0	73.1
Teaching Status:				
Non-teaching	3,809	4.8	33.1	62.1
Fewer than 100 Residents	852	4.9	35.7	59.4
100 or more Residents	240	2.9	32.9	64.2
Disproportionate share hospitals (DSH):				
Non-DSH	3,030	5.1	29.2	65.6
Urban DSH:				
100 or more beds	1,398	4.6	44.1	51.3
Less than 100 beds	82	2.4	26.8	70.7
Rural DSH:				
Sole Community (SCH/EACH)	162	4.3	22.8	72.8
Referral Center (RRC/EACH)	53	3.8	49.1	47.2
Other Rural:				
100 or more beds	60	1.7	40.0	58.3
Less than 100 beds	116	0.0	28.4	71.6
Urban teaching and DSH:.				
Both teaching and DSH	707	3.8	36.8	59.4
Teaching and no DSH	330	6.1	32.1	61.8
No teaching and DSH	773	5.0	49.0	45.9
No teaching and no DSH	1,026	6.3	41.5	52.1
Rural Hospital Types:				
Non special status hospitals	875	1.7	24.2	74.1
RRC/EACH	145	1.4	39.3	59.3
SCH/EACH	636	8.8	19.5	71.7
Medicare-dependent hospitals (MDH)	350	0.9	18.0	81.1

TABLE IV.—DISTRIBUTION BY METHOD OF PAYMENT (HOLD-HARMLESS/FULLY PROSPECTIVE) OF HOSPITALS RECEIVING CAPITAL PAYMENTS—Continued

	(1) Total No. of Hospitals	(2) Hold-harmless		(3) Percentage paid fully prospective rate
		Percentage paid hold-harmless (A)	Percentage paid fully federal (B)	
SCH, RRC and EACH	59	8.5	30.5	61.0
Type of Ownership:				
Voluntary	2,848	4.7	33.1	62.2
Proprietary	658	8.2	60.2	31.6
Government	1,329	3.2	21.1	75.6
Medicare Utilization as a Percent of Inpatient Days:				
0–25	237	3.8	32.1	64.1
25–50	1,259	5.3	41.5	53.1
50–65	1,972	5.3	33.4	61.4
Over 65	1,367	3.7	26.5	69.8

As we explain in Appendix B, we were not able to determine a hospital-specific rate for 74 of the 4,975 hospitals in our database. Consequently, the payment methodology distribution is based on 4,901 hospitals. These data should be fully representative of the payment methodologies that will be applicable to hospitals.

The cross-sectional distribution of hospital by payment methodology is presented by: (1) Geographic location, (2) region, and (3) payment classification. This provides an indication of the percentage of hospitals within a particular hospital grouping that will be paid under the fully prospective payment methodology and the hold-harmless payment methodology.

The percentage of hospitals paid fully Federal (100 percent of the Federal rate) as hold-harmless hospitals is expected to increase to 33.6 percent in FY 1999. We note that the number of hospitals paid fully Federal as hold-harmless hospitals has not increased as quickly as we predicted in the August 29, 1997 final rule with comment period because of revised estimates.

Table IV indicates that 61.7 percent of hospitals will be paid under the fully prospective payment methodology. (This figure, unlike the figure of 66 percent for low cost capital hospitals in the previous section, takes account of the effects of redeterminations. In other words, this figure does not include low cost hospitals that, following a hospital-specific rate redetermination, are now paid under the hold-harmless methodology.) As expected, a relatively higher percentage of rural and governmental hospitals (72.5 percent and 75.6 percent, respectively by payment classification) are being paid under the fully prospective methodology. This is a reflection of their lower than average capital costs per case. In contrast, only 31.6 percent of proprietary hospitals are being paid under the fully prospective methodology. This is a reflection of their higher than average capital costs per case. (We found at the time of the August 30, 1991 final rule (56 FR 43430) that 62.7 percent of proprietary hospitals had a capital cost per case above the national average cost per case.)

D. Cross-Sectional Analysis of Changes in Aggregate Payments

We used our FY 1999 actuarial model to estimate the potential impact of our final changes for FY 1999 on total capital payments per case, using a universe of 4,901 hospitals. The individual hospital payment parameters are taken from the best available data, including: the April 1, 1998 update to the provider-specific file, cost report data, and audit information supplied by intermediaries. In Table V we present the results of the cross-sectional analysis using the results of our actuarial model and the aggregate impact of the FY 1999 payment policies. Columns 3 and 4 show estimates of payments per case under our model for FY 1998 and FY 1999. Column 5 shows the total percentage change in payments from FY 1998 to FY 1999. Column 6 presents the percentage change in payments that can be attributed to Federal rate changes alone.

Federal rate changes represented in Column 6 include the 1.8 percent increase in the Federal rate, a 1.0 percent increase in case mix, changes in the adjustments to the Federal rate (for example, the effect of the new hospital wage index on the geographic adjustment factor), and reclassifications by the MGCRB. Column 5 includes the effects of the Federal rate changes represented in Column 6. Column 5 also reflects the effects of all other changes, including: the change from 70 percent to 80 percent in the portion of the Federal rate for fully prospective hospitals, the hospital-specific rate update, changes in the proportion of new to total capital for hold-harmless hospitals, changes in old capital (for example, obligated capital put in use), hospital-specific rate redeterminations, and exceptions. The comparisons are provided by: (1) Geographic location, (2) region, and (3) payment classification.

The simulation results show that, on average, capital payments per case can be expected to increase 5.1 percent in FY 1999. The results show that the effect of the Federal rate changes alone is to increase payments by 1.8 percent. In addition to the increase attributable to the Federal rate changes, a 3.3 percent increase is attributable to the effects of all other changes.

Our comparison by geographic location shows that urban and rural hospitals will experience slightly different rates of increase in capital payments per case (4.9 percent and 6.7 percent, respectively). This difference is due to the lower rate of increase for urban hospitals relative to rural hospitals (1.6 percent and 3.4 percent, respectively) from the Federal rate changes alone. Urban hospitals will gain approximately the same as rural hospitals (3.3 percent for both) from the effects of all other changes.

All regions are estimated to receive increases in total capital payments per case, partly due to the increased share of payments that are based on the Federal rate (from 70 to 80 percent). Changes by region vary from a low of 4.0 percent increase (West South Central urban region) to a high of 8.6 percent increase (Middle Atlantinc Rural Region).

By type of ownership, government hospitals are projected to have the largest rate of increase (6.6 percent, 2.2 percent due to Federal rate changes and 4.4 percent from the effects of all other changes). Payments to voluntary hospitals will increase 5.2 percent (a 1.8 percent increase due to Federal rate changes and a 3.4 percent increase from the effects of all other changes) and payments to proprietary hospitals will increase 3.1 percent (a 1.5 percent increase due to Federal rate changes and a 1.6 percent increase from the effects of all other changes).

Section 1886(d)(10) of the Act established the MGCRB. Hospitals may apply for reclassification for purposes of the standardized amount, wage index, or both and for purposes of DSH, for FY 1999–2001. Although the Federal capital rate is not affected, a hospital's geographic classification for purposes of the operating standardized amount does affect a hospital's capital payments as a result of the large urban adjustment factor and the disproportionate share adjustment for urban hospitals with 100 or more beds. Reclassification for wage index purposes affects the geographic adjustment factor since that factor is constructed from the hospital wage index.

To present the effects of the hospitals being reclassified for FY 1999 compared to the effects of reclassification for FY 1998, we show the average payment percentage increase for hospitals reclassified in each fiscal year and in total. For FY 1999 reclassifications, we indicate those hospitals reclassified for standardized amount purposes only, for wage index purposes only, and for both purposes. The reclassified groups are compared to all other nonreclassified hospitals. These categories are further identified by urban and rural designation.

Hospitals reclassified for FY 1999 as a whole are projected to experience a 7.1 percent increase in payments (a 3.8 percent increase attributable to Federal rate changes and a 3.3 percent increase attributable to the effects of all other changes). Payments to nonreclassified hospitals will increase slightly less (6.2 percent) than reclassified hospitals (7.1 percent) overall. Payments to nonreclassified hospitals will increase less than reclassified hospitals from the Federal rate changes (1.9 percent compared to 3.8 percent), but they will gain about the same from the effects of all other changes (3.3 percent for both).

TABLE V.—COMPARISON OF TOTAL PAYMENTS PER CASE

[FY 1998 Payments Compared to FY 1999 Payments]

	Number of hospitals	Average FY 1998 payments/case	Average FY 1999 payments/case	All changes	Portion attributable to Federal rate change
By Geographic Location:					
All hospitals	4,901	607	638	5.1	1.8
Large urban areas (populations over 1 million)	1,574	700	733	4.7	1.4
Other urban areas (populations of 1 million or fewer).	1,178	596	628	5.3	1.9
Rural areas	2,149	406	433	6.7	3.4
Urban hospitals	2,752	656	688	4.9	1.6
0–99 beds	656	482	502	4.3	1.5
100–199 beds	929	581	606	4.4	1.5
200–299 beds	567	626	655	4.8	1.6
300–499 beds	448	682	718	5.4	1.6
500 or more beds	152	830	872	5.1	1.6
Rural hospitals	2,149	406	433	6.7	3.4
0–49 beds	1,124	323	346	7.2	3.0
50–99 beds	632	389	413	6.2	2.8
100–149 beds	229	423	450	6.4	3.2
150–199 beds	90	437	468	7.2	4.2
200 or more beds	74	499	534	7.0	4.1
By Region:					
Urban by Region	2,752	656	688	4.9	1.6
New England	151	663	700	5.7	0.9
Middle Atlantic	421	711	747	5.1	2.0
South Atlantic	409	642	674	5.0	2.3
East North Central	472	615	646	4.9	0.9
East South Central	157	602	626	4.0	1.4
West North Central	183	638	677	6.1	2.6
West South Central	334	664	691	4.0	1.2
Mountain	125	684	715	4.6	1.5
Pacific	452	717	752	4.9	1.1
Puerto Rico	48	272	286	5.5	2.6
Rural by Region	2,149	406	433	6.7	3.4
New England	53	474	505	6.3	2.4
Middle Atlantic	79	427	463	8.6	3.9
South Atlantic	282	437	467	7.0	3.7
East North Central	283	402	431	7.2	3.5
East South Central	267	376	400	6.3	3.5
West North Central	498	387	410	6.0	3.4
West South Central	339	372	394	6.1	2.8
Mountain	203	421	442	4.9	2.3
Pacific	140	466	501	7.3	3.0
By Payment Classification:					
All hospitals	4,901	607	638	5.1	1.8
Large urban areas (populations over 1 million)	1,661	693	725	4.7	1.4
Other urban areas (populations of 1 million or fewer).	1,175	594	626	5.4	2.0
Rural areas	2,065	404	430	6.5	3.2
Teaching Status:					
Non-teaching	3,809	513	538	4.9	2.0
Fewer than 100 Residents	852	643	678	5.5	1.7
100 or more Residents	240	897	944	5.2	1.5
Urban DSH:					
100 or more beds	1,398	690	725	5.0	1.6
Less than 100 beds	82	457	475	3.9	1.0
Rural DSH:					
Sole Community (SCH/EACH)	162	362	379	4.7	2.7
Referral Center (RRC/EACH)	53	472	507	7.4	4.6
Other Rural:					
100 or more beds	60	378	397	5.1	2.8
Less than 100 beds	116	318	339	6.5	3.4

TABLE V.—COMPARISON OF TOTAL PAYMENTS PER CASE—Continued

[FY 1998 Payments Compared to FY 1999 Payments]

	Number of hospitals	Average FY 1998 payments/case	Average FY 1999 payments/case	All changes	Portion attributable to Federal rate change
Urban teaching and DSH:					
Both teaching and DSH	707	759	799	5.2	1.6
Teaching and no DSH	330	662	701	5.8	1.6
No teaching and DSH	773	580	607	4.7	1.8
No teaching and no DSH	1,026	554	576	3.9	1.6
Rural Hospital Types:					
Nonspecial status hospitals	875	368	391	6.1	2.7
RRC/EACH	145	469	503	7.3	4.3
SCH/EACH	636	390	412	5.9	2.3
Medicare-dependent hospitals (MDH)	350	323	352	9.0	3.7
SCH, RRC and EACH	59	499	526	5.5	3.2
Hospitals Reclassified by the Medicare Geographic Classification:					
Review Board:					
Reclassification Status During FY98 and FY99:					
Reclassified During Both FY98 and FY99	315	541	568	5.0	1.9
Reclassified During FY99 Only	170	466	521	11.8	7.8
Reclassified During FY98 Only	106	598	607	1.6	−1.4
FY99 Reclassifications:					
All Reclassified Hospitals	485	515	551	7.1	3.8
All Nonreclassified Hospitals	4,453	613	645	5.2	1.9
All Urban Reclassified Hospitals	87	651	695	6.7	2.3
Urban Nonreclassified Hospitals	2,638	657	689	4.9	1.6
All Reclassified Rural Hospitals	398	464	498	7.4	4.5
Rural Nonreclassified Hospitals	1,751	369	392	6.1	2.4
Other Reclassified Hospitals (Section 1886(D)(8)(B))	27	470	492	4.6	1.3
Type of Ownership:					
Voluntary	2,848	621	654	5.2	1.8
Proprietary	658	612	631	3.1	1.5
Government	1,329	530	566	6.6	2.2
Medicare Utilization as a Percent of Inpatient Days:					
0–25	237	687	736	7.2	1.2
25–50	1,259	726	761	4.7	1.5
50–65	1,972	561	591	5.3	2.0

Appendix B—Technical Appendix on the Capital Cost Model and Required Adjustments

Under section 1886(g)(1)(A) of the Act, we set capital prospective payment rates for FY 1992 through FY 1995 so that aggregate prospective payments for capital costs were projected to be 10 percent lower than the amount that would have been payable on a reasonable cost basis for capital-related costs in that year. To implement this requirement, we developed the capital acquisition model to determine the budget neutrality adjustment factor. Even though the budget neutrality requirement expired effective with FY 1996, we must continue to determine the recalibration and geographic reclassification budget neutrality adjustment factor, and the reduction in the Federal and hospital-specific rates for exceptions payments. To determine these factors, we must continue to project capital costs and payments.

We have used the capital acquisition model since the start of prospective payments for capital costs. We now have 4 years of cost reports under the capital prospective payment system. For FY 1998, we developed a new capital cost model to replace the capital acquisition model. This revised model makes use of the data from these cost reports.

The following cost reports are used in the capital cost model for this final rule: the March 31, 1998 update of the cost reports for PPS–IX (cost reporting periods beginning in FY 1992), PPS–X (cost reporting periods beginning in FY 1993), PPS–XI (cost reporting periods beginning in FY 1994), and PPS–XII (cost reporting periods beginning in FY 1995). In addition, to model payments, we use the April 1, 1998 update of the provider-specific file, and the March 1994 update of the intermediary audit file.

Since hospitals under alternative payment system waivers (that is, hospitals in Maryland) are currently excluded from the capital prospective payment system, we excluded these hospitals from our model.

We developed FY 1992 through FY 1998 hospital-specific rates using the provider-specific file and the intermediary audit file. (We used the cumulative provider-specific file, which includes all updates to each hospital's records, and chose the latest record for each fiscal year.) We checked the consistency between the provider-specific file and the intermediary audit file. We ensured that increases in the hospital-specific rates were at least as large as the published updates (increases) for the hospital-specific rates each year. We were able to match hospitals to the files as shown in the following table:

Source	Number of hospitals
Provider-Specific File Only	118
Provider-Specific and Audit File	4,857
Total	4,975

Ninety-seven of the 4,975 hospitals had unusable or missing data or had no cost reports available. We determined from the cost reports that 23 of the 97 hospitals were paid under the hold-harmless methodology. Since the hospital-specific amount is not used to determine payments for these hospitals, we were able to include these 23 hospitals in the analysis. We used the cost report data of 4,901 hospitals for the analysis. Seventy-four hospitals could not be used in the analysis because of insufficient information. These hospitals account for approximately 0.3 percent of admissions, therefore, any effects from the elimination of their cost report data should be minimal.

We analyzed changes in capital-related costs (depreciation, interest, rent, leases, insurance, and taxes) reported in the cost reports. We found a wide variance among hospitals in the growth of these costs. For hospitals with more than 100 beds, the distribution and mean of these cost increases were different for large changes in bed-size

(greater than +20 percent). We also analyzed changes in the growth in old capital and new capital for cost reports that provided this information. For old capital, we limited the analysis to decreases in old capital. We did this since the opportunity for most hospitals to treat ''obligated'' capital put into service as old capital has expired. Old capital costs should, therefore, decrease as assets become fully depreciated, and as interest costs decrease as the loan is amortized.

The new capital cost model separates the hospitals into three mutually exclusive groups. Hold-harmless hospitals with data on old capital were placed in the first group. Of the remaining hospitals, those hospitals with fewer than 100 beds comprise the second group. The third group consists of all hospitals that did not fit into either of the groups. Each of these groups displayed unique patterns of growth in capital costs. We found that the gamma distribution is useful in explaining and describing the patterns of increase in capital costs. A gamma distribution is a statistical distribution that can be used to describe patterns of growth rates, with greatest proportion of rates being at the low end. We use the gamma distribution to estimate individual hospital rates of increase as follows:

(1) For hold-harmless hospitals, old capital cost changes were fitted to a truncated gamma distribution, that is, a gamma distribution covering only the distribution of cost decreases. New capital costs changes were fitted to the entire gamma distribution allowing for both decreases and increases.

(2) For hospitals with fewer than 100 beds (small), total capital cost changes were fitted to the gamma distribution allowing for both decreases and increases.

(3) Other (large) hospitals were further separated into three groups:

- Bed-size decreases over 20 percent (decrease).
- Bed-size increases over 20 percent (increase).
- Other (no-change).

Capital cost changes for large hospitals were fitted to gamma distributions for each bed-size change group, allowing for both decreases and increases in capital costs. We analyzed the probability distribution of increases and decreases in bed-size for large hospitals. We found the probability somewhat dependent on the prior year change in bed-size and factored this dependence into the analysis. Probabilities of bed-size change were determined. Separate sets of probability factors were calculated to reflect the dependence on prior year change in bed-size (increase, decrease, and no change).

The gamma distributions were fitted to changes in aggregate capital costs for the entire hospital. We checked the relationship between aggregate costs and Medicare per discharge costs. For large hospitals, there was a small variance, but the variance was larger for small hospitals. Since costs are used only for the hold-harmless methodology and to determine exceptions, we decided to use the gamma distributions fitted to aggregate cost increases for estimating distributions of cost per discharge increases.

Capital costs per discharge calculated from the cost reports were increased by random numbers drawn from the gamma distribution to project costs in future years. Old and new capital were projected separately for hold-harmless hospitals. Aggregate capital per discharge costs were projected for all other hospitals. Because the distribution of increases in capital costs varies with changes in bed-size for large hospitals, we first projected changes in bed-size for large hospitals before drawing random numbers from the gamma distribution. Bed-size changes were drawn from the uniform distribution with the probabilities dependent on the previous year bed-size change. The gamma distribution has a shape parameter and a scaling parameter. (We used different parameters for each hospital group, and for old and new capital.)

We used discharge counts from the cost reports to calculate capital cost per discharge. To estimate total capital costs for FY 1997 (the MedPR data year) and later, we use the number of discharges from the MedPAR data. Some hospitals have considerably more discharges in FY 1997 than in the years for which we calculated cost per discharge from the cost report data. Consequently, a hospital with few cost report discharges would have a high capital cost per discharge since fixed costs would be allocated over only a few discharges. If discharges increase substantially, the cost per discharge would decrease because fixed costs would be allocated over more discharges. If the projection of capital cost per discharge is not adjusted for increases in discharges, the projection of exceptions would be overstated. We address this situation by recalculating the cost per discharge with the MedPAR discharges if the MedPAR discharges exceed the cost report discharges by more than 20 percent. We do not adjust for increases of less than 20 percent because we have not received all of the FY 1997 discharges, and we have removed some discharges from the analysis because they are statistical outliers. This adjustment reduces our estimate of exceptions payments, and consequently, the reduction to the Federal rate for exceptions is smaller. We will continue to monitor our modeling of exceptions payments and make adjustments as needed.

The average national capital cost per discharge generated by this model is the combined average of many randomly generated increases. This average must equal the projected average national capital cost per discharge, which we projected separately (outside this model). We adjusted the shape parameter of the gamma distributions so that the modeled average capital cost per discharge matches our projected capital cost per discharge. The shape parameter for old capital was not adjusted since we are modeling the aging of ''existing'' assets. This model provides a distribution of capital costs among hospitals that is consistent with our aggregate capital projections.

Once each hospital's capital-related costs are generated, the model projects capital payments. We use the actual payment parameters (for example, the case-mix index and the geographic adjustment factor) that are applicable to the specific hospital.

To project capital payments, the model first assigns the applicable payment methodology (fully prospective or hold-harmless) to the hospital as determined from the provider-specific file and the cost reports. The model simulates Federal rate payments using the assigned payment parameters and hospital-specific estimated outlier payments. The case-mix index for a hospital is derived from the FY 1997 MedPAR file using the FY 1999 DRG relative weights published in section V. of the Addendum to this final rule. The case-mix index is increased each year after FY 1997 based on analysis of past experiences in case-mix increases. Based on analysis of recent case-mix increases, we estimate that case-mix will increase 1.0 percent in FY 1998 and 1.0 percent in FY 1999. (Since we are using FY 1997 cases for our analysis, the FY 1997 increase in case mix has no effect on projected capital payments.)

Changes in geographic classification and revisions to the hospital wage data used to establish the hospital wage index affect the geographic adjustment factor. Changes in the DRG classification system and the relative weights affect the case-mix index.

Section 412.308(c)(4)(ii) requires that the estimated aggregate payments for the fiscal year, based on the Federal rate after any changes resulting from DRG reclassifications and recalibration and the geographic adjustment factor, equal the estimated aggregate payments based on the Federal rate that would have been made without such changes. For FY 1998, the budget neutrality adjustment factor was 1.00015.

Since we implemented a separate geographic adjustment factor for Puerto Rico, we applied separate budget neutrality adjustments for the national geographic adjustment factor and the Puerto Rico geographic adjustment factor. We applied the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. Separate adjustments were unnecessary for FY 1998 since the geographic adjustment factor for Puerto Rico was implemented in 1998.

To determine the factors for FY 1999, we first determined the portions of the Federal national and Puerto Rico rates that would be paid for each hospital in FY 1999 based on its applicable payment methodology. Using our model, we then compared, separately for the national rate and the Puerto Rico rate, estimated aggregate Federal rate payments based on the FY 1998 DRG relative weights and the FY 1998 geographic adjustment factor to estimated aggregate Federal rate payments based on the FY 1998 relative weights and the FY 1999 geographic adjustment factor. In making the comparison, we held the FY 1999 Federal rate portion constant and set the other budget neutrality adjustment factor and the exceptions reduction factor to 1.00. We determined that, to achieve budget neutrality for the changes in the national geographic adjustment factor, an incremental budget neutrality adjustment of 0.99930 for FY 1999 should be applied to the previous cumulative FY 1998 adjustment of 1.00015, yielding a cumulative adjustment of 0.99945 through FY 1999. Since this is the first adjustment for Puerto Rico, the incremental and cumulative adjustment for Puerto Rico would be 0.99883 through FY

1999. We apply these new adjustments, then compare estimated aggregate Federal rate payments based on the FY 1998 DRG relative weights and the FY 1999 geographic adjustment factors to estimated aggregate Federal rate payments based on the FY 1999 DRG relative weights and the FY 1999 geographic adjustment factors. The incremental adjustment for DRG classifications and changes in relative weights would be 1.00336 nationally and for Puerto Rico. The cumulative adjustments for DRG classifications and changes in relative weights and for changes in the geographic adjustment factors through 1999 would be 1.00281 nationally, and 1.00219 for Puerto Rico. The following table summarizes the adjustment factors for each fiscal year:

BUDGET NEUTRALITY ADJUSTMENT FOR DRG RECLASSIFICATIONS AND RECALIBRATION AND THE GEOGRAPHIC ADJUSTMENT FACTORS

Fiscal year	National				Puerto Rico			
	Incremental adjustment			Cumulative	Incremental adjustment			Cumulative
	Geographic adjustment factor	DRG reclassifications and recalibration	Combined		Geographic adjustment factor	DRG reclassifications and recalibration	Combined	
1992	.....	.....	.....	1.00000	.....	.....	.....	.....
1993	.....	.....	0.99800	0.99800	.....	.....	.....	.....
1994	.....	.....	1.00531	1.00330	.....	.....	.....	.....
1995	.....	.....	0.99980	1.00310	.....	.....	.....	.....
1996	.....	.....	0.99940	1.00250	.....	.....	.....	.....
1997	.....	.....	0.99873	1.00123	.....	.....	.....	.....
1998	.....	.....	0.99892	1.00015	.....	.....	.....	1.00000
1999	0.99930	1.00336	1.00266	1.00281	0.99883	1.00336	1.00219	1.00219

The methodology used to determine the recalibration and geographic (DRG/GAF) budget neutrality adjustment factor is similar to that used in establishing budget neutrality adjustments under the prospective payment system for operating costs. One difference is that, under the operating prospective payment system, the budget neutrality adjustments for the effect of geographic reclassifications are determined separately from the effects of other changes in the hospital wage index and the DRG relative weights. Under the capital prospective payment system, there is a single DRG/GAF budget neutrality adjustment factor (the national rate and the Puerto Rico rate are determined separately) for changes in the geographic adjustment factor (including geographic reclassification) and the DRG relative weights. In addition, there is no adjustment for the effects that geographic reclassification has on the other payment parameters, such as the payments for serving low-income patients or the large urban add-on payments.

In addition to computing the DRG/GAF budget neutrality adjustment factor, we used the model to simulate total payments under the prospective payment system.

Additional payments under the exceptions process are accounted for through a reduction in the Federal and hospital-specific rates. Therefore, we used the model to calculate the exceptions reduction factor. This exceptions reduction factor ensures that aggregate payments under the capital prospective payment system, including exceptions payments, are projected to equal the aggregate payments that would have been made under the capital prospective payment system without an exceptions process. Since changes in the level of the payment rates change the level of payments under the exceptions process, the exceptions reduction factor must be determined through iteration.

In the August 30, 1991 final rule (56 FR 43517), we indicated that we would publish each year the estimated payment factors generated by the model to determine payments for the next 5 years. The table below provides the actual factors for fiscal years 1992 through 1999, and the estimated factors that would be applicable through FY 2003. We caution that these are estimates for fiscal years 2000 and later, and are subject to revisions resulting from continued methodological refinements, receipt of additional data, and changes in payment policy changes. We note that in making these projections, we have assumed that the cumulative national DRG/GAF budget neutrality adjustment factor will remain at 1.00281 (1.00219 for Puerto Rico) for FY 1999 and later because we do not have sufficient information to estimate the change that will occur in the factor for years after FY 1999.

The projections are as follows:

Fiscal year	Update factor	Exceptions reduction factor	Budget neutrality factor	DRG/GAF adjustment factor [1]	Outlier adjustment factor	Federal rate adjustment	Federal rate (after outlier reduction)
1992	N/A	0.9813	0.9602		.9497		415.59
1993	6.07	.9756	.9162	.9980	.9496		417.29
1994	3.04	.9485	.8947	1.0053	.9454	[2] .9260	378.34
1995	3.44	.9734	.8432	.9998	.9414		376.83
1996	1.20	.9849	N/A	.9994	.9536	[3] .9972	461.96
1997	0.70	.9358	N/A	.9987	.9481		438.92
1998	0.90	.9659	N/A	.9989	.9382	[4] .8222	371.51
1999	0.10	.9783	N/A	1.0027	.9392		378.05
2000	0.70	.9763	N/A	[5] 1.0000	[5] .9392		379.92
2001	0.70	.9735	N/A	1.0000	.9392		381.48
2002	0.70	[6] 1.0000	N/A	1.0000	.9392		394.61
2003	0.80	[6] 1.0000	N/A	1.0000	.9392	[4] 1.0255	407.92

[1] Note: The incremental change over the previous year.
[2] Note: OBRA 1993 adjustment.

[3] Note: Adjustment for change in the transfer policy.
[4] Note: Balanced Budget Act of 1997 adjustment.
[5] Note: Future adjustments are, for purposes of this projection, assumed to remain at the same level.
[6] Note: We are unable to estimate exceptions payments for the year under the special exceptions provision (§ 412.348(g) of the regulations) because the regular exceptions provision (§ 412.348(e)) expires.

Appendix C—Recommendation of Update Factors for Operating Cost Rates of Payment for Inpatient Hospital Services

I. Background

Several provisions of the Act address the setting of update factors for inpatient services furnished in FY 1999 by hospitals subject to the prospective payment system and those excluded from the prospective payment system. Section 1886(b)(3)(B)(i)(XIV) of the Act sets the FY 1999 percentage increase in the operating cost standardized amounts equal to the rate of increase in the hospital market basket minus 1.9 percent for prospective payment hospitals in all areas. Section 1886(b)(3)(B)(iv) of the Act sets the FY 1999 percentage increase in the hospital-specific rates applicable to sole community and Medicare-dependent, small rural hospitals equal to the rate set forth in section 1886(b)(3)(B)(i) of the Act, that is, the same update factor as all other hospitals subject to the prospective payment system, or the rate of increase in the market basket minus 1.9 percentage points. Under section 1886(b)(3)(B)(ii)(VII) of the Act, the FY 1999 percentage increase in the rate of increase limits for hospitals excluded from the prospective payment system can range from the rate of increase in the excluded hospital market basket to zero, depending on the hospital's costs in relation to its limit for the most recent cost reporting period for which information is available.

In accordance with section 1886(d)(3)(A) of the Act, we are updating the standardized amounts, the hospital-specific rates, and the rate-of-increase limits for hospitals excluded from the prospective payment system as provided in section 1886(b)(3)(B) of the Act. Based on the second quarter 1998 forecast of the FY 1999 market basket increase of 2.4 percent for hospitals subject to the prospective payment system, the updates in the standardized amounts are 0.5 percent for hospitals in both large urban and other areas. The update in the hospital-specific rate applicable to sole community and Medicare-dependent, small rural hospitals is also 0.5 percent. The update for hospitals excluded from the prospective payment system can be as high as the percentage increase in the excluded hospital market basket (currently estimated at 2.4 percent) or as low as zero, depending on the hospital's costs in relation to its rate-of-increase limit. (See section V of the addendum to this final rule.)

Section 1886(e)(4) of the Act requires that the Secretary, taking into consideration the recommendations of the Medicare Payment Advisory Commission (MedPAC), recommend update factors for each fiscal year that take into account the amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. In its March 1, 1998 report, MedPAC stated that, although a somewhat lower update could be justified in light of changes in the utilization and provision of hospital inpatient care, the legislated update of the market basket increase minus 1.9 percentage points will provide a reasonable level of payments to hospitals.

Under section 1886(e)(5) of the Act, we are required to publish the update factors recommended under section 1886(e)(4) of the Act. Accordingly, we published the FY 1999 update factors recommended by the Secretary as Appendix D of the May 8, 1998 proposed rule (63 FR 25704).

II. Secretary's Final Recommendations

We received two comments concerning our proposed recommendations, neither of which took issue with the update recommendation itself. Therefore, our final recommendations for the operating update for both prospective and excluded hospitals do not differ from the proposed, except that the forecast of the market basket percentage increase has been revised from 2.6 to 2.4 percent for prospective payment hospitals and from 2.5 to 2.4 percent for excluded hospitals.

Comment: The commenters suggested that HCFA's update framework take into account the impact of ''Year 2000'' (Y2K) systems'' conversions on hospital expenditures.

Response: The purpose of the hospital input price indexes in the hospital market basket is to measure the price escalation associated with the inputs needed to provide hospital services, not to measure changes in the quantity and quality of inputs used to provide these services. The increased costs associated with Y2K systems conversions are in the form of 3 factors: (1) Increased quantities (such as more workers), (2) increased price levels for higher quality workers (with higher wage levels) or other inputs, and (3) increased price escalation, holding constant the quantity and quality of inputs (such as faster wage and input price escalation rates). The third factor of increased escalation for wages and prices should be picked up by the hospital input price indexes.

Since the input price indexes measure the ''pure price'' changes associated with the inputs needed to provide hospital services, they would reflect the potentially faster rate of price escalation faced by hospitals from Y2K. An example would be higher market prices paid by hospitals for goods and services purchased from suppliers that also incurred higher production costs due to the Y2K conversion. We believe that the price proxies used in the hospital input price indexes, such as CPIs, PPIs, and ECIs, will reflect any escalating prices since all sectors of the economy are faced with additional costs of Y2K. This escalation will show up in the monthly or quarterly updates of the price proxies from the Bureau of Labor Statistics.

Any change in the mix of inputs caused by Y2K would not be picked up in the index until it is rebased. Such a change would cause a modification of the weights in the input price index. However, any changes in the weights are likely to have a minimal effect on the overall percent change in the index. For example, we did a sensitivity analysis of this effect by increasing the weight for professional and technical wages and benefits by 10 percent with a corresponding 10 percent decrease in the non-professional and technical wages and benefits. Altering the weights in this manner had no impact on the overall percent change in the index.

Comment: MedPAC commented that HCFA's recommendations differed from those of MedPAC in the proposed rule because HCFA did not separately account for hospital product change. Hospital product change reflects the dramatic change in recent years in the role of the hospital inpatient setting in the continuum of care. More patients are receiving postacute care after a hospital stay, and the average length of acute care stays has declined sharply.

Response: HCFA recognizes the changes in hospital inpatient care delivery noted by MedPAC and for FY 1999, accounted for them in the determination of the intensity factor. To the extent that there is a mismatch in component designation between HCFA and MedPAC, HCFA is willing to work with MedPAC to set more clearly defined and mutually agreeable categories for future update recommendations.

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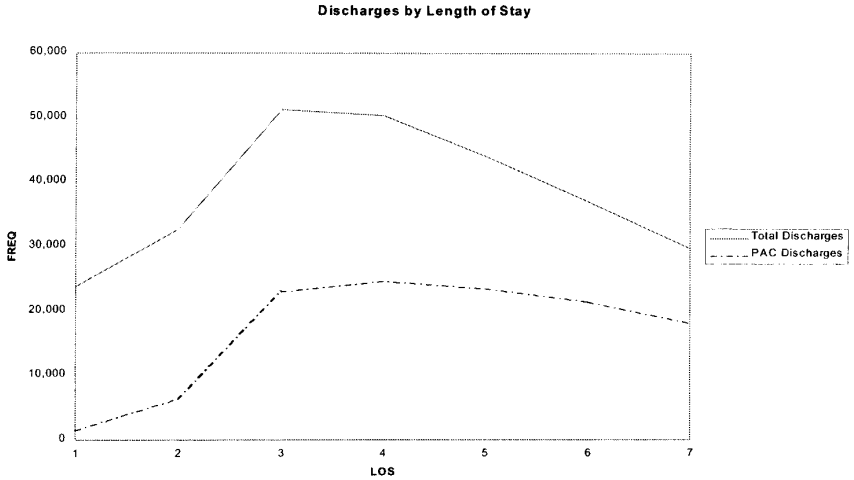
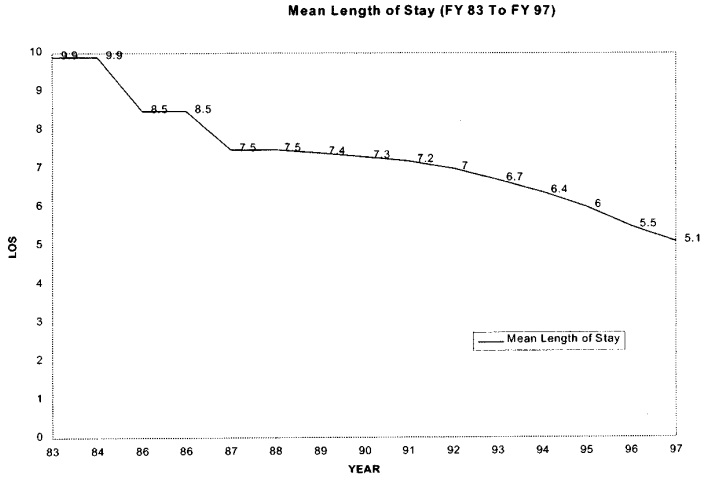
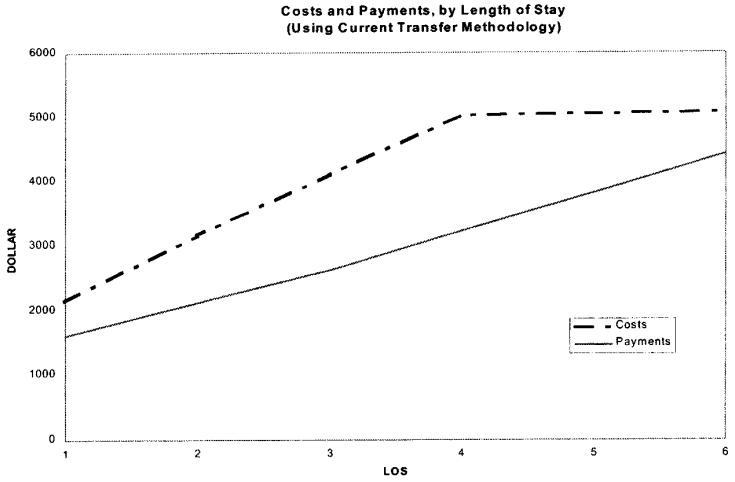
APPENDIX D: DRG Charts

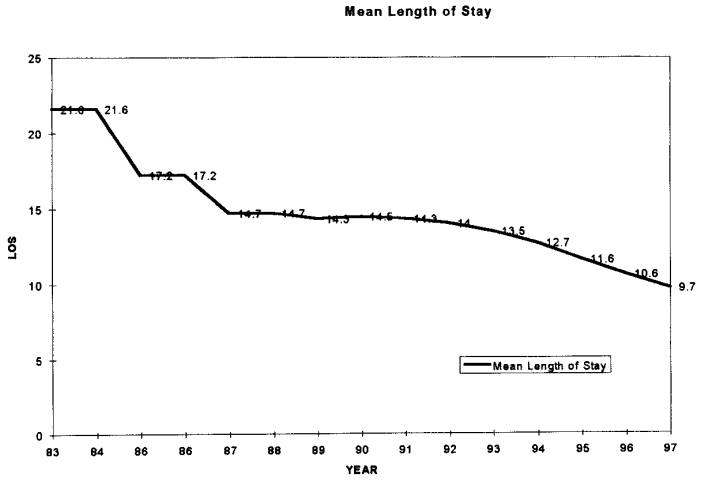
DRG 14
SPECIFIC CEREBROVASCULAR DISORDERS EXCEPT TIA (MEDICAL)

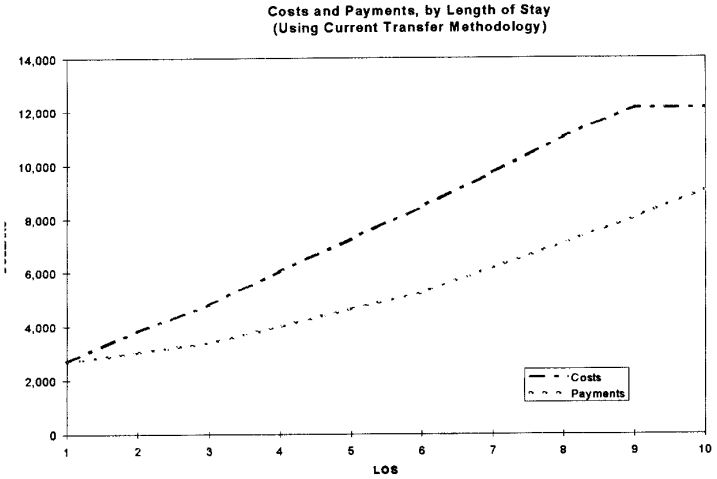






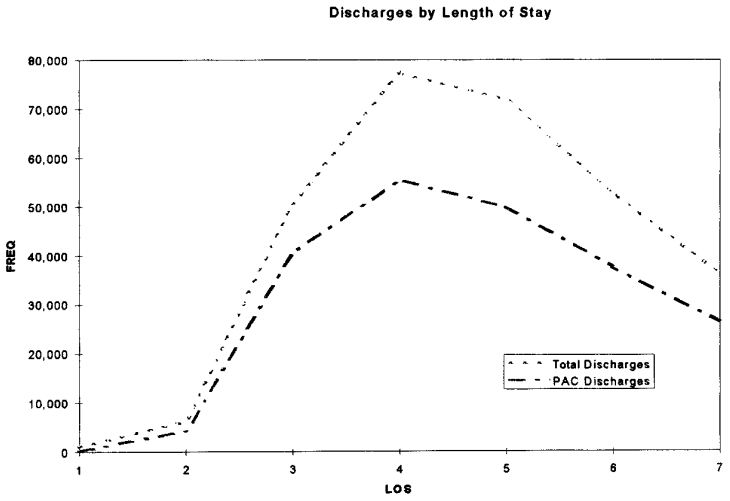
DRG 113
AMPUTATION FOR CIRCULATORY SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE (SURGICAL)

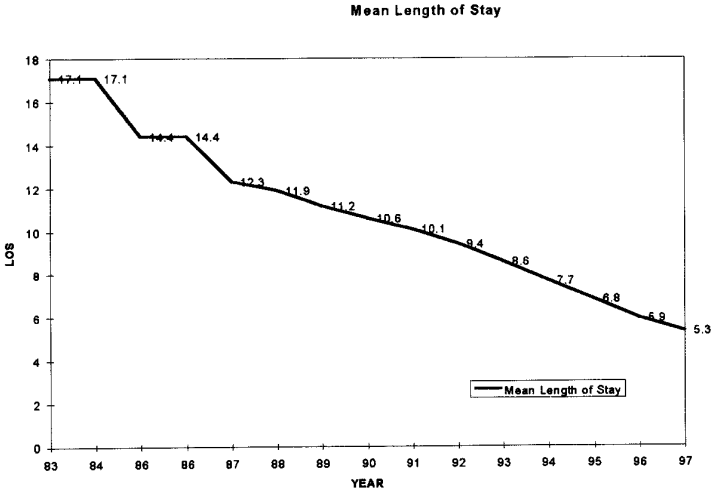


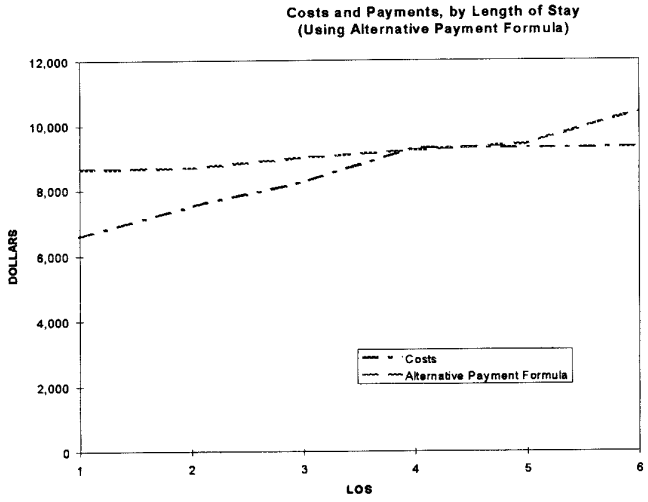


DRG 209

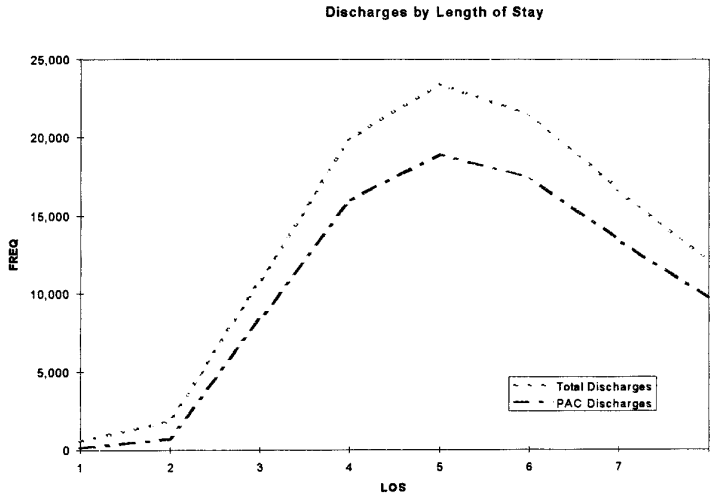
MAJOR JOINT LIMB REATTACHMENT PROCEDURES OF LOWER EXTREMITY (SURGICAL)

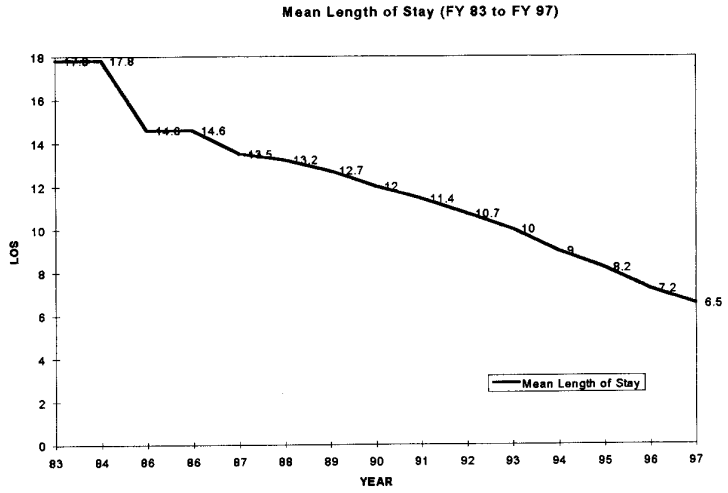


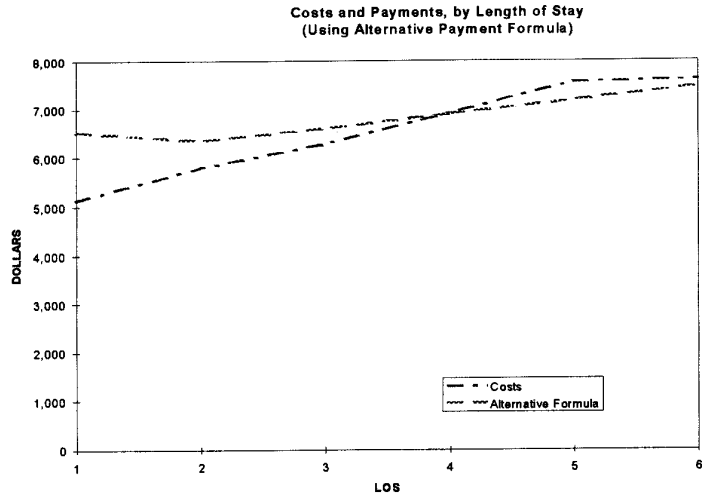




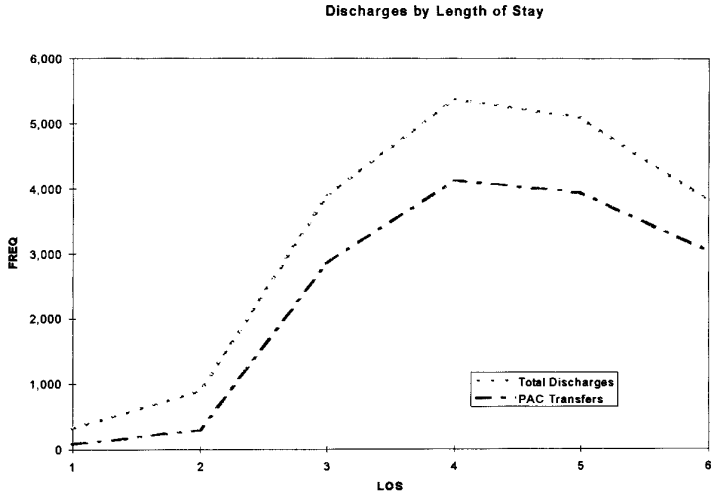
DRG 210
HIP FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 WITH CC (SURGICAL)

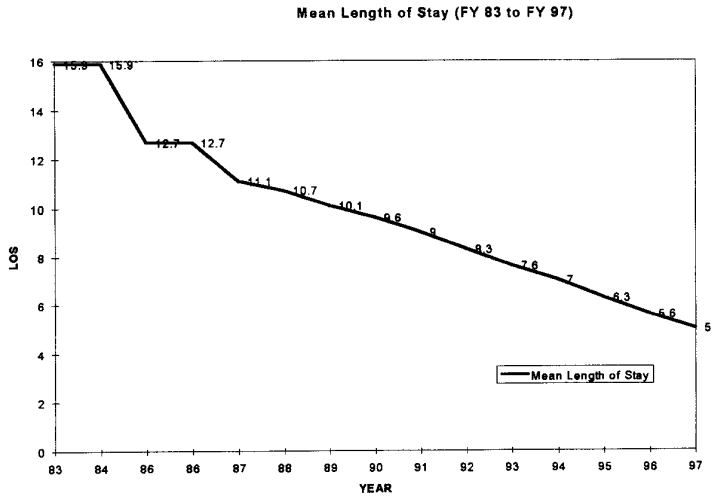


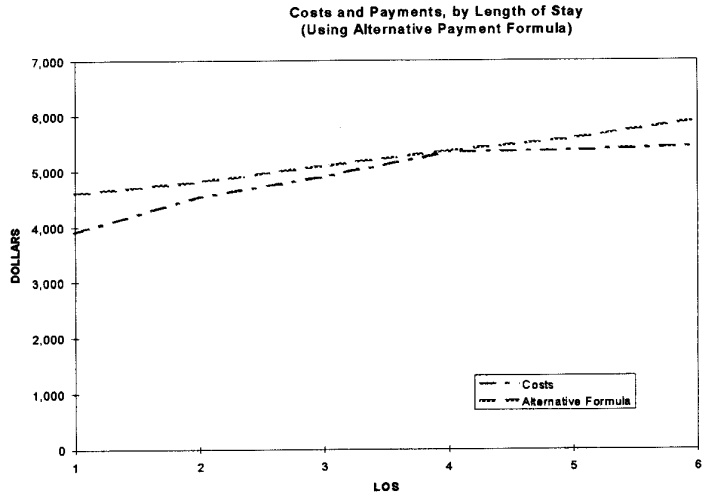




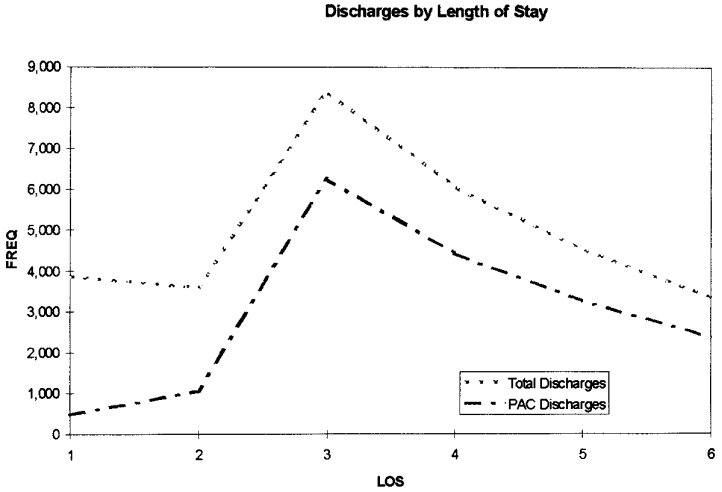
DRG 211
HIP FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC (SURGICAL)

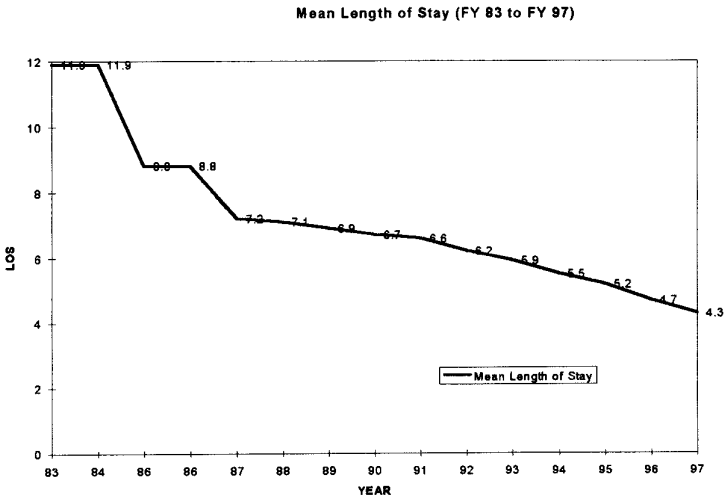


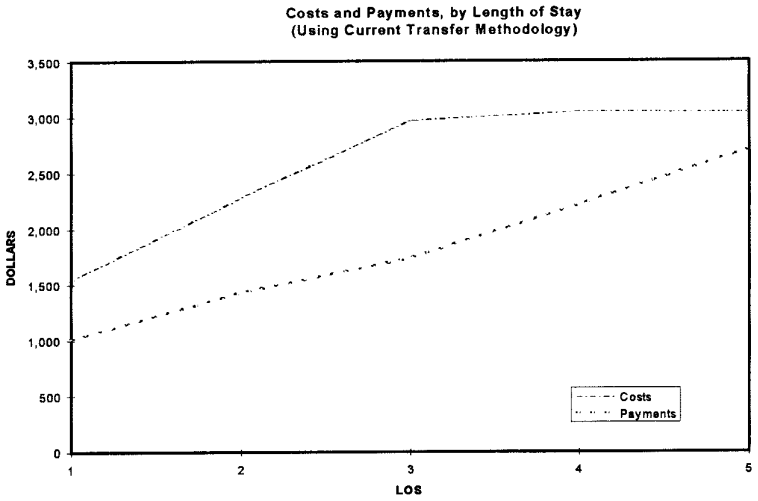




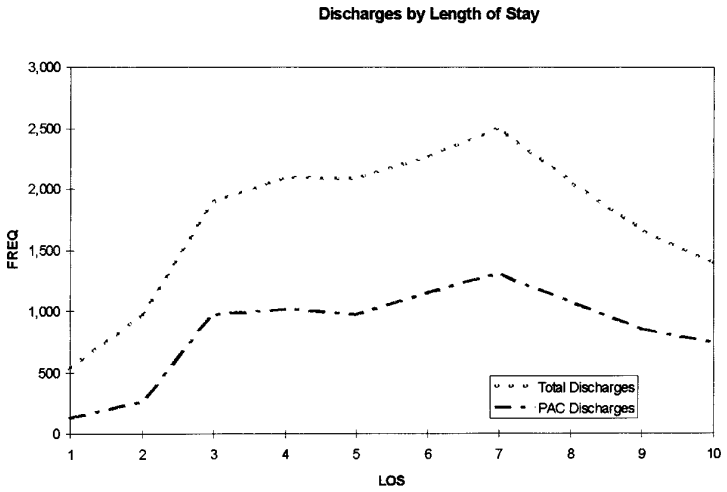
DRG 236
FRACTURE OF HIP PELVIS (MEDICAL)

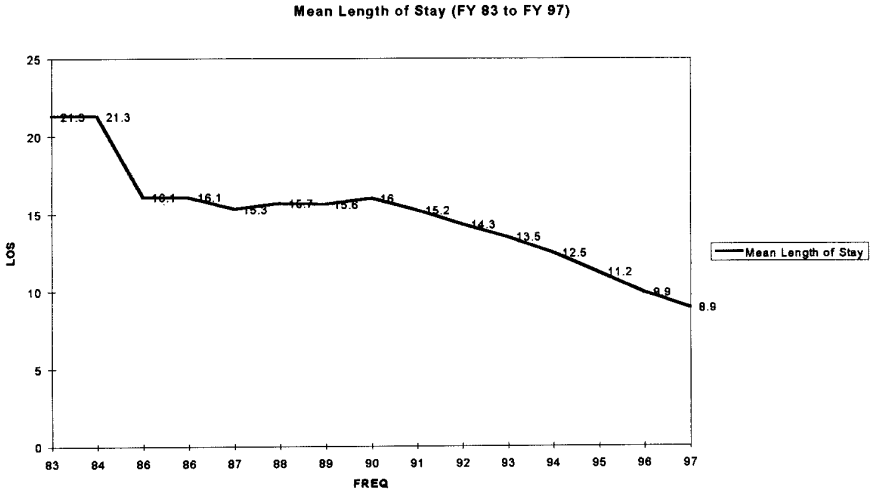


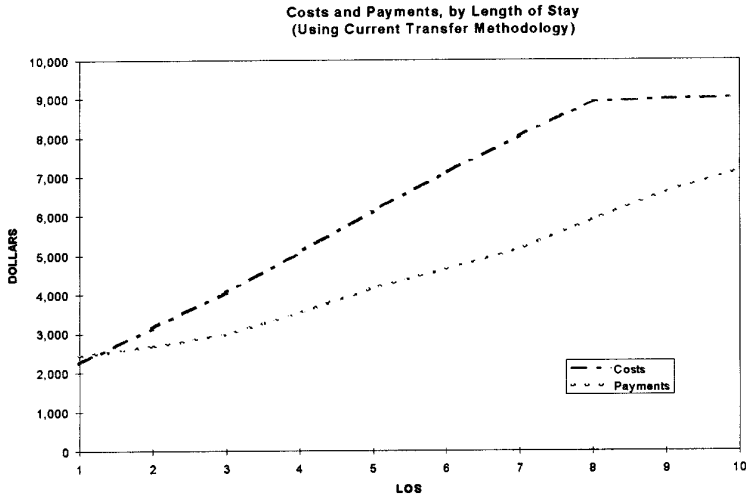




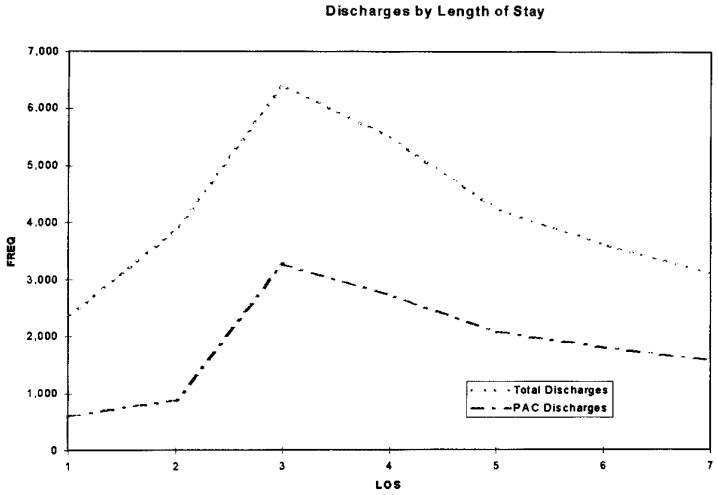
DRG 263
SKIN GRAFT AND/OR DEBRIDEMENT FOR SKIN ULCER OR CELLULITIS WITH CC (SURGICAL)

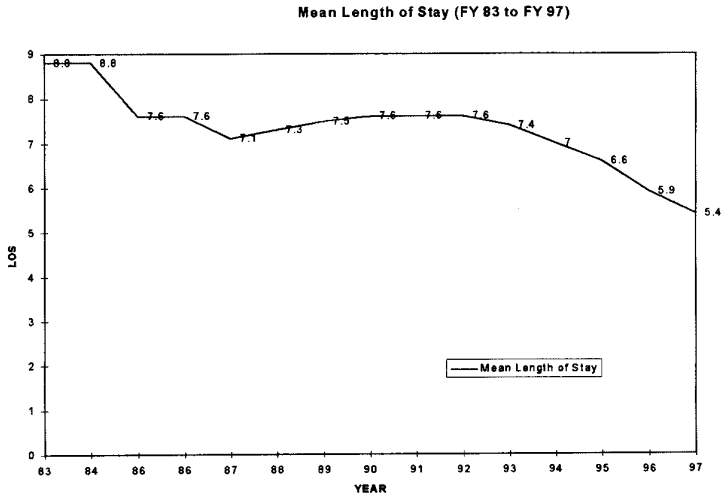


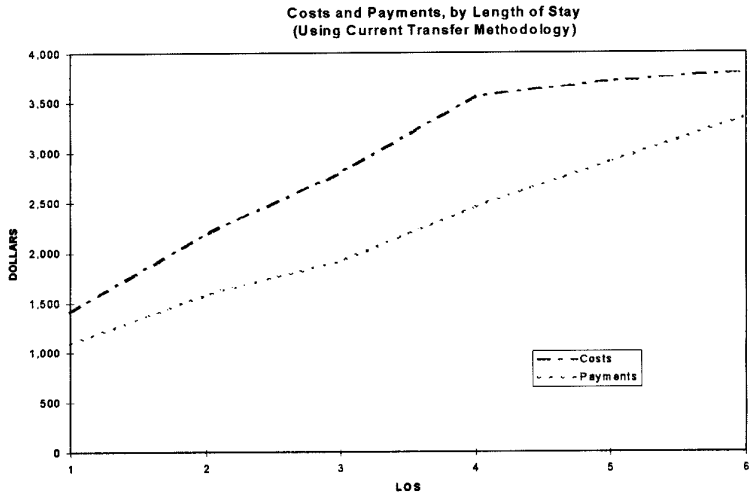




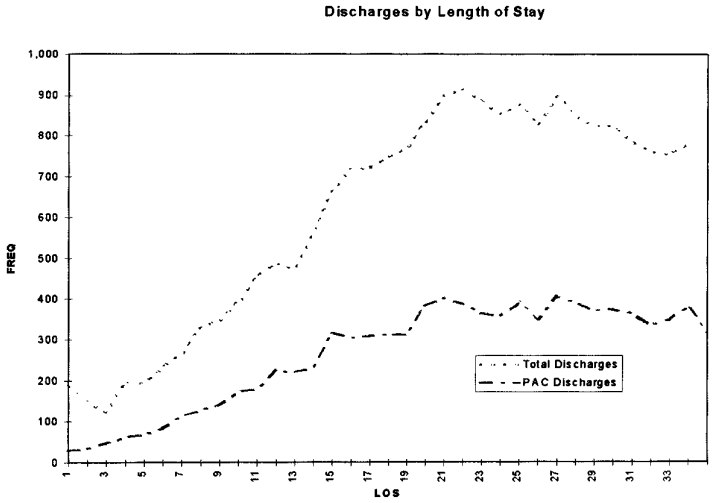
DRG 429
ORGANIC DISTURBANCES MENTAL RETARDATION (MEDICAL)

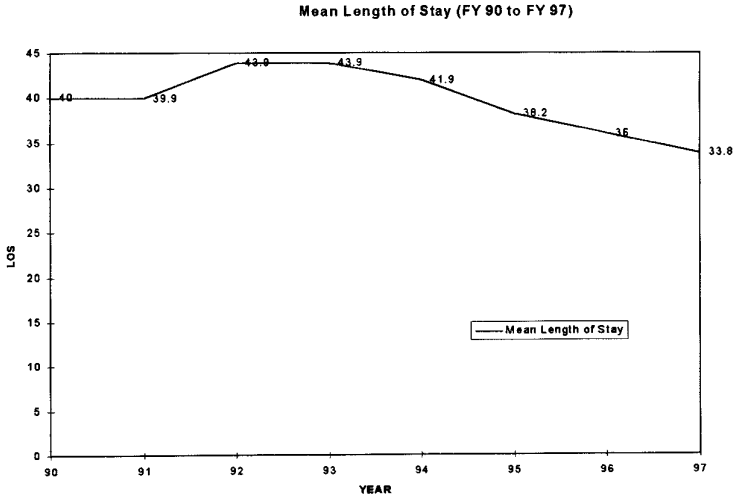


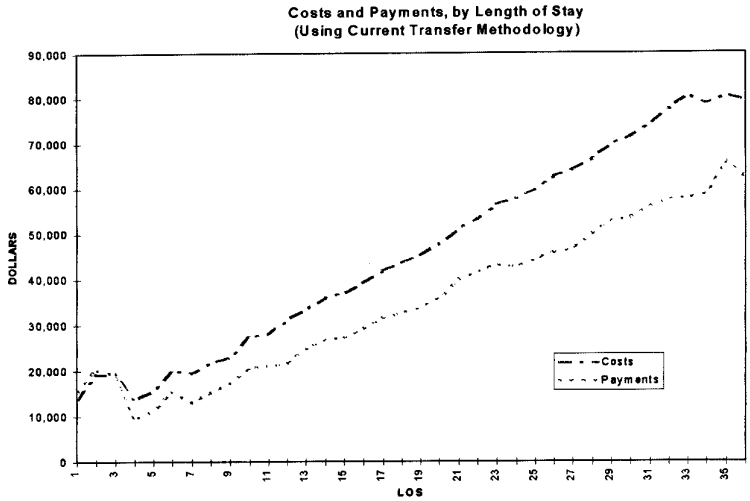




DRG 483
TRACHEOSTOMY EXCEPT FOR FACE, MOUTH, NECK DIAGNOSES (SURGICAL)







[FR Doc. 98–20459 Filed 7–30–98; 8:45 am]

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