DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 412, 413, 483, and 485

[HCFA–1053–F]

RIN 0938–AJ50

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

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

ACTION: Final rule.

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

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

FOR FURTHER INFORMATION CONTACT:
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SUPPLEMENTARY INFORMATION:

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I. Background

A. Summary

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C. Public Comments Received in Response to the Proposed Rule

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

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

II. Changes to DRG Reclassifications and Recalibrations of Relative Weights

A. Background

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

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

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

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

B. DRG Reclassification

1. General

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

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

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

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

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

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

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

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

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

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

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

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

We received one comment on this proposal.

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

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

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

connected to the amount of time spent in the hospital.

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

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

3. MDC 19 (Mental Diseases and Disorders)

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

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

4. MDC 22 (Burns)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5. Surgical Hierarchies

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

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

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

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

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

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

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

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

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

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

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

6. Refinement of Complications and Comorbidities (CC) List

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Adding Procedure Codes to MDCs

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9. Other Issues

a. Implantation of Muscle Stimulator

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

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

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

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

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

b. Pancreas Transplant

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

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

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

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

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

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

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

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

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

c. Immunotherapy

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

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

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

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

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

d. Heart Assist Devices

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

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

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

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

C. Recalibration of DRG Weights

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

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

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

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

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

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

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

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

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

1. Introduction

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

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

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

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

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

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

2. The DRG Reclassification and Recalibration Process

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

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

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

3. Feasible, Reliable, Validated Data

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

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

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

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

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

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

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

4. Submission of Data

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Response: Section 1886(d)(5)(A) of the Act provides for payments in addition to the basic prospective payments for outlier cases, cases involving extraordinarily high costs. Our statement in the proposed rule was meant to apply to all new technologies, and not specifically to platelet inhibitor therapy. As stated previously, the prospective payment system reflects ''averaging principles,'' which means, among other things, that a hospital might lose money on some cases but will gain money on other cases; sometimes new technologies lead to lower costs and we might Aoverpay@ hospitals for those cases. If a case does not qualify for an outlier payment, then presumably the case falls within the ''typical'' range of costs for cases in the DRG. We believe that, as a whole, the prospective payment system does ensure access to new technologies, including platelet inhibitor therapy.

III. Changes to the Hospital Wage Index

A. Background

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

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

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

B. FY 2000 Wage Index Update

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

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

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

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

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

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

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

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

C. FY 2000 Wage Index Methodology Changes

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

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

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

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

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

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

1. Teaching Physician Costs

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

to circumvent the cost reporting requirements of their participation agreements.

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

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

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

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

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

2. Resident and CRNA Part A Costs

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

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

We received no comments related to this change.

3. Transition Period

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

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

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

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

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

D. Verification of Wage Data from Medicare Cost Reports

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

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

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

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

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

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

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

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

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

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

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

E. Computation of the Wage Index

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

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

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

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

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

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

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

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

MIDPOINT OF COST REPORTING PERIOD

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

MIDPOINT OF COST REPORTING PERIOD—Continued

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

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

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

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

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

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

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

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

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

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

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

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

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

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

F. Revisions to the Wage Index Based on Hospital Redesignation

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

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

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

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

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

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

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

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

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

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

G. Wage Data Corrections

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. Rural Referral Centers (§ 412.96)

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

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

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

1. Case-Mix Index

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

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

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

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

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

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

2. Discharges

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Approved Geriatric Programs

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

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

2. Hospital Payment For Resident Training in Nonhospital Settings

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

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

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

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

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

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

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

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

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

3. New Residency Programs

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

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

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

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

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

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

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

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

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

We received a number of comments on our proposals.

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

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

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

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

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

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

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

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

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

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

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

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

Example 1

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

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

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

Example 2

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

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

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

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

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

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

[1] PGY = Program Year

Example 3

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Determining the Weighted Number of FTE Residents

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

prospective payment system established by the Secretary.'' Under the statute, the Secretary has broad authority in establishing and implementing the capital prospective payment system. We initially implemented the capital prospective payment system in the August 30, 1991 final rule (56 FR 43409), in which we established a 10-year transition period to change the payment methodology for Medicare inpatient capital-related costs from a reasonable cost-based methodology to a prospective methodology (based fully on the Federal rate).

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

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

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

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

Under the special exceptions provision at § 412.348(g), an additional payment may be made for up to 10 years beyond the end of the capital prospective payment system transition period for eligible hospitals that meet (1) a project need requirement as described at § 412.348(g)(2), which, in the case of certain urban hospitals, includes an excess capacity test; and (2) a project size requirement as described at § 412.348(g)(5). Eligible hospitals include sole community hospitals, urban hospitals with at least 100 beds that have a disproportionate share percentage of at least 20.2 percent, and hospitals with a combined Medicare and Medicaid inpatient utilization of at least 70 percent. In the September 1, 1994 final rule, we described the special exceptions process as ''* * * narrowly defined, focusing on a small group of hospitals who found themselves in a disadvantaged position. The target hospitals were those who had an immediate and imperative need to begin major renovations or replacements just after the beginning of the capital prospective payment system. These hospitals would not be eligible for protection under the old capital and obligated capital provisions, and would not have been allowed any time to accrue excess capital prospective payments to fund these projects'' (59 FR 45385).

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

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

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

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

In the May 7, 1999 proposed rule (64 FR 24736), we reported that four hospitals had responded timely to our solicitation with information on their major capital construction projects. The hospitals submitted information about their location, the cost of the project, the date that the CON approval was received, the start date of the project, and the anticipated completion date.

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

When we issued the May 7, 1999 proposed rule, we had no specific proposal to revise the special exceptions process. However, we invited comments from hospitals and other interested parties on the suggestions and recommendations discussed above. We noted that, since the capital special exceptions process is budget neutral, any liberalization of the policy would require a commensurate reduction in the capital rate paid to all hospitals. That is, even after the end of the capital prospective payment system transition, we will continue to make an adjustment to the capital Federal rate in a budget neutral manner to pay for exceptions, as long as an exceptions policy is in force. Currently, the limited special exceptions policy will allow for exceptions payments through September 30, 2011. We also noted that, based on the comments we received, we may make changes to the special exceptions criteria in the final regulation or propose changes in the FY 2001 proposed rule.

In the May 7, 1999 proposed rule, we indicated that we had little information about the impact of any of the suggested changes discussed in the proposed rule, since no hospitals are currently being paid under the special exceptions process. Until FY 2001, the special exceptions provision currently pays either the same as the regular exceptions process or less for high DSH and sole community hospitals. We indicated that we would attempt to obtain information on projects that might qualify for special exceptions payments through our fiscal intermediaries during the comment period. However, we noted that we were reluctant to impose a burden on the fiscal intermediaries at this time, since it could interfere with our major efforts to make the Medicare computer systems Y2K compliant prior to January 1, 2000.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Since publication of the proposed rule, we have attempted to obtain information on hospital projects that might qualify for special exceptions payments in order to assess the impact of the recommended changes to the existing policy. Because of the impracticality of obtaining data timely from every State in the country, we focused our efforts on certain States. Using information obtained from the Department of Housing and Urban Development (HUD) and the Health Resources and Services Administration (HRSA), we developed a list of States in which a large concentration of hospital construction occurred during the capital transition period. For several States, we contacted the State Department of Health's Facility and Planning Staff, who provided us with information on the hospital construction projects in their State, including the name and location of the hospital, the cost of the construction project, the date of CON approval (if required), the start date of the project, and the completion or anticipated completion date of the project. In conjunction with the most recent cost report data readily available (FY 1996), we attempted to estimate which of the hospital construction projects might qualify for special exception payments under the existing policy and how that universe of hospitals might change as a result of the recommended revisions to the special exceptions criteria.

Because exception payments to a hospital for a given cost reporting period are based on a percentage of the hospital's capital costs incurred during the cost reporting period, we were unable to determine a precise estimate of the amount of payments to hospitals that might be eligible for special exceptions. In addition, hospitals are not eligible for special exception payments until the assets are put into use for patient care. Once eligibility for special exceptions payment has been demonstrated, it is some time before completed and settled cost reports are available to determine these payments. It is also difficult to predict whether particular hospitals will be able to meet all of the special exceptions eligibility criteria (DSH percentage, inpatient margins, completion date, project size, and project need requirements) in future years based on the earlier cost report data.

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

might possibly qualify for special exception payments. Our data largely understate the total number of eligible projects that may qualify for special exception payments nationally since our estimate is based on data from only 2 of the 50 States in the country. Our estimate includes all inpatient hospital construction projects in those two States, of which only a subset of projects will qualify for special exception payments. Extrapolating our estimate to the large numbers of hospital construction projects nationally, we believe that any changes to the special exceptions policy may affect a significant number of hospitals.

Based on our belief that these changes may have an impact on a significant number of hospitals and our evaluation of the comments and after careful consideration of all the issues, we have concluded, as suggested by one commenter, that the more appropriate forum for addressing the capital special exception is the legislative process in Congress rather than the regulation process.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Updated Caps

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

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

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

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

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

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

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

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

a. Updated Caps for New Hospitals and Units

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

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

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

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

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

b. Multicampus Excluded Hospitals

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

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

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

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

3. Exceptions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

We received six comments on our proposal.

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

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

C. Payment for Services Furnished at Satellite Hospital Locations

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

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

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

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

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

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

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

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

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

We received 18 comments on this proposal.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

E. Critical Access Hospitals (CAHs)

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

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

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

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

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

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

We received three comments on our proposal.

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

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

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

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

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

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

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

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

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

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

3. Additional Comments Received on CAH Issues

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

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

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

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

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

VII. MedPAC Recommendations

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

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

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

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

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

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

number after it is calculated. We agree that the absence of an explicit instruction, in and of itself, does not necessarily mean that the Secretary cannot implement a wage adjustment. However, Congressional ''silence'' on this issue must be construed in light of the statutory scheme and the legislative history, as well as policy considerations.

With regard to the statutory scheme, we stated that in requiring that we calculate a separate number for each class of hospitals, the Congress established a scheme that directs us to recognize differences across types of hospitals, but does not direct us to recognize differences in wages. In addition to the scheme of section 4414 itself, we considered this section in light of other statutory provisions. We concluded that, because the Congress explicitly requires wage adjustments in some contexts, failure to require a wage adjustment in this context reflects a judgement by the Congress that we should not make one under section 4414. In terms of the legislative history, we noted that there is no reference in the Conference Report to a wage adjustment to the TEFRA caps.

Finally, we asserted that while from a broad policy perspective a wage adjustment might be appropriate, policy considerations do not dictate a wage adjustment. A payment cap is different from a payment rate in that a cap only affects hospitals that are above the cap, while a payment rate affects all hospitals. Thus, we believe that while a wage adjustment might be preferable policy, the lack of a wage adjustment is not unreasonable. We stated that we would support a hospital-sponsored legislative change to permit wage adjustments and we will continue to do so; however, our decision, as expressed in the May 12, 1998 final rule, remains unchanged.

B. Disproportionate Share Hospitals (DSH) (Recommendations 3C, 3D, and 3E)

Recommendations: The Congress should require that disproportionate share payments be distributed according to each hospital's share of low-income patient costs, defined broadly to include all care to the poor. The measure of low-income costs should reflect: (1) Medicare patients eligible for Supplemental Security Income, Medicaid patients, patients sponsored by other indigent care programs, and uninsured and underinsured patients as represented by uncompensated care (both charity and bad debts); and (2) services provided in both inpatient and outpatient settings.

As under current policy, disproportionate share payment should be made in the form of an adjustment to the per-case payment rate. In this way, the total payment each hospital receives will reflect its volume of Medicare patients.

Through a minimum threshold for low-income share, the formula for distributing disproportionate share payments should concentrate payments among hospitals with the highest shares of poor patients. A reasonable range for this threshold would be levels that make between 50 percent and 60 percent of hospitals eligible for a payment. However, the size of the payment adjustment should increase gradually from zero at the threshold. The same distribution formula should apply to all hospitals covered by prospective payment.

The Secretary should collect the data necessary to revise the disproportionate share payment system from all hospitals paid under the prospective payment system.

Response in the Proposed Rule: We continue to give careful consideration to MedPAC's recommendations concerning the DSH adjustment made to operating payments under the prospective payment system.

We are in the process of preparing a report to the Congress on the Medicare DSH adjustment that includes several options for amending the statutory disproportionate share adjustment formula. We believe that any adjustment to the DSH formula or data sources should be directed and supported by the Congress.

The MedPAC option involves collecting data on uncompensated care, that is, charity and bad debts. Ideally, this would be a direct measure of a hospital's indigent care burden. However, there are problems associated with verification of such data and consistency of reporting nationally. We appreciate the Commission's recommendations about and assistance with the Medicare DSH adjustment as we formulate our legislative proposal and await Congressional action.

Comment: MedPAC commented that it does not believe that the verification process for uncompensated care (charity and bad debt) data needs to be burdensome. It recommends that HCFA keep reporting requirements to a minimum to limit data collection problems. Specifically, MedPAC recommends that HCFA collect only total uncompensated care data rather than separate data on the two components of uncompensated care—bad debts and charity care. HCFA should publish guidelines specifying the types of unpaid charges that can be included so that reporting problems are minimal.

Response: As we noted in our response to this recommendation in the proposed rule, we are preparing a Report to Congress on the revision of the DSH adjustment formula and have taken into consideration the inclusion of a recommendation to collect uncompensated care charge data by payer category (inpatient and outpatient) for our analysis. We believe it is important to promote the consistent reporting of data to the extent possible. We plan to minimize reporting problems by collecting only total uncompensated care data, thereby avoiding the problem of different definitions of bad debts, indigent care, and uncompensated care among States. However, we continue to anticipate other reporting problems such as hospital recordkeeping of these data.

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 or cartridge format; however, some files are available on diskette as well as on the Internet at HTTP://WWW.HCFA.GOV/STATS/PUBFILES.HTML. In our May 7, 1999 proposed rule, we published a list of data files that are available for purchase (64 FR 24746 and 24747).

List of Subjects

42 CFR Part 412

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

42 CFR Part 413

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

42 CFR Part 483

Grant programs-health, Health facilities, Health professions, Health records, Medicaid, Medicare, Nursing homes, Nutrition, Reporting and recordkeeping requirements, Safety.

42 CFR Part 485

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

42 CFR Chapter IV is amended as set forth below:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

A. Part 412 is amended as follows:

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

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

2. In § 412.2, the introductory text of paragraph (e) is republished and paragraph (e)(4) is revised to read as follows:

§ 412.2 Basis of payment.

* * * * *

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

* * * * *

(4) Heart, kidney, liver, lung, and pancreas acquisition costs incurred by approved transplantation centers.

* * * * *

3. Section 412.22 is amended by adding a new paragraph (h) to read as follows:

§ 412.22 Excluded hospitals and hospital units: General rules.

* * * * *

(h) *Satellite facilities.* (1) For purposes of paragraphs (h)(2) through (h)(4) of this section, a satellite facility is a part of a hospital that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital.

(2) Except as provided in paragraph (h)(3) of this section, effective for cost reporting periods beginning on or after October 1, 1999, a hospital that has a satellite facility must meet the following criteria in order to be excluded from the prospective payment systems for any period:

(i) In the case of a hospital (other than a children's hospital) that was excluded from the prospective payment systems for the most recent cost reporting period beginning before October 1, 1997, the hospital's number of State-licensed and Medicare-certified beds, including those at the satellite facilities, does not exceed the hospital's number of State-licensed and Medicare-certified beds on the last day of the hospital's last cost reporting period beginning before October 1, 1997.

(ii) The satellite facility independently complies with—

(A) For psychiatric hospitals, the requirements under § 412.23(a);

(B) For rehabilitation hospitals, the requirements under § 412.23(b)(2);

(C) For children's hospitals, the requirements under § 412.23(d)(2); or

(D) For long-term care hospitals, the requirements under §§ 412.23(e)(1) through (e)(3)(i).

(iii) The satellite facility meets all of the following requirements:

(A) It maintains admission and discharge records that are separately identified from those of the hospital in which it is located and are readily available.

(B) It has beds that are physically separate from (that is, not commingled with) the beds of the hospital in which it is located.

(C) It is serviced by the same fiscal intermediary as the hospital of which it is a part.

(D) It is treated as a separate cost center of the hospital of which it is a part.

(E) For cost reporting and apportionment purposes, it uses an accounting system that properly allocates costs and maintains adequate statistical data to support the basis of allocation.

(F) It reports its costs on the cost report of the hospital of which it is a part, covering the same fiscal period and using the same method of apportionment as the hospital of which it is a part.

(3) Except as provided in paragraph (h)(4) of this section, the provisions of paragraph (h)(2) of this section do not apply to—

(i) Any hospital structured as a satellite facility on September 30, 1999, and excluded from the prospective payment systems on that date, to the extent the hospital continues operating under the same terms and conditions, including the number of beds and square footage considered, for purposes of Medicare participation and payment, to be part of the hospital, in effect on September 30, 1999; or

(ii) Any hospital excluded from the prospective payment systems under § 412.23(e)(2).

(4) In applying the provisions of paragraph (h)(3) of this section, any hospital structured as a satellite facility on September 30, 1999, may increase or decrease the square footage of the satellite facility or may decrease the number of beds in the satellite facility if these changes are made necessary by relocation of a facility—

(i) To permit construction or renovation necessary for compliance with changes in Federal, State, or local law; or

(ii) Because of catastrophic events such as fires, floods, earthquakes, or tornadoes.

4. Section 412.25 is amended by revising paragraphs (b) and (c) and adding a new paragraph (e) to read as follows:

§ 412.25 Excluded hospital units: Common requirements.

* * * * *

(b) *Changes in the size of excluded units.* For purposes of exclusions from the prospective payment systems under this section, changes in the number of beds and square footage considered to be part of each excluded unit are allowed as specified in paragraphs (b)(1) through (b)(3) of this section.

(1) *Increase in size.* Except as described in paragraph (b)(3) of this section, the number of beds and square footage of an excluded unit may be increased only at the start of a cost reporting period.

(2) *Decrease in size.* Except as described in paragraph (b)(3) of this section, the number of beds and square footage of an excluded unit may be decreased at any time during a cost reporting period if the hospital notifies its fiscal intermediary and the HCFA Regional Office in writing of the planned decrease at least 30 days before the date of the decrease, and maintains the information needed to accurately determine costs that are attributable to the excluded unit. Any decrease in the number of beds or square footage considered to be part of an excluded unit made during a cost reporting period must remain in effect for the rest of that cost reporting period.

(3) *Exception to changes in square footage and bed size.* The number of beds in an excluded unit may be decreased, and the square footage considered to be part of the unit may be either increased or decreased, at any time, if these changes are made necessary by relocation of a unit—

(i) To permit construction or renovation necessary for compliance with changes in Federal, State, or local law affecting the physical facility; or

(ii) Because of catastrophic events such as fires, floods, earthquakes, or tornadoes.

(c) *Changes in the status of hospital units.* For purposes of exclusions from the prospective payment systems under this section, the status of each hospital unit (excluded or not excluded) is determined as specified in paragraphs (c)(1) and (c)(2) of this section.

(1) The status of a hospital unit may be changed from not excluded to excluded only at the start of the cost reporting period. If a unit is added to a

hospital after the start of a cost reporting period, it cannot be excluded from the prospective payment systems before the start of a hospital's next cost reporting period.

(2) The status of a hospital unit may be changed from excluded to not excluded at any time during a cost reporting period, but only if the hospital notifies the fiscal intermediary and the HCFA Regional Office in writing of the change at least 30 days before the date of the change, and maintains the information needed to accurately determine costs that are or are not attributable to the excluded unit. A change in the status of a unit from excluded to not excluded that is made during a cost reporting period must remain in effect for the rest of that cost reporting period.

* * * * *

(e) *Satellite facilities.* (1) For purposes of paragraphs (e)(2) through (e)(4) of this section, a satellite facility is a part of a hospital unit that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital.

(2) Except as provided in paragraph (e)(3) of this section, effective for cost reporting periods beginning on or after October 1, 1999, a hospital unit that establishes a satellite facility must meet the following requirements in order to be excluded from the prospective payment systems for any period:

(i) In the case of a unit excluded from the prospective payment systems for the most recent cost reporting period beginning before October 1, 1997, the unit's number of State-licensed and Medicare-certified beds, including those at the satellite facility, does not exceed the unit's number of State-licensed and Medicare-certified beds on the last day of the unit's last cost reporting period beginning before October 1, 1997.

(ii) The satellite facility independently complies with—

(A) For a rehabilitation unit, the requirements under § 412.23(b)(2); or

(B) For a psychiatric unit, the requirements under § 412.27(a).

(iii) The satellite facility meets all of the following requirements:

(A) It maintains admission and discharge records that are separately identified from those of the hospital in which it is located and are readily available.

(B) It has beds that are physically separate from (that is, not commingled with) the beds of the hospital in which it is located.

(C) It is serviced by the same fiscal intermediary as the hospital unit of which it is a part.

(D) It is treated as a separate cost center of the hospital unit of which it is a part.

(E) For cost reporting and apportionment purposes, it uses an accounting system that properly allocates costs and maintains adequate statistical data to support the basis of allocation.

(F) It reports its costs on the cost report of the hospital of which it is a part, covering the same fiscal period and using the same method of apportionment as the hospital of which it is a part.

(3) Except as specified in paragraph (e)(4) of this section, the provisions of paragraph (e)(2) of this section do not apply to any unit structured as a satellite facility on September 30, 1999, and excluded from the prospective payment systems on that date, to the extent the unit continues operating under the same terms and conditions, including the number of beds and square footage considered to be part of the unit, in effect on September 30, 1999.

(4) In applying the provisions of paragraph (h)(3) of this section, any unit structured as a satellite facility as of September 30, 1999, may increase or decrease the square footage of the satellite facility or may decrease the number of beds in the satellite facility at any time, if these changes are made necessary by relocation of the facility—

(i) To permit construction or renovation necessary for compliance with changes in Federal, State, or local law affecting the physical facility; or

(ii) Because of catastrophic events such as fires, floods, earthquakes, or tornadoes.

§ 412.105 [Amended]

5. Section 412.105 is amended by revising the cross reference ''paragraph (g)(1)(ii) of this section'' in paragraphs (f)(1)(iii) (three times) and (f)(2)(v) to read ''paragraph (f)(1)(ii) of this section''.

§ 412.256 [Amended]

6. In § 412.256, paragraph (c)(2), the date ''October 1'', appearing in two places, is revised to read ''September 1''.

7. Section 412.276 is amended by revising paragraph (a) to read as follows:

§ 412.276 Timing of MGCRB decision and its appeal.

(a) *Timing.* The MGCRB notifies the parties in writing, with a copy to HCFA, and issues a decision within 180 days after the first day of the 13-month period preceding the Federal fiscal year for which a hospital has filed a complete application. The hospital has 15 days from the date of the decision to request Administrator review.

* * * * *

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

B. Part 413 is amended as follows:

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

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

2. Section 413.40 is amended by adding a sentence containing paragraphs (A) and (B) at the end of the definition of ''ceiling'' in paragraph (a)(3) and revising paragraphs (b)(1)(iii), (c)(4)(v), (f)(2)(ii)(A), and (g)(1) to read as follows:

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

(a) *Introduction.* * * *

(3) *Definitions.* * * *

Ceiling * * * For a hospital-within-a-hospital, as described in § 412.22(e) of this chapter, the number of Medicare discharges in a cost reporting period does not include discharges of a patient to another hospital in the same building on or on the same campus, if—

(A) The patient is subsequently readmitted to the hospital-within-a-hospital directly from the other hospital; and

(B) The hospital-within-a-hospital has discharged to the other hospital and subsequently readmitted more than 5 percent (that is, in excess of 5.0 percent) of the total number of inpatients discharged from the hospital-within-a-hospital in that cost reporting period.

* * * * *

(b) *Cost reporting periods subject to the rate-of-increase ceiling.* (1) *Base period.* * * *

(iii) When the operational structure of a hospital or unit changes (that is, a freestanding hospital becomes an excluded unit or an excluded unit becomes a freestanding hospital, or an entity of a multicampus hospital becomes a newly created hospital or unit or a hospital or unit becomes a part of a multicampus hospital), the base period for the hospital or unit that

changed its operational structure is the first cost reporting period of at least 12 months effective with the revised Medicare certification classification.

* * * * *

(c) *Cost subject to the ceiling.* * * *

(4) *Target amounts.* * * *

(v) In the case of a hospital that received payments under paragraph (f)(2)(ii) of this section as a newly created hospital or unit, to determine the hospital's target amount for the hospital's third 12-month cost reporting period, the payment amount determined under paragraph (f)(2)(ii) of this section for the preceding cost report period is updated to the third cost reporting period.

* * * * *

(f) *Comparison to the target amount for new hospitals and units.* * * *

(2) *Comparison.* * * *

(ii) *Median target amount.* (A) For cost reporting periods beginning on or after October 1, 1997, the amount of payment for a new psychiatric hospital or unit, a new rehabilitation hospital or unit, or a new long-term care hospital that was not paid as an excluded hospital prior to October 1, 1997, is the lower of the hospital's net inpatient operating cost per case or 110 percent of the national median of the target amounts for the class of excluded hospitals and units (psychiatric, rehabilitation, long-term care) as adjusted for differences in wage levels and updated to the first cost reporting period in which the hospital receives payment. The second cost reporting period is subject to the same target amount as the first cost reporting period.

* * * * *

(g) *Adjustment.* (1) *General rules.* (i) HCFA adjusts 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.

(ii) When the hospital requests an adjustment, 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.

(iii) When the hospital requests an adjustment, HCFA makes an adjustment only if the hospital's operating costs exceed the rate-of-increase ceiling imposed under this section.

(iv) In the case of a psychiatric hospital or unit, rehabilitation hospital or unit, or long-term care hospital, the amount of payment under paragraph (g)(3) of this section may not exceed the payment amount based on the target amount determined under paragraph (c)(4)(iii) of this section.

(v) In the case of a hospital or unit that received a revised FY 1998 target amount under the rebasing provisions of paragraph (b)(1)(iv) of this section, the amount of an adjustment payment for a cost reporting period is based on a comparison of the hospital's operating costs for the cost reporting period to the average costs and statistics for the cost reporting periods used to determine the FY 1998 rebased target amount.

* * * * *

§ 413.86 [Amended]

3. Section 413.86 is amended as follows:

a. In paragraph (b), the definition of ''approved geriatric program'' is revised to read as set forth below.

b. In paragraph (b), under paragraph (1) of the definition of ''approved medical residency program'', the reference ''§ 415.200(a) of this chapter'' is revised to read ''§ 415.152 of this chapter''.

c. In paragraph (e)(1)(ii)(C), the reference ''paragraph (j)(2) of this section'' is revised to read ''paragraph (k)(1) of this section''.

d. In paragraph (e)(1)(iv), the reference, ''paragraph (j)(1) of this section'', is revised to read ''paragraph (k)(1) of this section''.

e. A new paragraph (f)(4)(iii) is added, paragraphs (g)(1)(i), (ii), and (iii), (g)(6) introductory text, (g)(6)(i) and (ii), and the first sentence of paragraph (g)(6)(iii) are revised, paragraph (g)(7) is redesignated as paragraph (g)(9), and new paragraphs (g)(7) and (g)(8) are added to read as follows:

§ 413.86 Direct graduate medical education payments.

* * * * *

(b) * * *

Approved geriatric program means a fellowship program of one or more years in length that is approved by one of the national organizations listed in § 415.152 of this chapter under that respective organization's criteria for geriatric fellowship programs.

* * * * *

(f) *Determining the total number of FTE residents.* * * *

(4) * * *

(iii) The hospital must incur all or substantially all of the costs for the training program in the nonhospital setting in accordance with the definition in paragraph (b) of this section.

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

(1) * * *

(i) For residency programs other than those specified in paragraphs (g)(1)(ii) and (g)(1)(iii) of this section, the initial residency period is the minimum number of years of formal training necessary to satisfy the requirements for initial board eligibility in the particular specialty for which the resident is training, as specified in the most recently published edition of the Graduate Medical Education Directory.

(ii) For residency programs in osteopathy, dentistry, and podiatry, the minimum requirement for certification in a specialty or subspecialty is the minimum number of years of formal training necessary to satisfy the requirements of the appropriate approving body listed in § 415.152 of this chapter.

(iii) For residency programs in geriatric medicine, accredited by the appropriate approving body listed in 415.152 of this chapter, these programs are considered approved programs on the later of—

(A) The starting date of the program within a hospital; or

(B) The hospital's cost reporting periods beginning on or after July 1, 1985.

* * * * *

(6) If a hospital establishes a new medical residency training program as defined in paragraph (g)(9) of this section on or after January 1, 1995, the hospital's FTE cap described under paragraph (g)(4) of this section may be adjusted as follows:

(i) If a hospital had no allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, and it establishes a new medical residency training program on or after January 1, 1995, the hospital's unweighted FTE resident cap under paragraph (g)(4) of this section may be adjusted based on the product of the highest number of residents in any program year during the third year of the first program's existence for all new residency training programs and the number of years in which residents are expected to complete the program based on the minimum accredited length for the type of program. The adjustment to the cap may not exceed the number of accredited slots available to the hospital for the new program.

(A) If the residents are spending an entire program year (or years) at one hospital and the remainder of the program at another hospital, the adjustment to each respective hospital's

cap is equal to the product of the highest number of residents in any program year during the third year of the first program's existence and the number of years the residents are training at each respective hospital.

(B) Prior to the implementation of the hospital's adjustment to its FTE cap beginning with the fourth year of the hospital's residency program(s), the hospital's cap may be adjusted during each of the first 3 years of the hospital's new residency program using the actual number of residents participating in the new program. The adjustment may not exceed the number of accredited slots available to the hospital for each program year.

(C) Except for rural hospitals, the cap will not be adjusted for new programs established more than 3 years after the first program begins training residents.

(D) An urban hospital that qualifies for an adjustment to its FTE cap under paragraph (g)(6)(i) of this section is not permitted to be part of an affiliated group for purposes of establishing an aggregate FTE cap.

(E) A rural hospital that qualifies for an adjustment to its FTE cap under paragraph (g)(6)(i) of this section is permitted to be part of an affiliated group for purposes of establishing an aggregate FTE cap.

(ii) If a hospital had allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, the hospital's unweighted FTE cap may be adjusted for new medical residency training programs established on or after January 1, 1995 and on or before August 5, 1997. The adjustment to the hospital's FTE resident limit for the new program is based on the product of the highest number of residents in any program year during the third year of the newly established program and the number of years in which residents are expected to complete each program based on the minimum accredited length for the type of program.

(A) If the residents are spending an entire program year (or years) at one hospital and the remainder of the program at another hospital, the adjustment to each respective hospital's cap is equal to the product of the highest number of residents in any program year during the third year of the first program's existence and the number of years the residents are training at each respective hospital.

(B) Prior to the implementation of the hospital's adjustment to its FTE cap beginning with the fourth year of the hospital's residency program, the hospital's cap may be adjusted during each of the first 3 years of the hospital's new residency program, using the actual number of residents in the new programs. The adjustment may not exceed the number of accredited slots available to the hospital for each program year.

(iii) If a hospital with allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, is located in a rural area (or other hospitals located in rural areas that added residents under paragraph (g)(6)(i) of this section), the hospital's unweighted FTE limit may be adjusted in the same manner described in paragraph (g)(6)(ii) of this section to reflect the increase for residents in the new medical residency training programs established after August 5, 1997. * * *

(7) A hospital that began construction of its facility prior to August 5, 1997, and sponsored new medical residency training programs on or after January 1, 1995 and on or before August 5, 1997, that either received initial accreditation by the appropriate accrediting body or temporarily trained residents at another hospital(s) until the facility was completed, may receive an adjustment to its FTE cap.

(i) The newly constructed hospital's FTE cap is equal to the lesser of:

(A) The product of the highest number of residents in any program year during the third year of the newly established program and the number of years in which residents are expected to complete the programs based on the minimum accredited length for each type of program; or

(B) The number of accredited slots available to the hospital for each year of the programs.

(ii) If the new medical residency training programs sponsored by the newly constructed hospital have been in existence for 3 years or more by the time the residents begin training at the newly constructed hospital, the newly constructed hospital's cap will be based on the number of residents training in the third year of the programs begun at the temporary training site.

(iii) If the new medical residency training programs sponsored by the newly constructed hospital have been in existence for less than 3 years by the time the residents begin training at the newly constructed hospital, the newly constructed hospital's cap will be based on the number of residents training at the newly constructed hospital in the third year of the programs (including the years at the temporary training site).

(iv) A hospital that qualifies for an adjustment to its FTE cap under paragraph (g)(7) of this section may be part of an affiliated group for purposes of establishing an aggregate FTE cap.

(v) The provisions of this paragraph (g)(7) are applicable during portions of cost reporting periods occurring on or after October 1, 1999.

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

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

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

(iii) For purposes of paragraph (g)(8) of this section, ''closure'' means the hospital terminates its Medicare agreement under the provisions of § 489.52 of this chapter.

* * * * *

PART 483—REQUIREMENTS FOR STATES AND LONG-TERM CARE FACILITIES

C. Part 483 is amended as set forth below:

1. The authority citation for Part 483 continues to read as follows:

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

2. In § 483.20, the introductory text of paragraph (b)(2) is revised to read as follows:

§ 483.20 Resident assessment.

* * * * *

(b) *Comprehensive assessments.* * * *

(2) *When required.* Subject to the timeframes prescribed in § 413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2) (i) through (iii) of this section. The timeframes prescribed in § 413.343(b) of this chapter do not apply to CAHs.

* * * * *

PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

D. Part 485 is amended as follows:

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

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

2. Section 485.618 is amended by revising paragraph (d) to read as follows:

§ 485.618 Conditions of participation: Emergency services.

* * * * *

(d) *Standard: Personnel.* There must be a doctor of medicine or osteopathy, a physician assistant, or a nurse practitioner with training or experience in emergency care on call and immediately available by telephone or radio contact, and available on site within the following timeframes:

(1) Within 30 minutes, on a 24-hour a day basis, if the CAH is located in an area other than an area described in paragraph (d)(2) of this section; or

(2) Within 60 minutes, on a 24-hour a day basis, if all of the following requirements are met:

(i) The CAH is located in an area designated as a frontier area (that is, an area with fewer than six residents per square mile based on the latest population data published by the Bureau of the Census) or in an area that meets criteria for a remote location adopted by the State in its rural health care plan, and approved by HCFA, under section 1820(b) of the Act.

(ii) The State has determined under criteria in its rural health care plan that allowing an emergency response time longer than 30 minutes is the only feasible method of providing emergency care to residents of the area served by the CAH.

(iii) The State maintains documentation showing that the response time of up to 60 minutes at a particular CAH it designates is justified because other available alternatives would increase the time needed to stabilize a patient in an emergency.

* * * * *

3. In § 485.645, the introductory text of paragraph (d) is republished and paragraph (d)(6) is revised to read as follows:

§ 485.645 Special requirements for CAH providers of long-term care services (''swing beds'').

* * * * *

(d) *SNF services.* The CAH is substantially in compliance with the following SNF requirements contained in subpart B of part 483 of this chapter:

* * * * *

(6) Comprehensive assessment, comprehensive care plan, and discharge planning (§ 483.20 (b), (d), and (e) of this chapter, except that the CAH is not required to comply with the requirements for frequency, scope and number of assessments prescribed in § 413.343(b)).

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance)

Dated: July 21, 1999.

Michael M. Hash,

Deputy Administrator, Health Care Financing Administration.

Dated: July 22, 1999.

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, 1999; Payment Amounts for Blood Clotting Factor Effective for Discharges Occurring On or After October 1, 1999; and Update Factors and Rate-of-Increase Percentages Effective With Cost Reporting Periods Beginning On or After October 1, 1999

I. Summary and Background

In this addendum, we are setting forth the amounts and factors for determining prospective payment rates for Medicare inpatient operating costs and Medicare inpatient capital-related costs. We are also setting 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, 1999, 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 yields 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 for FY 2000. The changes, to be applied prospectively, affect the calculation of the Federal rates. In section III of this addendum, we are updating the payments per unit for blood clotting factor provided to hospital inpatients who have hemophilia. We are also adding another product (clotting factor, porcine (HCPCS code J7191)) to the list of clotting factors that are paid under this benefit.

In section IV of this addendum, we discuss our changes for determining the prospective payment rates for Medicare inpatient capital-related costs for FY 2000. Section V of this addendum sets forth our changes for determining the rate-of-increase limits for hospitals excluded from the prospective payment system for FY 2000. 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 2000

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, once issued as final, will be effective with discharges occurring on or after October 1, 1999. 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 2000.

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

- Updates of 1.1 percent for all areas (that is, the market basket percentage increase of 2.9 percent minus 1.8 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 1999 budget neutrality factor and applying a revised factor;

- An adjustment to apply the revised outlier offset by removing the FY 1999 outlier offsets and applying a new offset; and
- An adjustment in the Puerto Rico standardized amounts to reflect the application of a Puerto Rico-specific wage index.

A. Calculation of Adjusted Standardized Amounts

1. Standardization of Base-Year Costs or Target Amounts

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

Section 1886(d)(9)(B)(i) of the Act required us to determine the Medicare target amounts for each hospital located in Puerto Rico for its cost reporting period beginning in FY 1987. The September 1, 1987 final rule 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 us to update base-year per discharge costs for FY 1984 and then standardize the cost data in order to remove the effects of certain sources of variation in cost among hospitals. These effects include case mix, differences in area wage levels, cost-of-living adjustments for Alaska and Hawaii, indirect medical education costs, and payments to hospitals serving a disproportionate share of low-income patients.

Under sections 1886 (d)(2)(H) and (d)(3)(E) of the Act, in making payments under the prospective payment system, the Secretary estimates from time to time the proportion of costs that are wages and wage-related costs. Since October 1, 1997, when the market basket was last revised, we have considered 71.1 percent of costs to be labor-related for purposes of the prospective payment system. The average labor share in Puerto Rico is 71.3 percent. We are 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 1998 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 2000. These areas are identified by a footnote in Table 4A. We note that on July 6, 1999, the Office of Management and Budget announced the designation of the Corvallis, Oregon and the Auburn-Opelika, Alabama MSAs. We have incorporated these changes 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 areas' and the other areas' average standardized amounts for FY 2000 using the applicable percentage increases specified in section 1886(b)(3)(B)(i) of the Act. Section 1886(b)(3)(B)(i)(XV) of the Act specifies that, for hospitals in all areas, the update factor for the standardized amounts for FY 2000 is equal to the market basket percentage increase minus 1.8 percentage points.

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 2000 is 2.9 percent. Thus, for FY 2000, the update to the average standardized amounts equals 1.1 percent.

As in the past, we are adjusting the FY 1999 standardized amounts to remove the effects of the FY 1999 geographic reclassifications and outlier payments before applying the FY 2000 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 2000.

Although the update factor for FY 2000 is set by law, we are required by section 1886(e)(3) of the Act to report to the Congress on our final recommendation of update factors for FY 2000 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 requires us to update the hospital wage index on an annual basis beginning October 1, 1993. This provision also requires us to make any updates or adjustments to the wage index in a manner that ensures that aggregate payments to hospitals are not affected by the change in the wage index.

To comply with the requirement of section 1886(d)(4)(C)(iii) of the Act that DRG reclassification and recalibration of the relative weights be budget neutral, and the requirement in section 1886(d)(3)(E) of the Act that the updated wage index be budget neutral, we used historical discharge data to simulate payments and compared aggregate payments using the FY 1999 relative weights and wage index to aggregate payments using the FY 2000 relative weights and wage index. The same methodology was used for the FY 1999 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 0.997808. We also adjust the Puerto Rico-specific standardized amounts for the effect of DRG reclassification and recalibration. We computed a budget neutrality adjustment factor for Puerto Rico-specific standardized amounts equal to 0.999745. These budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the FY 1999 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 these same adjustment factors to the hospital-specific rates that are effective for cost reporting periods beginning on or after October 1, 1999. (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 May 7, 1999 proposed rule, we applied an adjustment factor of 0.994453 to ensure that the effects of reclassification are budget neutral. The final budget neutrality adjustment factor is 0.993799.

The adjustment factor is applied to the standardized amounts after removing the effects of the FY 1999 budget neutrality adjustment factor. We note that the proposed FY 2000 adjustment reflects wage index and standardized amount reclassifications approved by the MGCRB or the Administrator as of February 26, 1999. The effects of any additional reclassification changes resulting from appeals and reviews of the MGCRB decisions for FY 2000 or from a hospital's request for the withdrawal of a reclassification request are reflected in the final budget neutrality adjustment required under section 1886(d)(8)(D) of the Act and 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 2000 outlier thresholds. For FY 1999, the fixed loss cost outlier threshold is equal to the prospective payment for the DRG plus $11,100 ($10,129 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 1999 standardized amounts of 0.948740 for the large urban and other areas rates and 0.9392 for the capital Federal rate.

For FY 2000, we proposed to establish a fixed loss cost outlier threshold equal to the prospective payment rate for the DRG plus the IME and DSH payments plus $14,575 ($13,309 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 2000 outlier thresholds, we used updated data. In this final rule, we are establishing a fixed loss cost outlier threshold for FY 2000 equal to the prospective payment rate for the DRG plus the IME and DSH payments plus $14,050 ($12,827 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. As we have explained in the past, to calculate outlier thresholds we apply a cost inflation factor to update costs for the cases used to simulate payments. For FY 1998, we used a cost inflation factor of minus 2.005 percent (a cost per case decrease of 2.005 percent). For FY 1999, we used a cost inflation factor of minus 1.724 percent. To set the proposed FY 2000 outlier thresholds, we used a cost inflation factor (or cost adjustment factor) of zero percent. We are using a cost inflation factor of zero percent to set the final FY 2000 outlier thresholds. This factor reflects our analysis of the best available cost report data as well as calculations (using the best available data) indicating that the percentage of actual outlier payments for FY 1998 is higher than we projected before the beginning of FY 1998, and that the percentage of actual outlier payments for FY 1999 will likely be higher than we projected before the beginning of FY 1999. The calculations of ''actual'' outlier payments are discussed further below.

ii. Other changes concerning outliers. In accordance with section 1886(d)(5)(A)(iv) of the Act, we calculated 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 2000 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 2000 will result in outlier payments equal to 5.1 percent of operating DRG payments and 6.0 percent of capital payments based on the Federal rate.

The proposed outlier adjustment factors applied to the standardized amounts for FY 2000 were as follows:

	Operating standard-ized amounts	Capital federal rate
National	0.948934	0.9397
Puerto Rico	0.969184	0.9334

The final outlier adjustment factors applied to the standardized amounts for FY 2000 are as follows:

	Operating standard-ized amounts	Capital federal rate
National	0.948859	0.9402
Puerto Rico	0.968581	0.9331

As in the proposed rule, we apply the outlier adjustment factors after removing the effects of the FY 1999 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 fiscal intermediary is unable to compute a reasonable hospital-specific cost-to-charge ratio. Effective October 1, 1999, these Statewide average ratios replace the ratios published in the July 31, 1998 final rule (63 FR 41099). Table 8B contains comparable Statewide average capital cost-to-charge ratios. These average ratios would be used to calculate cost outlier payments for those hospitals for which the fiscal intermediary computes operating cost-to-charge ratios lower than 0.209551 OR greater than 1.284349 and capital cost-to-charge ratios lower than 0.01290 or greater than 0.17205. 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 2000 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 1998 and FY 1999 outlier payments. In the July 31, 1998 final rule (63 FR 41009), we stated that, based on available data, we estimated that actual FY 1998 outlier payments would be approximately 5.4 percent of actual total DRG payments. This was computed by simulating payments using actual FY 1997 bill data available at the time. That is, the estimate of actual outlier payments did not reflect FY 1998 bills but instead reflected the application of FY 1998 rates and policies to available FY 1997 bills. Our current estimate, using available FY 1998 bills, is that actual outlier payments for FY 1998 were approximately 6.5 percent of actual total DRG payments. We note that the MedPAR file for FY 1998 discharges continues to be updated. Thus, the data indicate that, for FY 1998, the percentage of actual outlier payments relative to actual total payments is higher than we projected before FY 1998 (and thus exceeds the percentage by which we reduced the standardized amounts for FY 1998). In fact, the data indicate that the proportion of actual outlier payments for FY 1998 exceeds 6 percent. Nevertheless, consistent with the policy and statutory interpretation we have maintained since the inception of the prospective payment system, we do not plan to recoup money and make retroactive adjustments to outlier payments for FY 1998.

We currently estimate that actual outlier payments for FY 1999 will be approximately 6.3 percent of actual total DRG payments, higher than the 5.1 percent we projected in setting outlier policies for FY 1999. This estimate is based on simulations using the March 1999 update of the provider-specific file and the March 1999 update of the FY 1998 MedPAR file (discharge data for FY 1998 bills). We used these data to calculate an estimate of the actual outlier percentage for FY 1999 by applying FY 1999 rates and policies to available FY 1998 bills.

Comment: Several commenters indicated that the proposed 30-percent increase in the cost outlier threshold is too great and implementing that threshold will cause significant revenue losses for hospitals with large numbers of high-cost cases. They observed that the proposed increase in the fixed loss threshold may be reasonable to reach the 5.1 percent level of outlier payments, but suggested an increase in funding for outlier cases from the current level of 5.1 percent to 5.5 percent, or even 6.0 percent, with a corresponding reduction in the fixed loss threshold.

Response: Outlier payments are meant to protect hospitals against the financial effects of treating extraordinarily high-cost cases. Increasing the level of outlier payments to 5.5 percent would result in a corresponding offset to the standardized amounts, proportionally reducing payments for typical cases. We believe that it is in the best interest of hospitals and the program to maintain the level of outliers at 5.1 percent, thereby providing all hospitals with somewhat larger rates for typical cases.

We also note that we estimate that actual outlier payments for FY 1998 were equal to 6.5 percent of actual total DRG payments, and 6.3 percent for FY 1999. We believe that outlier payments are greater than expected for these years in part because actual hospital costs may be higher than reflected in the methodology used to set outlier thresholds for those years. While we are attempting to improve our estimate of payments for FY 2000 by using a cost inflation factor of zero percent rather than a negative inflation factor, we believe it would be imprudent to raise the estimated level of outlier payments at a time when actual outlier payments have exceeded our estimates by more than one percentage point for the past 2 years.

Comment: One commenter expressed concern that, in the proposed rule, we referenced our longstanding policy regarding overpayments and underpayments and retroactive adjustments to outlier payments. The commenter stated that this reference appears to be necessitated by a large number of hospital appeals and questioned whether we intend to provide a clarification instead of what appears to be a new interpretation.

Response: As we stated in the proposed rule, our statement that ''we do not plan to recoup money and make retroactive adjustments to outlier payments for FY 1998,'' because the actual outlier payments exceed 6 percent of total payments, is consistent with the policy and statutory interpretation we have maintained since the inception of the prospective payment system. We have publicly stated our policy on several occasions. For example, in the January 3, 1984 final rule (49 FR 234, 265), we stated:

''Using data we had available, we set the outlier criteria so that an estimated 6 percent of total payments would be made for outliers. Nevertheless, there is no necessary connection between the amount of estimated outlier payments and the actual payments made to hospitals for cases that actually meet the outlier criteria. While we expect that under these criteria, outlier payments will approximate 6 percent of total payments, we will pay for any outlier that meets the criteria, even if aggregate outlier payments result in more than 6 percent of total payments.'' Also, in the September 1, 1992 final rule (57 FR 39784), we stated that ''* * * in light of the nature of the prospective payment system, and our attempts to estimate outlier payments as accurately as possible, we believe that we have satisfied the statute and that no retroactive adjustment is warranted.'' In the same rule, we also stated that ''* * * retroactive adjustment of system wide elements would be contrary to the nature of the prospective payment system.'' Therefore, our comment in the proposed rule concerning the overpayment or underpayment of outliers was a restatement of our longstanding policy.

5. FY 2000 Standardized Amounts

The adjusted standardized amounts are divided into labor and nonlabor portions. Table 1A 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). The labor and nonlabor portions of the national average standardized amounts for Puerto Rico hospitals are set forth in Table 1C. This table also includes the Puerto Rico standardized amounts.

B. Adjustments for Area Wage Levels and Cost of Living

Tables 1A and 1C, as set forth in this addendum, contain the 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 requires that we make an adjustment to the labor-related portion of the prospective payment rates to account for area differences in hospital wage levels. This adjustment is made by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. In section III of this preamble, we discuss the data and methodology for the FY 2000 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 2000, 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	1.25
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 2000. These factors have been recalibrated as explained in section II of the preamble.

D. Calculation of Prospective Payment Rates for FY 2000

General Formula for Calculation of Prospective Payment Rates for FY 2000

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

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, 1999 and before October 1, 2000, 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 in section VI of this addendum).

Step 2—Multiply the labor-related portion of the standardized amount by the applicable wage index for the geographic area in which the hospital is located (see Tables 4A, 4B, and 4C of section 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 of 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 2000.

We are increasing the hospital-specific rates by 1.1 percent (the hospital market basket percentage increase of 2.9 percent minus 1.8 percentage points) for sole community hospitals and Medicare-dependent, small rural hospitals located in all areas for FY 2000. 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 2000, is the market basket rate of increase minus 1.8 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 2000, is the market basket rate of increase minus 1.8 percentage points.

b. Calculation of Hospital-Specific Rate.

For sole community hospitals and Medicare-dependent, small rural hospitals, the applicable FY 2000 hospital-specific rate is calculated by increasing the hospital's hospital-specific rate for the preceding fiscal year by the applicable update factor (1.1 percent), which is the same as the update for all prospective payment hospitals. In addition, the hospital-specific rate is adjusted by the budget neutrality adjustment factor (that is, 0.997808) as discussed in section II.A.4.a of this Addendum. The resulting rate is 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, 1999, 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, 1999 and Before October 1, 2000

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

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

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

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

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

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

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

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

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

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

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

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

Comment: One commenter asked if the temporary relief payment provision of the Balanced Budget Act of 1997 (BBA) would continue into FY 2000. The commenter suggested that, in light of reports that implementation of the hospital-related provisions of the BBA provided larger than expected savings, we consider extending the provision into next year and increasing the amount of relief.

Response: Under section 4401(b) of the BBA, the temporary special payment for certain hospitals that did not receive IME or DSH payments and that did not qualify as Medicare-dependent, small rural hospitals is limited to FY 1998 and FY 1999. The statute does not provide for the special payment in later fiscal years. We believe that the temporary special payment provided under section 4401(b) of the BBA was meant to partially protect qualifying hospitals from the initial effects of the reduced updates to hospital payment rates enacted by the BBA. We believe that two years of relief payments is adequate to allow hospitals to adjust to the reduced payment updates under the BBA.

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

As discussed in our May 7, 1999 proposed rule (64 FR 24756), section 4452 of the BBA 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. The add-on payment amount for each clotting factor, as described in HCFA's Common Procedure Coding System (HCPCS), is based on the median average wholesale price (AWP) of the several products available in that category of factor, discounted by 15 percent.

Also, we are adding HCPCS code J7191 (clotting factor, porcine) to the list of clotting factors that will be paid under this benefit. This code was recently reestablished in the HCPCS coding system because it represents a unique product that is different from the other clotting factors listed.

Based on the methodology described above, the prices per unit of factor for FY 2000 are as follows:

J7190 Factor VIII (antihemophilic factor, human) 0.79

J7191 Factor VIII (antihemophilic factor, porcine)	1.87
J7192 Factor VIII (antihemophilic factor, recombinant)	1.03
J7194 Factor IX (complex)	0.45
J7196 Other hemophilia clotting factors (for example, anti-inhibitors)	1.43
Q0160 Factor IX (antihemophilic factor, purified, nonrecombinant)	0.97
Q0161 Factor IX (antihemophilic factor, 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, 1999 through September 30, 2000. Payment will be made for the blood clotting factor only if there is an ICD–9–CM diagnosis code for hemophilia included on the bill.

We received one comment on this proposed provision.

Comment: One commenter indicated that there is a new clotting factor product, recombinant coagulation Factor VIIa, that is covered by this benefit, but was not mentioned in the proposed rule. Because this product is unique and packaged and dosed per microgram, and not per IU as the other clotting factor products listed in the HCPCS, the commenter requested a separate temporary code and price to be added to the final rule.

Response: We agree that recombinant coagulation Factor VIIa is covered by this benefit. We also agree that no appropriate HCPCS code exists for this product. Because of constraints on Year 2000 computer systems changes, we are not able to establish a new HCPCS code or a claims process to pay for this product at this time. Therefore, any providers furnishing recombinant coagulation Factor VIIa to hospital inpatients who have hemophilia should hold their billings for Factor VIIa until we announce by instructions to our fiscal intermediaries that a new code and claims process have been established. These hospitals should continue to submit claims for all other covered items and services furnished to these Medicare beneficiaries in accordance with established program procedures. The price for recombinant coagulation Factor VIIa for FY 2000 will be $1.19 per microgram.

IV. Changes to Payment Rates for Inpatient Capital-Related Costs for FY 2000

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 2000. The rates would be effective for discharges occurring on or after October 1, 1999.

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 that was made in FY 1994, and § 412.308(b)(3) describes the 0.28 percent reduction to the rate made in FY 1996 as a result of the revised policy of paying for transfers. In the FY 1998 final rule with comment period (62 FR 45966), we implemented section 4402 of the BBA, which requires that for discharges occurring on or after October 1, 1997, and before October 1, 2002, the unadjusted standard Federal rate is reduced by 17.78 percent. A small part of that reduction will be restored effective October 1, 2002. As a result of the February 25, 1999 final rule (64 FR 9378), the Federal rate changed effective March 1, 1999, because of revisions to the GAF.

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. 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 this reduction will 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, 1998, as a result of enactment 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

In the July 31, 1998 final rule (63 FR 41011), we established a capital Federal rate of $378.05 for FY 1999. As of the March 1, 1999 revision, the Federal rate for FY 1999 is $378.10. In the proposed rule, we stated that the proposed FY 2000 Federal rate was $374.31. In this final rule, we are establishing a FY 2000 Federal rate of $377.03.

In the discussion that follows, we explain the factors that were used to determine the FY 2000 capital Federal rate. In particular, we explain why the FY 2000 Federal rate has decreased 0.28 percent compared to the FY 1999 Federal rate. Even though the FY 2000 Federal capital rate is less than the FY 1999 Federal rate, we estimate aggregate capital payments will increase by 3.64 percent during this same period. This increase is primarily due to the increase in the Federal blend percentage from 80 to 90 percent for fully prospective payment hospitals.

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 2000 compared to FY 1999.

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 and other factors. The update framework consists of a capital input price index (CIPI) and several policy adjustment factors. Specifically, we have adjusted the projected CIPI rate of increase as appropriate each year for case-mix index related changes, for intensity, and for errors in previous CIPI forecasts. The proposed rule reflected an update factor of −0.6 percent, based on the data available at that time. Under the update framework, the final update factor for FY 2000 is 0.3 percent. This update factor is based on a projected 0.6 percent increase in the CIPI, a 0.1 percent adjustment for the FY 1998 DRG reclassification and recalibration, and a forecast error correction of −0.4 percent. We explain the basis for the FY 2000 CIPI projection in section II.D of this addendum.

Below we describe the policy adjustments that have been applied to the FY 2000 capital payment rates update.

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'').
- 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 1998 DRG reclassification and recalibration as part of our FY 2000 update recommendation.) We have adopted this case-mix index adjustment in the capital update framework as well.

For FY 2000, we are projecting a 0.5 percent increase in the case-mix index. We estimate that real case-mix increase will equal 0.5 percent in FY 2000. Therefore, the net adjustment for case-mix change in FY 2000 is 0.0 percentage points.

We estimate that FY 1998 DRG reclassification and recalibration resulted in a −0.1 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. In the framework, we make an adjustment for DRG reclassification and recalibration to account for the 2-year lag on the available data used to estimate the effect of DRG changes. A DRG reclassification and recalibration adjustment of 0.1 percentage points was calculated for the FY 2000 update as the 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 based on FY 1998 data. That is, in determining the effect of DRG reclassification and recalibration using FY 1998 data, the actual effect of DRG reclassification and recalibration was understated by −0.1 percent. Therefore, we are making a 0.1 percent adjustment for DRG reclassification and recalibration in the update for FY 2000.

Comment: One commenter noted that the magnitude of the −0.7 adjustment for FY 1998 Reclassification and Recalibration (GROUPER Effect) in the proposed capital (and operating) update framework appears to be inconsistent with past numbers published by HCFA. Accordingly, the commenter requested that HCFA review the data and computation of that adjustment in the capital update framework.

Response: In the May 7, 1999 proposed rule (64 FR 24578), we estimated that FY 1998 DRG reclassification and recalibration resulted in a 0.7 percent change in the case-mix index when compared with the case-mix index that would have resulted if we had not made the reclassification and recalibration changes to the DRGs. Therefore, we proposed making a −0.7 percent adjustment for DRG reclassification and recalibration in the proposed capital update recommendation for FY 2000.

Upon review, we have discovered that incorrect data were used in estimating the proposed −0.7 adjustment for the effect of FY 1998 reclassification and recalibration. We have recalculated the adjustment based on correct and updated data and the revised adjustment for the effect of FY 1998 reclassification and recalibration for the FY 2000 capital update is +0.1.

The capital update framework contains an adjustment for forecast

error. The input price index forecast is based on historical trends and relationships ascertainable at the time the update factor is established for the upcoming year. In any given year, there may be unanticipated price fluctuations that may result in differences between the actual increase in prices and the forecast used in calculating the update factors. In setting a prospective payment rate under the framework, we make an adjustment for forecast error only if our estimate of the change in the capital input price index for any year is incorrect by 0.25 percentage points or more. There is a 2-year lag between the forecast and the measurement of the forecast error. A forecast error of −0.4 percentage points was calculated for the FY 1998 update. That is, current historical data indicate that the FY 1998 CIPI used in calculating the forecasted FY 1998 update factor overstated realized price increases by 0.4 percent. Therefore, we are making a −0.4 percent adjustment for forecast error in the update for FY 2000.

Under the capital prospective payment system update 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. Therefore, we have incorporated the intensity adjustment from the operating update framework into the capital update framework. Without reliable estimates of the proportions of the overall annual intensity increases that are due, respectively, to ineffective practice patterns and to the combination of quality-enhancing new technologies and within-DRG complexity, we assume, as in the revised operating update framework, that one-half of the annual increase is due to each of these factors. The capital update framework thus provides an add-on to the input price index rate of increase of one-half of the estimated annual increase in intensity to allow for within-DRG severity increases and the adoption of quality-enhancing technology.

For FY 2000, we have developed a Medicare-specific intensity measure based on a 5-year average using FY 1994 through FY 1998 data. In determining case-mix constant intensity, we found that observed case-mix increase was 0.8 percent in FY 1994, 1.7 percent in FY 1995, 1.6 percent in FY 1996, 0.3 percent in FY 1997, and −0.4 percent in FY 1998. 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 1994 through FY 1998. Based on this analysis, we believe that all of the observed case-mix increase for FY 1994, FY 1997, and FY 1998 is real. The increases for FY 1995 and FY 1996 were in excess of our estimate of real case-mix increase.

We calculate case-mix constant intensity as the change in total charges per admission, adjusted for price level changes (the CPI hospital component), and changes in real case-mix. Given estimates of real case mix of 0.8 percent for FY 1994, 1.0 percent for FY 1995, 1.0 percent for FY 1996, 0.3 percent for FY 1997, and −0.4 for FY 1998, we estimate that case-mix constant intensity declined by an average 1.3 percent during FYs 1994 through 1998, for a cumulative decrease of 6.3 percent. If we assume that real case-mix increase was 0.8 percent for FY 1994, 1.4 percent for FY 1995, 1.4 percent for FY 1996, 0.3 percent for FY 1997, and −0.4 for FY 1998, we estimate that case-mix constant intensity declined by an average 1.5 percent during FYs 1994 through 1998, for a cumulative decrease of 7.1 percent. Since we estimate that intensity has declined during that period, we are making a 0.0 percent intensity adjustment for FY 2000.

In summary, the FY 2000 final capital update under our framework is 0.3 percent. This update is based on a projected 0.6 increase in the CIPI, policy adjustment factors of 0.0, a 0.1 adjustment for the effect of FY 1998 reclassification and recalibration, and a forecast error correction of −0.4.

b. Comparison of HCFA and MedPAC Update Recommendations.

As discussed in the proposed rule, MedPAC recommended a −1.1 to 1.8 percent update to the standard capital Federal rate and we recommended a −0.6 percent update. (See the May 7, 1999 proposed rule for the differences between the MedPAC and HCFA update frameworks (64 FR 24758)). In this final rule, as discussed in the previous section, we are implementing a 0.3 percent update to the capital Federal rate.

Comment: MedPAC noted that our update recommendation of −0.6 percent was within the range of the −1.1 to 1.8 percent that they recommended. They also asserted that the distinction between inpatient operating and capital payment rates is arbitrary and does not foster efficient overall decision making about the allocation of resources. Accordingly, MedPAC recommended that once the transition to fully prospective capital payment is completed, a single prospective payment rate should be developed for hospital inpatient services to Medicare beneficiaries. MedPAC indicated that a single prospective payment rate for both operating and capital costs would be consistent with the way that hospitals purchase a majority of goods and services. MedPAC plans to investigate options for coordinating the capital and operating updates and would be pleased to work with HCFA on this effort.

Response: We responded to a similar comment in the May 7, 1999 proposed rule (64 FR 24759), the July 31, 1998 final rule (63 FR 41013), and in the September 1, 1995 final rule (60 FR 45816). In those rules, we stated that our long-term goal was to develop a single update framework for operating and capital prospective payments and that we would begin development of a unified framework. We indicated that, in the meantime, we would maintain as much consistency as possible between the current operating and capital frameworks in order to facilitate the eventual development of a unified framework. In addition, we stated that because of the similarity of the update frameworks, the update frameworks could be combined without too much difficulty. We maintain our goal of combining the update frameworks and

may examine combining the payment systems after the conclusion of the capital prospective payment transition period. While we welcome MedPAC's assistance in the eventual development of a unified operating and capital update framework, we believe that developing a unified operating and capital update framework would become a higher priority if the actual operating update was no longer determined by Congress through the statute and the unified update would be appropriately applied directly to a combined payment rate for operating and capital costs.

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, 90 percent for cost reporting periods beginning in FY 2000 for hospitals paid under the fully prospective payment 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 July 31, 1998 final rule, we estimated that outlier payments for capital in FY 1999 would equal 6.08 percent of inpatient capital-related payments based on the Federal rate (63 FR 41013). Accordingly, we applied an outlier adjustment factor of 0.9392 to the Federal rate. For FY 2000, we estimate that outlier payments for capital will equal 5.98 percent of inpatient capital-related payments based on the Federal rate. Therefore, we are establishing an outlier adjustment factor of 0.9402 to the Federal rate. Thus, estimated capital outlier payments for FY 2000 represent a lower percentage of total capital standard payments than in FY 1999.

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 2000 is 1.0011 (0.9402/0.9392). The outlier adjustment increases the FY 2000 Federal rate by 0.11 percent compared with the FY 1999 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 1999, we calculated a GAF/DRG budget neutrality factor of 1.0027. In the February 25, 1999 final rule (64 FR 9381), we adopted an incremental GAF/DRG budget neutrality factor of 1.0028 for discharges on or after March 1, 1999. In the proposed rule for FY 2000, we proposed a GAF/DRG budget neutrality factor of 0.9986. In this final rule, based on calculations using updated data, we are applying a factor of 0.9985. 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 1999 to FY 2000 is 0.9985. The cumulative change in the rate due to this adjustment is 1.0014 (the product of the incremental factors for FY 1993, FY 1994, FY 1995, FY 1996, FY 1997, FY 1998, FY 1999, and FY 2000: $0.9980 \times 1.0053 \times 0.9998 \times 0.9994 \times 0.9987 \times 0.9989 \times 1.0028 \times 0.9985 = 1.0014$).

This factor accounts for DRG reclassifications and recalibration and for changes in the GAF. It also incorporates the effects on the GAF of FY 2000 geographic reclassification decisions made by the MGCRB compared to FY 1999 decisions. However, it does not account for changes in payments due to changes in the DSH and IME adjustment factors or in the large urban add-on.

4. Exceptions Payment Adjustment Factor

Section 412.308(c)(3) requires that the standard Federal rate for inpatient capital-related costs be reduced by an adjustment factor equal to the estimated proportion of additional payments for exceptions under § 412.348 relative to total 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 1999, we estimated that exceptions payments would equal 2.17 percent of aggregate payments based on the Federal rate and the hospital-specific rate. Therefore, we applied an exceptions reduction factor of 0.9783 (1—0.0217) in determining the Federal rate. In the May 7, 1999 proposed rule, we estimated that exceptions payments for FY 2000 would equal 2.48 percent of aggregate payments based on the Federal rate and the hospital-specific rate. Therefore, we proposed an exceptions payment reduction factor of 0.9752 to the Federal rate for FY 2000. For this final rule, based on updated data, we estimate that exceptions payments for FY 2000 will equal 2.70 percent of aggregate payments based on the Federal rate and hospital-specific rate. We are, therefore, applying an exceptions payment reduction factor of 0.9730 (1—0.0270) to the Federal rate for FY 2000. The final exceptions reduction factor for FY 2000 is 0.54 percent lower than the factor for FY 1999 and 0.23 percent lower than the factor in the FY 2000 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 2000 Federal rate is 0.9730/0.9783, or 0.9946.

5. Standard Capital Federal Rate for FY 2000

For FY 1999 (effective March 1, 1999), the capital Federal rate was $378.10. As a result of changes we proposed to the factors used to establish the Federal rate, we proposed that the FY 2000 Federal rate would be $374.31. In this final rule, we are establishing a FY 2000 Federal rate of $377.03. The Federal rate for FY 2000 was calculated as follows:

- The FY 2000 update factor is 1.0030; that is, the update is 0.30 percent.
- The FY 2000 budget neutrality adjustment factor that is applied to the standard Federal payment rate for changes in the DRG relative weights and in the GAF is 0.9985.
- The FY 2000 outlier adjustment factor is 0.9402.
- The FY 2000 exceptions payments adjustment factor is 0.9730.

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 2000 affected the computation of the FY 2000 Federal rate in comparison to the FY 1999 Federal rate. The FY 2000 update factor has the effect of increasing the Federal rate by 0.30 percent compared to the rate in FY 1999, while the final geographic and DRG budget neutrality factor has the effect of decreasing the Federal rate by 0.15 percent. The FY 2000 outlier adjustment factor has the effect of increasing the Federal rate by 0.11 percent compared to FY 1999. The FY 2000 exceptions reduction factor has the effect of decreasing the Federal rate by 0.54 percent compared to the exceptions reduction for FY 1999. The combined effect of all the changes is to decrease the Federal rate by 0.28 percent compared to the Federal rate for FY 1999.

COMPARISON OF FACTORS AND ADJUSTMENTS: FY 1999 FEDERAL RATE AND FY 2000 FEDERAL RATE

	FY 1999	FY 2000	Change	Percent change
Update Factor [1]	1.0010	1.0030	1.0030	0.30
GAF/DRG Adjustment Factor [1]	1.0028	0.9985	0.9985	−0.15
Outlier Adjustment Factor [2]	0.9392	0.9402	1.0011	0.11
Exceptions Adjustment Factor [2]	0.9783	0.9730	0.9946	−0.54
Federal Rate	$378.10	$377.03	0.9972	−0.28

[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 1999 to FY 2000 resulting from the application of the 0.9985 GAF/DRG budget neutrality factor for FY 2000 is 0.9985.

[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 2000 outlier reduction factor is 0.9402/0.9392, or 1.0011.

As stated previously in this section, the FY 2000 Federal rate has decreased 0.28 percent compared to the FY 1999 Federal rate, even though the capital rate update factor has increased from 0.1 percent in FY 1999 to 0.3 percent in FY 2000. The 0.28 percent decrease in the Federal capital rate is a result of the combination of the FY 2000 factors and adjustments applied to the Federal rate. Specifically, the exceptions reduction factor decreased 0.54 percent from 0.9783 for FY 1999 to 0.9730 for FY 2000, which results in a larger reduction to the Federal capital rate for FY 2000 compared to FY 1999. Also, the GAF/DRG adjustment factor decreased 0.42 percent from 1.0027 for FY 1999 to 0.9985 for FY 2000, which results in a decrease the Federal capital rate for FY 2000 compared to FY 1999. The outlier adjustment factor increased 0.11 percent from 0.9392 for FY 1999 to 0.9402 for FY 2000, which results in an increase to the Federal capital rate for FY 2000 compared to FY 1999. The effect of all of these changes is a −0.28 percent decrease in the FY 2000 Federal rate compared to FY 1999.

Even though the FY 2000 Federal capital rate is less than the FY 1999 Federal rate, we estimate that aggregate capital payments will increase 3.64 percent during this same period, primarily due to the increase in the Federal blend percentage (from 80 to 90 percent) for fully prospective payment hospitals.

We are also providing a chart that shows how the final FY 2000 Federal rate differs from the proposed FY 2000 Federal rate.

COMPARISON OF FACTORS AND ADJUSTMENTS: FY 2000 PROPOSED FEDERAL RATE AND FY 2000 FINAL FEDERAL RATE

	Proposed FY 2000	Final FY 2000	Change	Percent change
Update Factor [1]	0.9940	1.0030	1.0091	0.91
GAF/DRG Adjustment Factor	0.9986	0.9985	0.9999	−0.01
Outlier Adjustment Factor	0.9397	0.9402	1.0005	0.05
Exceptions Adjustment Factor	0.9752	0.9730	0.9977	−0.23
Federal Rate	$374.31	$377.03	1.0073	0.73

[1] As noted previously in section IV.A.1.a of this addendum, upon review we discovered that incorrect data were used in estimating the proposed adjustment for the effect of FY 1998 reclassification and recalibration in the proposed rule. As a result, the revised adjustment for the effect of FY 1998 reclassification and recalibration for the capital update for FY 2000 is +0.1 (compared to the proposed −0.7). Accordingly, the FY 2000 final update is 0.30 (compared to the proposed −0.06), which accounts for the 0.73 increase in the Federal rate from the FY 2000 proposed to FY 2000 final rule.

6. Special Rate for Puerto Rico Hospitals

As explained above, 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 prospective payment system wage index and varies depending on the MSA or rural area in which the hospital is located. We use the Puerto Rico wage index to determine the GAF for the Puerto Rico part of the capital blended rate and the national wage index to determine the GAF for the national part of the blended rate. Since we implemented a separate GAF for Puerto Rico in 1998, we also 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. The Puerto Rico GAF budget neutrality factor is 0.9991, while the DRG adjustment is 0.9999, for a combined cumulative adjustment of 0.9990.

In computing the payment for a particular Puerto Rico hospital, the Puerto Rico portion of the rate (50 percent) is multiplied by the Puerto Rico-specific GAF for the MSA in which the hospital is located, and the national portion of the rate (50 percent) is multiplied by the national GAF for the MSA in which the hospital is located (which is computed from national data for all hospitals in the United States and Puerto Rico). In FY 1998, we implemented a 17.78 percent reduction to the Puerto Rico rate as required by the BBA. For FY 1999, before application of the GAF, the special rate for Puerto Rico hospitals was $181.10. With the changes we proposed to the factors used to determine the rate, the proposed FY 2000 special rate for Puerto Rico was $174.15. In this final rule, the FY 2000 capital rate for Puerto Rico is $174.81.

B. Determination of Hospital-Specific Rate Update

Section 412.328(e) of the regulations provides that the hospital-specific rate for FY 2000 be determined by adjusting the FY 1999 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 2000, we are updating the hospital-specific rate by a factor of 1.0030.

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 2000, we estimated in the proposed rule that exceptions payments would be 2.48 percent of aggregate payments based on the Federal rate and the hospital-specific rate. Therefore, we proposed that the updated hospital-specific rate be reduced by a factor of 0.9752. In this final rule, we estimate that exceptions payments will be 2.70 percent of aggregate payments based on the Federal rate and hospital-specific rate. Accordingly, for FY 2000, we are applying an exceptions reduction factor of 0.9730 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 2000 hospital-specific rate is 0.9730/0.9783, or 0.9946.

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 1999 and FY 2000 and the net adjustment for each factor. It also shows that the cumulative net adjustment from FY 1999 to FY 2000 is 0.9976, which represents a decrease of 0.24 percent to the hospital-specific rate. For each hospital, the FY 2000 hospital-specific rate is determined by multiplying the FY 1999 hospital-specific rate by the cumulative net adjustment of 0.9976.

FY 2000 UPDATE AND ADJUSTMENTS TO HOSPITAL-SPECIFIC RATES

	FY 1999	Final FY 2000	Net adjustment	Percent change
Update Factor	1.0010	1.0030	1.0030	0.30
Exceptions Payment Adjustment Factor	0.9783	0.9730	0.9946	−0.54
Cumulative Adjustments	0.9793	0.9769	0.9976	−0.24

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 1999 to FY 2000 is 1.0030. In contrast, the exceptions payment adjustment factor is not applied cumulatively. Thus, for example, the incremental increase in the exceptions reduction factor from FY 1999 to FY 2000 is 0.9730/0.9783, or 0.9946.

C. Calculation of Inpatient Capital-Related Prospective Payments for FY 2000

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 hospital (DSH) adjustment factor, and the indirect medical education (IME) adjustment factor, when appropriate).

If the hospital-specific rate is higher than the applicable Federal rate, the hospital is paid under the hold-harmless methodology. If the hospital-specific rate is lower than 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) × (DRG weight) × (GAF) × (Large Urban Add-on, if applicable) × (COLA adjustment for hospitals located in Alaska and Hawaii) × (1 + DSH Adjustment Factor + IME Adjustment Factor). 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 2000 are 90 percent of the adjusted Federal rate and 10 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 90 percent of the Federal rate for discharges occurring in cost reporting periods beginning during FY 2000. Thus, a fully prospective hospital will receive 90 percent of the capital-related outlier payment calculated for the case for discharges occurring in cost reporting periods beginning in FY 2000. 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 2000 are in section II.A.4.c of this Addendum. For FY 2000, a case qualifies as a cost outlier if the cost for the case is greater than the prospective payment rate for the DRG (and any IME and DSH payments) plus $14,050.

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 occurring in FY 2000 are as follows:

- 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.
- 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 operating input price index, the Capital Input Price Index (CIPI) is a fixed-weight price index that measures the price changes associated with costs during a given year. The CIPI differs from the operating input price index in one important aspect—the CIPI reflects the vintage nature of capital, which is the acquisition and use of capital over time. Capital expenses in any given year are determined by the stock of capital in that year (that is, capital that remains on hand from all current and prior capital acquisitions). An index measuring capital price changes needs to reflect this vintage nature of capital. Therefore, the CIPI was developed to capture the vintage nature of capital by using a weighted-average of past capital purchase prices up to and including the current year.

Using Medicare cost reports, American Hospital Association (AHA) data, and Securities Data 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 on August 29, 1997 (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), June 2, 1997 (62 FR 29953), August 29, 1997 (62 FR 46050), May 8, 1998 (63 FR 25619), July 31, 1998 (63 FR 41017), and May 7, 1999 (64 FR 24763).

2. Forecast of the CIPI for Federal Fiscal Year 2000

We are forecasting the CIPI to increase 0.6 percent for FY 2000. This reflects a projected 1.6 percent increase in vintage-weighted depreciation prices (building and fixed equipment, and movable equipment) and a 3.5 percent increase in other capital expense prices in FY 2000, partially offset by a 2.9 percent decline in vintage-weighted interest rates in FY 2000. The weighted average of these three factors produces the 0.6 percent increase for the CIPI as a whole.

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

The inpatient operating costs of hospitals and hospital units excluded from the prospective payment system are subject to rate-of-increase limits established under the authority of section 1886(b) of the Act, which is implemented in regulations at § 413.40. Under these limits, a hospital-specific target amount (expressed in terms of the inpatient operating cost per discharge) is set for each hospital, based on the hospital's own historical cost experience trended forward by the applicable rate-of-increase percentages (update factors). In the case of a psychiatric hospital or hospital unit, rehabilitation hospital or hospital unit, or long-term care hospital, the target amount may not exceed the updated figure for the 75th percentile of target amounts for hospitals and units in the same class (psychiatric, rehabilitation, and long-term care) for cost reporting periods ending during FY 1996. The target amount is multiplied by the number of Medicare discharges in a hospital's cost reporting period, yielding the ceiling on aggregate Medicare inpatient operating costs for the cost reporting period.

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

Section 1886(b)(3)(B) of the Act, which is implemented in regulations at § 413.40(c)(3)(vii), provides that for cost reporting periods beginning on or after October 1, 1999 and before October 1, 2000, the update factor depends on the hospital's or hospital 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 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 2000 for hospitals and hospital units excluded from the prospective payment system is 2.9 percent. Therefore, the update to a hospital's target amount for its cost reporting period beginning in FY 2000 would be between 0.4 and 2.9 percent, or 0 percent.

In addition, § 413.40(c)(4)(iii) requires that for cost reporting periods beginning on or after October 1, 1999 and before October 1, 2000, the target amount for each psychiatric hospital or hospital unit, rehabilitation hospital or hospital unit, and long-term care hospital cannot exceed a cap on the target amounts for hospitals in the same class. In the May 7, 1999 proposed rule, based on available data, we estimated that, for cost reporting periods beginning in FY 2000, the caps on target amounts would be $11,067 for psychiatric hospitals and hospital units, $20,071 for rehabilitation hospitals and hospital units, and $39,596 for long-term care hospitals. In this final rule, based on updated data, we are establishing the caps as follows: $11,100 for psychiatric hospitals and hospital units, $20,129 for rehabilitation hospitals and hospital units, and $36,712 for long-term care hospitals. Regulations at § 413.40(d) specify the formulas for determining bonus and relief payments for excluded hospitals and specify established criteria for an additional bonus payment for continuous improvement. Regulations at § 413.40(f)(2)(ii) specify the payment methodology for new hospitals and hospital units (psychiatric, rehabilitation, and long-term care) effective October 1, 1997.

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, 3C, 4A, 4B, 4C, 4D, 4E, 4F, 5, 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 3C—Hospital Case-Mix Indexes for Discharges Occurring in Federal Fiscal Year 1998 and Hospital Average Hourly Wage for Federal Fiscal Year 2000 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

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 7A—Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 98 MEDPAR Update 3/99 GROUPER V16.0

Table 7B—Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 98 MEDPAR Update 3/99 GROUPER V17.0

Table 8A—Statewide Average Operating Cost-to-Charge Ratios for Urban and Rural Hospitals (Case Weighted) July 1999

Table 8B—Statewide Average Capital Cost-to-Charge Ratios (Case Weighted) July 1999

Table 10—Percentage Difference in 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
$2,809.18	$1,141.85	$2,764.70	$1,123.76

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

	Large urban areas		Other areas	
	Labor	Nonlabor	Labor	Nonlabor
National	$2,785.40	$1,132.18	$2,785.40	$1,132.18
Puerto Rico	1,336.54	538.00	1,315.38	529.48

TABLE 1D.—CAPITAL STANDARD FEDERAL PAYMENT RATE

	Rate
National	$377.03
Puerto Rico	174.81

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX

Prov.	Case mix index	Avg. hour wage
010001	1.4595	15.85
010004	0.9933	15.02
010005	1.1767	16.26
010006	1.4579	17.31
010007	1.1421	14.80
010008	1.1818	17.65
010009	1.0941	17.53
010010	1.0799	15.91
010011	1.5835	20.63
010012	1.2614	19.30
010015	1.0478	18.35
010016	1.2492	16.13
010018	0.9696	18.96
010019	1.2766	15.49
010021	1.2490	14.63
010022	0.9597	20.51
010023	1.6881	16.26
010024	1.4243	16.03
010025	1.3513	14.53
010027	0.8132	14.93
010029	1.6000	16.41
010031	1.4175	18.02
010032	0.8803	12.65
010033	1.9945	19.68
010034	1.0473	14.73
010035	1.2411	17.48
010036	1.0916	17.29
010038	1.2337	18.33
010039	1.6337	18.81
010040	1.4963	19.10
010043	1.0500	16.20
010044	1.0246	17.02
010045	1.1799	15.01
010046	1.4713	17.18
010047	0.9285	16.38
010049	1.1887	14.48
010050	1.0755	15.42
010051	0.8965	9.94

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
010052	1.0154	13.86
010053	1.0508	13.18
010054	1.1318	17.12
010055	1.4221	18.19
010056	1.3283	19.08
010058	1.0358	12.78
010059	1.0567	18.19
010061	1.1098	15.92
010062	1.0102	13.57
010064	1.7584	20.90
010065	1.3234	15.64
010066	0.9014	12.07
010068	1.3052	18.74
010069	1.1329	13.57
010072	1.0785	14.35
010073	0.8800	12.83
010078	1.2901	17.71
010079	1.1867	16.87
010080	.....	13.85
010081	1.6351	16.98
010083	1.0586	16.21
010084	1.5089	18.78
010085	1.3152	18.87
010086	1.0122	14.93
010087	1.7288	18.39
010089	1.1989	16.61
010090	1.6540	18.11
010091	0.9933	16.36
010092	1.4279	16.50
010094	1.1544	18.56
010095	1.0456	11.90
010097	0.8654	12.90
010098	0.9896	14.28
010099	1.1725	15.93
010100	1.2912	15.48
010101	1.0199	15.42
010102	0.9314	12.73
010103	1.8375	19.31

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
010104	1.6950	18.10
010108	1.1528	20.79
010109	1.0504	14.09
010110	0.9691	15.91
010112	1.1495	15.11
010113	1.6159	17.24
010114	1.2530	17.26
010115	0.8495	13.75
010118	1.2464	16.69
010119	0.8457	18.17
010120	0.9886	17.03
010121	1.2822	15.18
010123	1.1647	18.16
010124	1.2264	16.27
010125	1.0590	14.42
010126	1.1224	17.64
010127	1.3140	19.61
010128	0.9265	12.57
010129	1.0647	14.43
010130	1.0418	16.35
010131	1.3325	17.91
010134	0.8150	10.78
010137	1.3106	15.93
010138	0.9196	12.13
010139	1.6338	19.95
010143	1.2282	15.71
010144	1.4120	17.12
010145	1.3336	20.75
010146	1.1894	18.86
010148	0.9791	14.64
010149	1.2567	17.08
010150	1.0438	16.97
010152	1.2508	17.38
010155	1.0794	16.70
020001	1.5235	27.97
020002	1.0556	26.91
020004	1.1841	26.40
020005	0.8955	29.01

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
020006	1.1238	26.77
020007	0.8205	24.96
020008	1.0781	30.47
020009	0.8199	23.18
020010	0.9473	18.64
020011	0.9160	29.47
020012	1.2763	23.92
020013	0.9595	26.82
020014	1.1151	24.09
020017	1.4946	24.97
020018	0.8973	.....
020019	0.7991	.....
020021	0.8011	.....
020024	1.1106	22.73
020025	0.9156	27.15
020026	1.2660	.....
020027	0.9434	.....
030001	1.2614	19.87
030002	1.8069	21.63
030003	2.2742	23.67
030004	1.0231	17.73
030006	1.5269	17.64
030007	1.2538	18.56
030008	2.1843	.....
030009	1.2486	17.93
030010	1.3867	18.80
030011	1.4361	20.08
030012	1.2389	19.42
030013	1.2741	21.02
030014	1.5098	19.47
030016	1.2340	20.56
030017	1.4178	20.42
030018	1.8584	18.91
030019	1.2403	19.92
030022	1.4895	15.79
030023	1.4965	22.44
030024*	1.7469	21.67
030025	0.9555	17.67
030027	0.9624	17.58
030030	1.6450	21.62
030033	1.2353	16.84
030034	0.9867	19.09
030035	1.1548	19.72
030036	1.2810	18.94
030037	2.0844	21.44
030038	1.6163	22.08
030040	1.0766	17.97
030041	0.8880	17.44
030043	1.2200	20.77
030044	0.8787	16.47
030047	0.8899	19.69
030049	0.8711	19.09
030054	0.8646	14.49
030055	1.2312	18.28
030059	1.2853	21.71
030060	1.1435	16.77
030061	1.6875	17.35
030062	1.1800	17.48
030064	1.7662	18.54
030065	1.8097	19.93
030067	1.0273	15.62
030068	1.0246	17.35
030069	1.3639	19.00
030071	0.9602	.....

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
030072	0.8682	.....
030073	1.0290	.....
030074	0.8858	.....
030075	0.7952	.....
030076	0.8826	.....
030077	0.8563	.....
030078	1.1470	.....
030079	0.9065	.....
030080	1.3762	19.99
030083	1.2775	23.64
030084	1.1378	.....
030085	1.4648	17.84
030086	1.4452	18.50
030087	1.6802	20.05
030088	1.3656	19.58
030089	1.6781	19.90
030092	1.5831	21.56
030093	1.4204	19.47
030094	1.2697	19.48
030095	1.1371	14.25
030099	0.9411	18.07
030100	2.0364	.....
030101	1.4114	.....
030102	2.5824	.....
040001	1.0888	15.57
040002	1.1552	14.09
040003	1.1003	14.00
040004	1.6291	17.29
040005	1.0368	12.88
040007	1.6975	19.53
040008	1.0417	12.70
040010	1.3432	17.62
040011	0.9412	12.27
040014	1.3255	15.39
040015	1.2147	14.60
040016	1.6858	17.54
040017	1.1675	14.95
040018	1.2212	17.56
040019	1.0337	25.71
040020	1.6146	14.81
040021	1.1844	16.46
040022	1.4741	16.00
040024	0.9980	15.73
040025	0.9100	10.95
040026	1.5789	18.24
040027	1.2523	14.54
040028	1.0074	12.84
040029	1.2995	17.78
040030	0.8754	14.15
040032	0.9633	13.33
040035	0.9500	11.21
040036	1.4559	17.91
040037	1.0687	13.48
040039	1.2281	13.84
040040	0.9162	17.43
040041	1.2619	13.36
040042	1.2098	14.66
040044	1.0386	11.44
040045	1.0121	18.77
040047	1.0270	16.39
040048	.....	15.82
040050	1.1544	11.79
040051	1.0845	16.28
040053	1.0708	15.82

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
040054	0.9798	15.04
040055	1.4290	16.10
040058	1.0566	15.67
040060	0.9763	11.47
040062	1.6600	17.28
040064	1.0495	12.40
040066	1.0504	17.64
040067	1.0989	13.49
040069	1.0278	16.11
040070	0.9313	15.48
040071	1.6676	16.30
040072	1.0377	15.84
040074	1.2314	17.38
040075	1.0145	12.75
040076	1.0802	18.55
040077	1.0508	12.46
040078	1.5191	17.86
040080	1.0065	15.74
040081	0.8669	10.68
040082	1.0972	16.51
040084	1.1085	17.25
040085	1.1526	15.78
040088	1.3887	15.67
040090	0.8950	17.55
040091	1.1702	17.04
040093	0.9194	12.90
040100	1.1477	14.97
040105	0.9904	14.24
040106	0.9680	15.40
040107	1.0685	19.62
040109	1.1497	13.98
040114	1.8340	18.31
040116	1.1343	19.57
040118	1.4205	17.43
040119	1.1612	15.38
040124	1.0612	17.25
040126	0.9478	11.68
040132	.....	13.18
040134	2.7047	.....
040135	2.3711	.....
050002	1.4963	27.60
050006	1.4139	19.53
050007	1.4840	29.54
050008	1.4234	25.86
050009	1.6827	26.25
050013	1.9903	24.85
050014	1.2091	24.53
050015	1.4488	25.38
050016	1.1522	20.15
050017	2.0965	23.66
050018	1.3646	14.66
050021	.....	28.50
050022	1.6612	22.96
050024	1.3214	20.34
050025*	1.7668	22.00
050026	1.5146	28.69
050028	1.3702	16.45
050029	1.4013	23.29
050030	1.3135	21.01
050032	1.3391	22.59
050033	1.4640	24.56
050036	1.7264	20.47
050038	1.3454	27.83
050039	1.6288	22.25

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
050040	1.1955	30.67
050042	1.2702	22.23
050043	1.4927	33.23
050045	1.2716	20.73
050046	1.1729	31.38
050047	1.5619	29.44
050051	1.1199	17.84
050054	1.1899	19.37
050055	1.2399	29.09
050056	1.3404	23.85
050057	1.5981	21.76
050058	1.4969	25.73
050060	1.5506	20.92
050061	1.4125	23.74
050063	1.3477	23.07
050065	1.6835	21.18
050066	1.3006	21.42
050067	1.2503	21.30
050068	1.1029	28.48
050069	1.6082	29.30
050070	1.2340	32.60
050071	1.3229	33.14
050072	1.3883	32.97
050073	1.2621	34.61
050074	0.8073	.....
050075	1.3460	33.52
050076	2.0321	33.88
050077	1.5585	23.30
050078	1.2960	22.80
050079	1.4849	34.43
050082	1.6734	21.70
050084	1.6102	23.10
050088	0.9681	24.06
050089	1.3381	20.02
050090	1.2652	23.90
050091	1.0925	22.22
050092	0.8481	15.38
050093	1.5646	24.08
050095	.....	33.38
050096	1.1459	21.67
050097	1.5292	22.61
050099	1.4630	24.29
050100	1.6425	30.06
050101	1.3595	30.01
050102	1.3792	21.29
050103*	1.5724	25.34
050104	1.4491	25.44
050107	1.4640	21.76
050108	1.8389	25.21
050109	.....	26.48
050110	1.2148	20.18
050111	1.2943	21.74
050112	1.3851	26.29
050113	1.3172	27.78
050114	1.3842	25.91
050115	1.4915	21.05
050116	1.5226	25.59
050117	1.3979	20.44
050118	1.1870	24.00
050121	1.2882	18.88
050122	1.5694	.....
050124	1.2826	23.02
050125	1.3726	24.04
050126	1.4571	23.84
050127	1.2537	19.76
050128	1.6061	24.18
050129	1.7541	27.16
050131	1.2640	29.06
050132	1.3641	22.91
050133	1.2717	24.40
050135	1.4811	27.03
050136	1.3553	24.43
050137	1.3023	30.07
050138	2.0450	37.41
050139	1.2542	31.38
050140	1.3201	33.66
050144	1.4211	25.75
050145	1.3762	33.06
050146	1.5826	.....
050148	1.1126	21.06
050149	1.4979	23.38
050150	1.2673	23.48
050152	1.3291	27.75
050153	1.6393	29.59
050155	1.0972	22.94
050158	1.3019	27.98
050159	1.3226	25.21
050167	1.3813	21.68
050168	1.5382	25.25
050169	1.4765	24.64
050170	1.4490	22.20
050172	1.2543	17.70
050173	1.3755	23.33
050174	1.7008	31.21
050175	1.2707	27.79
050177	1.1869	20.25
050179	1.2337	19.29
050180	1.5831	32.19
050183	1.2743	19.98
050186	1.3443	21.91
050188	1.4374	27.44
050189	0.9674	23.24
050191	1.4686	26.73
050192	1.1474	17.81
050193	1.1575	23.73
050194	1.2304	28.27
050195	1.5638	34.78
050196	1.2799	16.69
050197	1.9550	31.45
050204	1.5274	24.39
050205	1.2839	21.15
050207	1.2607	20.86
050211	1.3187	31.22
050213	1.5919	20.73
050214	1.5454	20.87
050215	1.5686	28.41
050217	1.2859	19.89
050219	1.1417	25.47
050222	1.5169	27.07
050224	1.5831	23.79
050225	1.5688	20.80
050226	1.3277	26.93
050228	1.3226	30.38
050230	1.4125	25.36
050231	1.6438	25.58
050232	1.5691	23.38
050233	.....	31.40
050234	1.1501	28.52
050235	1.5560	25.86
050236	1.5100	26.27
050238	1.5300	24.00
050239	1.5979	20.41
050240	1.5284	25.25
050241	1.1379	27.22
050242	1.4436	30.14
050243	1.5323	22.91
050245	1.5075	24.40
050248	1.2025	27.42
050251	1.1079	18.50
050253	1.4192	20.07
050254	1.2000	19.69
050256	1.7675	23.53
050257	0.9509	19.59
050260	0.9690	23.52
050261	1.2104	20.45
050262	1.8179	29.01
050264	1.3472	29.45
050267	1.6945	24.75
050270	1.3631	23.73
050272	1.3984	21.44
050274	0.9467	21.19
050276	1.1734	28.51
050277	1.4821	22.31
050278	1.5187	23.84
050279	1.2881	21.06
050280	1.6532	24.43
050281	1.3916	18.59
050282	1.3212	24.46
050283	1.5054	27.88
050286	0.9172	17.80
050289	1.7326	26.72
050290	1.6720	26.37
050291	1.1953	26.49
050292	1.1088	22.49
050293	1.0656	19.18
050295	1.4570	20.74
050296	1.2166	25.32
050298	1.3348	20.52
050299	1.3248	25.77
050300	1.4160	22.74
050301	1.2329	26.03
050302	.....	29.20
050305	1.5886	32.71
050307	1.2758	27.98
050308	1.5082	28.40
050309	1.2826	24.40
050310	.....	20.62
050312	1.9732	23.79
050313	1.1561	23.10
050315	1.3435	21.92
050317	.....	19.45
050320	1.2358	30.60
050324	2.0041	26.27
050325	1.2290	23.24
050327	1.6638	22.85
050328	.....	23.19
050329	1.2988	21.41
050331	1.3506	25.53
050333	1.0612	20.15
050334	1.7488	32.02
050335	1.4579	20.20
050336	1.3568	20.10

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
050342	1.2515	19.35
050343	0.9701	17.34
050348	1.8021	20.75
050349	0.8875	15.05
050350	1.4042	25.07
050351	1.4941	24.69
050352	1.3148	23.59
050353	1.6191	23.25
050355	0.8391	17.16
050357	1.3422	23.64
050359	1.2474	20.40
050360	1.4310	31.76
050366	1.3326	21.34
050367	1.2594	29.48
050369	1.3034	24.26
050373	1.3971	26.65
050376	1.4232	25.30
050377	1.0200	25.64
050378	1.0934	22.24
050379	1.0197	15.50
050380	1.6047	30.58
050382	1.3597	26.15
050385	1.3419	25.92
050388	0.8725	13.79
050390	1.1965	22.57
050391	1.3438	22.49
050392	0.9370	21.93
050393	1.4352	23.14
050394	1.5741	22.24
050396	1.6444	23.63
050397	0.9367	20.77
050401	1.1055	17.78
050404	1.0664	19.28
050406	1.0245	16.89
050407	1.2842	30.12
050410	1.0668	16.47
050411	1.3582	32.24
050414	1.2992	24.42
050417	1.3197	21.89
050419	1.3788	23.12
050420	1.3062	22.68
050421	1.2343	.....
050423	1.0112	23.33
050424	1.8400	23.78
050425	1.2315	33.69
050426	1.3898	23.71
050427	0.9468	20.07
050430	1.0003	21.34
050432	1.5198	21.50
050433	0.9711	16.80
050434	1.0631	15.63
050435	1.1647	32.99
050436	1.0075	16.36
050438	1.7349	24.08
050440	1.2722	21.11
050441	1.9397	28.71
050443	0.8705	16.43
050444	1.3224	24.67
050446	0.8088	20.54
050447	1.0850	18.42
050448	1.1055	20.08
050449	1.2871	22.18
050454*	1.7729	28.69
050455	1.7949	19.92

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
050456	1.2213	17.62
050457	1.9129	31.25
050459	1.5220	37.09
050464	1.7089	22.31
050468	1.5589	23.17
050469	1.1499	23.44
050470	1.1391	17.03
050471	1.8969	24.29
050476	1.3686	23.14
050477	1.4367	27.78
050478	0.9911	23.05
050481	1.3949	26.83
050482	1.0569	16.93
050483	2.2575	21.60
050485	1.6066	23.19
050486	.....	24.50
050488	1.3257	32.86
050491	1.2006	25.10
050492	1.4183	21.42
050494	1.2386	25.41
050496	1.7595	33.02
050497	0.8258	.....
050498	1.2296	24.84
050502	1.7271	22.63
050503	1.3477	23.59
050506	1.3621	21.22
050510	1.2784	33.46
050512	1.4429	34.31
050515	1.3439	35.04
050516	1.5017	25.19
050517	1.2038	20.37
050522	1.1593	31.73
050523	1.2442	28.42
050526	1.2943	26.92
050528	1.1883	18.69
050531	1.1101	20.73
050534	1.2834	23.30
050535	1.5140	24.23
050537	1.3698	22.21
050539	1.3269	23.25
050541	1.5646	34.62
050542	0.9786	17.85
050543	0.8445	23.04
050545	0.7658	27.57
050546	0.6961	27.76
050547	0.9008	27.08
050548	.....	26.59
050549	1.6034	27.91
050550	1.3697	25.75
050551	1.3532	24.05
050552	1.2766	22.87
050557	1.5203	22.14
050559	1.2865	24.67
050561	1.2133	33.93
050564	1.3237	24.51
050565	1.3123	22.88
050566	0.9219	18.33
050567	1.5570	24.23
050568	1.3420	20.52
050569	1.2025	24.94
050570	1.6497	24.50
050571	1.3946	24.37
050573	1.5647	25.14
050575	1.1467	.....

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
050577	1.3600	20.52
050578	1.2666	28.91
050579	1.4322	30.07
050580	1.2849	23.92
050581	1.4507	23.57
050583	1.6163	23.36
050584	1.2401	23.16
050585	1.2561	26.50
050586	1.3532	23.84
050588	1.2801	30.39
050589	1.2395	24.35
050590	1.3227	.....
050591	1.3156	22.32
050592	1.2663	26.05
050594	1.6277	22.78
050597	1.2260	23.18
050598	1.3410	28.11
050599	1.5942	26.32
050601	1.6465	32.87
050603	1.4208	22.75
050604	1.4564	33.32
050607	.....	24.10
050608	1.2793	16.15
050609	1.4917	31.93
050613	1.1189	23.48
050615	1.5453	23.70
050616	1.3449	22.80
050618	1.0867	21.70
050623	1.5638	30.32
050624	1.3297	22.34
050625	1.6305	24.35
050630	1.2762	24.10
050633	1.2825	21.98
050635	.....	37.85
050636	1.4239	20.83
050638	1.1491	23.63
050641	1.2971	21.36
050643	0.9604	.....
050644	1.0737	23.12
050660	1.4966	.....
050661	.....	20.48
050662	0.8151	28.29
050663	1.1758	23.71
050667	1.0967	24.11
050668	1.0944	39.90
050670	0.7555	21.88
050674	1.2425	36.24
050675	2.2195	15.84
050676	1.0018	17.53
050677	1.3679	33.71
050678	1.2889	22.66
050680	1.1178	27.32
050682	0.9234	17.97
050684	1.2409	21.81
050685	1.1904	32.13
050686	1.2866	33.25
050688	1.1936	30.00
050689	1.4920	34.19
050690	1.4168	33.83
050693	1.3155	33.30
050694	1.3866	22.57
050695	1.0607	23.52
050696	2.1060	26.41
050697	1.3204	21.47

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
050699	0.5913	28.48
050700	.....	28.45
050701	1.3166	27.62
050702	.....	12.25
050704	1.0855	20.76
050707	0.9714	27.51
050708	1.4500	21.91
050709	1.2519	19.42
050710	1.3390	26.81
050713	0.7909	15.30
050714	1.3510	.....
050715	.....	19.12
050717	1.2647	.....
050718	0.7579	.....
050719	3.1984	.....
050720	0.9044	.....
060001	1.6835	20.59
060003	1.2708	19.32
060004	1.1987	21.79
060006	1.2571	17.86
060007	1.1650	16.38
060008	1.0843	17.09
060009	1.4985	21.18
060010	1.6674	22.72
060011	1.3925	21.97
060012	1.3814	19.77
060013	1.3217	19.14
060014	1.8153	20.53
060015	1.6320	23.57
060016	1.1638	15.96
060018	1.2867	21.86
060020	1.6130	17.73
060022	1.5677	19.65
060023	1.6323	19.65
060024	1.7015	22.83
060027	1.6925	21.67
060028	1.5331	22.25
060029	0.8925	21.41
060030	1.3542	20.03
060031	1.5383	19.40
060032	1.4782	22.37
060033	1.1398	13.82
060034	1.5846	21.41
060036	1.1376	19.24
060037	1.0079	14.05
060038	0.9440	14.31
060041	0.9246	14.83
060042	1.0356	20.08
060043	0.8801	13.05
060044	1.1681	22.53
060046	1.0302	20.44
060047	0.9655	15.12
060049	1.3171	20.64
060050	1.2512	16.80
060052	1.0404	12.55
060053	1.0148	14.94
060054	1.4104	19.39
060056	0.9051	17.05
060057	1.0273	23.38
060058	0.9425	16.91
060060	0.9200	14.89
060062	0.8628	14.94
060063	.....	15.09
060064	1.4833	20.93

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
060065	1.2913	24.30
060066	0.9930	14.07
060068	.....	19.64
060070	1.1250	16.58
060071	1.2078	16.95
060073	0.9583	15.84
060075	1.2425	22.85
060076	1.4325	19.29
060085	0.8869	13.48
060087	.....	21.03
060088	0.9983	16.67
060090	0.8997	14.51
060096	1.1067	23.12
060100	1.5321	22.00
060103	1.3211	22.34
060104	1.2351	22.30
060107	1.1955	13.64
060108	0.4789	.....
060109	1.1185	.....
070001	1.7614	26.51
070002	1.8336	25.46
070003	1.1215	26.09
070004	1.2043	23.27
070005	1.4436	25.57
070006	1.3881	28.71
070007	1.3524	27.19
070008	1.2506	26.03
070009	1.2685	23.47
070010	1.6992	25.94
070011	1.3820	23.96
070012	1.1724	25.10
070015	1.3890	25.33
070016	1.4259	26.30
070017	1.3718	24.80
070018	1.3684	28.88
070019	1.1838	24.70
070020	1.3222	23.72
070021	1.2362	26.52
070022	1.8643	25.08
070024	1.3255	25.15
070025	1.8686	25.41
070026	.....	18.79
070027	1.3113	23.64
070028	1.5522	24.69
070029	1.3352	22.75
070030	1.2883	24.97
070031	1.2420	21.66
070033	1.4115	28.81
070034	1.3893	29.12
070035	1.4205	23.06
070036	1.7251	28.95
070038	0.7729	.....
070039	0.9555	21.78
080001	1.7133	25.28
080002	.....	15.60
080003	1.3835	22.40
080004	1.2651	19.77
080005	.....	14.43
080006	1.3003	22.26
080007	1.4176	20.38
090001	1.6034	25.89
090002	1.3475	19.70
090003	1.3718	28.61
090004	1.7978	24.43

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
090005	1.3706	24.88
090006	1.3152	20.08
090007	1.3040	21.66
090008	1.5064	21.60
090010	1.0721	15.87
090011	2.1194	27.37
100001	1.5307	17.69
100002	1.4390	21.32
100004	1.0119	15.25
100006	1.6160	20.63
100007	1.8871	21.72
100008	1.5830	20.72
100009	1.4671	24.29
100010	1.4977	21.91
100012	1.6382	18.52
100014	1.4823	19.83
100015	1.4805	18.24
100017	1.5923	17.77
100018	1.5493	20.84
100019	1.5572	19.81
100020	1.3926	26.18
100022	1.7978	25.89
100023	1.3578	21.11
100024	1.3497	20.78
100025	1.7580	19.12
100026	1.5873	20.76
100027	1.0231	12.94
100028	1.2105	19.75
100029	1.3375	19.18
100030	1.2542	18.82
100032	1.8533	19.32
100034	1.7580	18.23
100035	1.5894	19.58
100038	1.6636	24.78
100039	1.5287	20.25
100040	1.7501	18.64
100043	1.3307	17.52
100044	1.3922	21.14
100045	1.3923	20.77
100046	1.4279	21.21
100047	1.8496	18.87
100048	0.9391	13.50
100049	1.2653	18.56
100050	1.1494	16.60
100051	1.2391	18.84
100052	1.3875	16.19
100053	1.2128	18.71
100054	1.2776	18.19
100055	1.3755	17.62
100056	1.4973	23.65
100057	1.3595	18.75
100060	1.8341	22.39
100061	1.4541	21.79
100062	1.7297	17.96
100063	1.1596	16.23
100067	1.3589	17.40
100068	1.3600	18.65
100069	1.2996	16.14
100070	1.4348	20.33
100071	1.2324	16.48
100072	1.2519	19.22
100073	1.7170	18.16
100075	1.5967	18.05
100076	1.2999	16.25

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
100077	1.3907	19.62
100078	1.0296	18.28
100079	1.3325	.....
100080	1.6004	21.16
100081	1.1059	13.96
100082	1.4981	19.80
100084	1.3484	20.40
100085	1.4397	21.08
100086	1.2337	21.16
100087	1.8332	23.12
100088	1.6560	20.06
100090	1.3796	17.88
100092	1.5762	18.19
100093	1.5951	16.63
100098	1.0984	19.03
100099	1.2207	15.30
100102	1.0153	19.33
100103	0.9374	18.10
100105	1.4538	21.50
100106	1.0262	19.31
100107	1.3128	18.01
100108	0.9979	11.47
100109	1.3846	22.17
100110	1.3687	19.64
100112	0.9703	9.77
100113	1.9526	22.26
100114	1.3378	23.45
100117	1.1904	18.86
100118	1.2978	19.76
100121	1.1778	19.34
100122	1.2065	18.06
100124	1.2961	19.05
100125	1.2709	17.33
100126	1.4682	18.09
100127	1.6587	19.87
100128	2.2076	21.37
100129	1.3074	18.57
100130	1.1759	19.10
100131	1.3440	22.17
100132	1.2920	16.90
100134	0.9738	13.47
100135	1.5672	17.48
100137	1.2758	19.05
100138	1.0055	11.01
100139	1.0894	15.64
100140	1.2173	17.35
100142	1.2261	18.68
100144	1.1622	15.02
100145	.....	19.11
100146	0.9697	17.87
100147	1.0080	14.68
100150	1.3244	21.02
100151	1.7687	19.40
100154	1.5832	19.85
100156	1.1101	17.13
100157	1.5609	21.03
100159	0.9570	16.38
100160	1.2026	21.63
100161	1.6995	21.50
100162	1.3955	19.87
100165	1.1535	18.57
100166	1.4349	20.42
100167	1.3548	21.81
100168	1.3372	20.13

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
100169	1.7623	20.78
100170	1.4159	15.12
100172	1.4335	15.18
100173	1.6528	17.34
100174	1.3768	20.51
100175	1.1543	17.82
100176	2.0764	24.70
100177	1.2977	22.00
100179	1.7103	20.91
100180	1.4415	18.48
100181	1.1065	24.57
100183	1.1888	20.86
100187	1.4299	20.69
100189	1.3286	21.01
100191	1.3182	18.47
100199	1.3519	23.37
100200	1.2409	22.26
100203	.....	18.86
100204	1.6272	20.20
100206	1.3739	20.35
100207	.....	15.92
100208	1.3673	20.83
100209	1.4791	19.73
100210	1.5718	19.18
100211	1.3991	25.53
100212	1.6224	25.34
100213	1.5100	19.12
100217	1.2751	19.87
100220	1.6355	19.91
100221	1.8110	22.25
100222	0.9440	22.19
100223	1.4651	18.76
100224	1.3349	24.70
100225	1.3371	20.64
100226	1.3508	24.86
100228	1.2825	23.70
100229	1.3326	18.21
100230	1.3523	20.60
100231	1.6815	17.40
100232	1.2511	17.32
100234	1.2587	21.58
100235	.....	17.66
100236	1.3925	21.81
100237	2.1893	22.93
100238	1.5454	17.63
100239	1.4287	19.76
100240	1.0888	17.93
100241	0.8994	13.83
100242	1.4298	17.12
100243	1.4071	20.38
100244	1.3741	17.41
100246	1.3686	21.22
100248	1.5873	21.54
100249	1.3084	19.02
100252	1.2005	17.87
100253	1.4323	20.60
100254	1.5401	20.91
100255	1.2559	21.02
100256	2.0104	23.56
100258	1.6901	21.88
100259	1.3409	19.86
100260	1.4570	21.22
100262	1.3448	19.59
100263	.....	16.90

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
100264	1.3620	17.61
100265	1.2932	19.86
100266	1.3567	17.73
100267	1.3056	17.10
100268	1.1952	23.59
100269	1.4345	21.20
100270	1.0181	19.86
100271	1.7715	19.92
100275	1.3944	21.33
100276	1.2371	21.98
100277	1.0333	16.14
100279	1.2721	23.02
100280	1.2951	16.58
100281	1.2795	22.02
100282	1.0837	19.77
100284	1.0855	.....
110001	1.2552	18.06
110002	1.2532	17.37
110003	1.3637	16.91
110004	1.3569	18.95
110005	1.1963	19.26
110006	1.4201	20.13
110007	1.6114	23.50
110008	1.2419	18.26
110009	1.1355	14.82
110010	2.1768	24.55
110011	1.1631	18.28
110013	1.0596	16.03
110014	0.9442	16.12
110015	1.1403	19.48
110016	1.2284	15.30
110017	0.9311	10.54
110018	1.1969	21.04
110020	1.1913	18.53
110023	1.3377	18.65
110024	1.3651	19.79
110025	1.3872	18.65
110026	1.1354	16.14
110027	1.1200	14.68
110028	1.7799	19.89
110029	1.3551	20.05
110030	1.2989	17.68
110031	1.2252	21.58
110032	1.2518	16.19
110033	1.4207	21.41
110034	1.5887	18.19
110035	1.3910	21.17
110036	1.8557	24.42
110038	1.4440	16.38
110039	1.4173	20.77
110040	1.0663	16.40
110041	1.1827	16.69
110042	1.1533	20.65
110043	1.8094	17.22
110044	1.1898	19.60
110045	1.1386	19.94
110046	1.2456	19.23
110048	1.2372	15.65
110049	1.0992	14.21
110050	1.1823	18.75
110051	1.0253	15.75
110052	.....	15.06
110054	1.3647	19.27
110056	1.0854	16.50

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
110059	1.2176	17.70
110061	1.0960	13.72
110062	0.9082	12.21
110063	1.0542	17.97
110064	1.4891	18.34
110065	1.0304	13.32
110066	1.4455	20.65
110069	1.2576	18.35
110070	1.1398	18.23
110071	1.0981	14.89
110072	0.9710	12.43
110073	1.1423	15.14
110074	1.5078	20.76
110075	1.3221	17.01
110076	1.4652	20.44
110078	1.7591	24.71
110079	1.4560	20.14
110080	1.3568	23.43
110082	2.0994	22.01
110083	1.7625	21.36
110086	1.2841	14.98
110087	1.3556	20.54
110089	1.2027	18.58
110091	1.2778	21.38
110092	1.0882	15.09
110093	0.9940	14.80
110094	0.9912	13.87
110095	1.3528	15.95
110096	1.0800	16.32
110097	1.0625	15.62
110098	0.9868	14.01
110100	1.0558	20.38
110101	1.1014	11.73
110103	0.9292	11.94
110104	1.0957	15.32
110105	1.3084	16.52
110107	1.8959	17.39
110108	0.9495	15.14
110109	1.1092	16.37
110111	1.2038	17.32
110112	0.9910	19.13
110113	1.0478	15.19
110114	1.0443	15.13
110115	1.7515	24.83
110118	1.1342	15.40
110120	1.0378	15.19
110121	1.2814	15.58
110122	1.3852	18.85
110124	1.2083	17.13
110125	1.2563	17.33
110127	0.8834	13.76
110128	1.1927	18.97
110129	1.6606	18.12
110130	1.0077	13.08
110132	1.1467	15.02
110134	0.9641	11.56
110135	1.3364	17.08
110136	1.1043	16.17
110140	1.0432	17.88
110141	0.9978	12.51
110142	0.9537	12.30
110143	1.4324	21.69
110144	1.0701	17.98
110146	1.0869	17.61

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
110149	1.1792	22.23
110150	1.4100	18.77
110152	1.0430	14.77
110153	1.0935	18.69
110154	0.9773	14.81
110155	1.1373	17.14
110156	1.0500	15.34
110161	1.3183	20.87
110162	0.7522	.....
110163	1.4626	18.20
110164	1.4197	19.49
110165	1.4296	19.00
110166	1.4485	19.85
110168	1.6662	19.82
110169	1.2028	18.72
110171	1.6129	20.09
110172	1.3551	25.44
110174	0.9161	14.30
110176	3.7291	22.40
110177	1.5099	19.59
110178	.....	16.85
110179	1.1506	20.52
110181	0.9051	13.72
110183	1.3138	21.18
110184	1.2424	20.95
110185	1.1859	16.25
110186	1.2579	17.34
110187	1.2755	21.45
110188	1.3546	20.05
110189	1.1719	18.86
110190	1.0646	19.43
110191	1.3087	19.11
110192	1.4455	20.77
110193	1.2441	18.78
110194	0.8928	15.09
110195	1.0992	10.52
110198	1.2874	26.19
110200	1.8858	17.21
110201	1.5098	19.24
110203	0.9319	20.30
110204	0.8239	20.57
110205	1.0578	26.12
110207	1.0141	12.87
110208	0.9593	14.89
110209	0.7100	20.46
110211	0.9611	21.82
110212	1.0031	12.66
110213	.....	13.20
110215	1.0915	.....
110216	2.1653	.....
110217	2.8336	.....
120001*	1.8210	26.71
120002	1.2129	24.38
120003	1.1495	23.85
120004	1.2588	24.05
120005	1.2449	20.54
120006	1.2730	23.72
120007	1.7318	23.27
120009	0.9876	19.02
120010*	1.8326	25.40
120011	1.3630	33.55
120012	0.8391	22.52
120014	1.2760	24.05
120015	1.0355	29.07

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
120016	1.0574	29.41
120018	1.2117	25.61
120019	1.3192	21.92
120021	0.8937	19.42
120022*	1.6843	17.93
120024	1.0727	22.28
120025	.....	19.02
120026	1.2648	23.22
120027	1.4048	24.55
120028	1.2481	23.49
130001	0.9681	24.95
130002	1.3266	16.19
130003	1.3394	19.95
130005	1.4416	20.17
130006	1.8354	18.87
130007	1.6730	19.84
130008	0.9590	12.92
130009	0.9302	18.30
130010	0.8926	21.43
130011	1.2859	19.08
130012	0.9911	22.62
130013	1.3306	19.22
130014	1.3247	17.98
130015	0.8768	15.27
130016	1.0211	17.00
130017	1.1066	16.88
130018	1.6255	17.97
130019	1.1213	17.23
130021	0.9692	12.26
130022	1.2150	19.50
130024	1.1595	18.38
130025	1.0955	15.27
130026	1.1725	20.55
130027	0.9334	20.70
130028	1.2849	18.21
130029	1.0697	20.32
130030	0.8448	18.40
130031	1.0229	17.65
130034	1.0325	18.82
130035	1.1048	20.47
130036	1.3938	13.79
130037	1.3059	17.74
130043	0.9589	16.07
130044	0.9748	13.18
130045	0.9802	16.47
130048	0.9813	15.09
130049	1.2324	20.39
130054	0.9573	17.78
130056	0.8508	15.66
130058	.....	17.75
130060	1.2887	20.85
130061	1.2950	16.78
130062	0.7200	15.11
130063	1.4979	.....
140001	1.2255	15.44
140002	1.2571	19.26
140003	1.0026	18.00
140004	1.1707	17.52
140005	0.9673	10.87
140007	1.4692	22.40
140008	1.4670	21.28
140010	1.3723	25.22
140011	1.2034	17.28
140012	1.2770	19.44

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
140013	1.5752	17.35
140014	1.1751	20.76
140015	1.2854	15.02
140016	1.0294	12.54
140018	1.2556	21.41
140019	1.1123	15.34
140024	0.9557	14.67
140025	1.0826	16.95
140026	1.2234	15.96
140027	1.2694	17.50
140029	1.3385	21.03
140030	1.8214	22.44
140031	1.2008	15.94
140032	1.3345	17.34
140033	1.2874	22.56
140034	1.1851	19.15
140035	1.0002	13.00
140036	1.2407	17.04
140037	1.0383	12.50
140038	1.1029	17.61
140040	1.2581	16.25
140041	1.1609	17.28
140042	1.0170	15.61
140043	1.1892	18.95
140045	1.0315	20.65
140046	1.3045	16.46
140047	1.0950	16.33
140048	1.3056	20.58
140049	1.6537	21.59
140051	1.5128	20.85
140052	1.3027	19.60
140053	2.0158	17.82
140054	1.3339	26.15
140055	1.0225	14.80
140058	1.2340	17.27
140059	1.1394	15.39
140061	1.0953	15.96
140062	1.2457	27.09
140063	1.4375	22.39
140064	1.3249	19.25
140065	1.4610	23.16
140066	1.1773	16.17
140067	1.8177	18.40
140068	1.2883	18.87
140069	1.0457	16.15
140070	1.2636	19.30
140074	1.0760	19.01
140075	1.3671	22.51
140077	1.2557	16.64
140079	1.2639	21.92
140080	1.5815	21.00
140081	1.0826	15.51
140082	1.3675	22.62
140083	1.2487	18.13
140084	1.2529	20.01
140086	1.1147	17.37
140087	1.3481	18.36
140088	1.7136	24.26
140089	1.2745	17.21
140090	1.5324	23.59
140091	1.9057	20.70
140093	1.1687	19.15
140094	1.3422	20.61
140095	1.4016	21.54

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
140097	0.9525	16.90
140100	1.3286	19.06
140101	1.2240	26.09
140102	1.0445	15.08
140103	1.4231	17.86
140105	1.2926	20.91
140107	1.0113	12.76
140108	1.3335	28.60
140109	1.1446	15.47
140110	1.2400	18.81
140112	1.1563	16.24
140113	1.5588	17.92
140114	1.3342	20.48
140115*	1.3041	20.09
140116	1.2341	21.83
140117	1.5614	19.64
140118	1.7249	23.08
140119	1.7816	26.50
140120	1.3740	14.84
140121	1.3607	9.53
140122	1.5542	23.75
140124	1.1024	26.97
140125	1.3478	17.10
140127	1.4164	19.42
140128	1.0296	17.67
140129	1.1659	15.25
140130	1.2488	23.77
140132	1.4905	23.04
140133	1.4025	19.91
140135	1.2759	17.69
140137	1.0383	16.51
140138	1.0650	14.59
140139	1.1039	16.58
140140	1.1395	15.30
140141	1.2644	15.18
140143	1.0957	18.76
140144	0.9933	19.79
140145	1.1514	16.61
140146	1.0740	23.74
140147	1.2519	24.82
140148	1.8274	19.50
140150	1.6434	27.85
140151	1.0618	19.30
140152	1.1951	22.43
140155	1.3310	17.31
140158	1.3594	22.27
140160	1.1737	17.88
140161	1.2224	19.04
140162	1.6988	18.42
140164	1.4390	18.61
140165	1.0866	15.42
140166	1.1670	17.54
140167	1.0995	16.57
140168	1.1303	16.46
140170	1.1327	14.14
140171	0.9915	14.73
140172	1.5915	20.80
140173	0.8685	18.48
140174	1.6130	19.92
140176	1.2480	21.41
140177	1.2010	18.17
140179	1.3630	22.70
140180	1.4469	23.25
140181	1.4232	20.55

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
140182	1.3607	20.70
140184	1.2116	14.98
140185	1.4938	17.36
140186	1.3429	18.99
140187	1.5865	17.69
140188	0.9985	14.84
140189	1.2534	19.08
140190	1.0757	15.88
140191	1.4399	24.74
140193	1.0289	15.52
140197	1.2537	17.98
140199	1.0816	18.83
140200	1.4773	21.65
140202	1.3290	22.18
140203	1.1563	20.78
140205	0.9296	17.24
140206	1.2023	20.51
140207	1.2939	20.20
140208	1.7156	23.94
140209	1.6271	17.79
140210	1.1138	12.66
140211	1.2095	20.96
140213	1.2790	26.20
140215	0.9874	14.45
140217	1.3233	23.32
140218	0.9871	15.08
140220	1.1223	16.73
140223	1.5508	21.47
140224	1.4309	22.99
140228	1.6773	18.67
140230	0.9381	16.60
140231	1.5608	21.61
140233	1.7813	18.37
140234	1.2225	18.72
140236	1.0843	13.13
140239	1.7318	18.88
140240	1.3948	24.21
140242	1.6371	22.67
140245	1.2029	15.56
140246	1.0621	12.82
140250	1.3281	23.41
140251	1.3069	20.58
140252	1.4989	24.49
140253	1.1634	16.74
140258	1.5765	21.13
140271	0.9795	15.36
140275	1.2739	17.96
140276	2.0654	23.72
140280	1.3786	18.84
140281	1.6496	23.34
140285	1.2739	14.71
140286	1.1863	19.95
140288	1.6193	21.82
140289	1.3459	16.45
140290	1.3383	21.24
140291	1.3339	22.44
140292	1.2911	22.71
140294	1.1347	17.52
140297	.....	21.47
140300	1.4559	23.26
150001	1.1041	21.70
150002	1.4489	18.76
150003	1.8053	19.31
150004	1.5183	19.70

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
150005	1.1499	19.00
150006	1.2599	20.04
150007	1.2063	19.53
150008	1.4364	20.97
150009	1.3649	18.22
150010	1.3600	18.48
150011	1.2166	19.19
150012	1.6210	20.52
150013	1.1027	16.00
150014	1.6030	21.28
150015	1.2975	22.05
150017	1.9021	18.89
150018	1.4575	19.56
150019	1.0931	15.29
150020	1.1536	14.46
150021	1.6905	19.02
150022	1.0882	17.92
150023	1.5779	18.66
150024	1.3427	17.83
150025	1.4440	18.15
150026	1.2077	20.51
150027	1.0057	16.48
150029	1.3399	21.74
150030	1.2418	17.33
150031	1.0791	18.01
150032	.....	20.64
150033	1.5759	21.69
150034	1.4830	21.29
150035	1.4915	19.82
150036	1.0011	20.38
150037	1.2875	17.79
150038	1.2923	20.25
150039	1.0012	17.49
150042	1.2828	17.12
150043	1.1061	17.98
150044	1.2617	17.64
150045	1.0943	17.04
150046	1.3952	17.32
150047	1.5995	24.88
150048	1.1920	16.96
150049	1.2163	16.85
150050	1.1659	17.14
150051	1.5091	18.20
150052	1.0896	15.36
150053	0.9867	18.75
150054	1.1338	17.33
150056	1.8954	23.30
150057	2.2387	16.86
150058	1.7048	20.95
150059	1.3598	20.80
150060	1.1844	16.01
150061	1.2118	17.21
150062	1.1077	18.41
150063	1.0850	21.09
150064	1.1848	17.03
150065	1.1695	19.01
150066	1.0217	14.60
150067	1.1259	17.08
150069	1.2229	17.39
150070	0.9568	17.20
150071	1.0951	14.73
150072	1.1985	16.11
150073	1.0647	19.03
150074	1.6339	18.86

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
150075	1.1208	14.98
150076	1.1839	22.34
150077	0.8124	17.58
150078	1.0539	19.01
150079	1.1723	15.45
150082	1.5245	17.88
150084	1.9902	22.92
150086	1.2532	17.34
150088	1.3451	19.45
150089	1.4582	22.94
150090	1.3308	19.06
150091	1.0358	19.89
150092	1.0090	15.92
150094	0.9814	18.34
150095	1.0848	17.12
150096	1.0067	20.03
150097	1.0940	18.31
150098	1.1571	14.30
150099	.....	18.97
150100	1.6554	17.48
150101	1.0910	17.56
150102	1.0778	11.50
150103	0.9707	17.31
150104	1.1260	17.26
150105	1.3381	19.17
150106	1.0525	18.91
150109	1.3958	18.23
150110	0.9834	18.58
150111	1.1588	16.17
150112	1.2455	19.82
150113	1.2372	19.20
150114	0.9743	16.96
150115	1.3404	17.06
150122	1.1625	19.35
150123	1.1180	15.16
150124	1.0843	15.07
150125	1.4619	20.32
150126	1.4866	20.30
150127	1.0396	22.81
150128	1.2478	19.92
150129	1.1853	23.47
150130	1.3391	16.41
150132	1.4200	19.48
150133	1.1910	16.49
150134	1.1949	17.06
150136	0.9556	19.28
160001	1.2585	19.03
160002	1.0936	15.37
160003	0.9994	15.77
160005	1.0825	15.23
160007	1.0218	15.66
160008	1.1402	14.97
160009	1.2212	16.09
160012	1.0500	16.54
160013	1.1368	17.06
160014	1.0250	15.09
160016	1.1678	18.37
160018	0.9630	14.16
160020	1.0690	14.41
160021	1.1123	15.49
160023	1.0852	14.20
160024	1.6086	18.95
160026	1.0312	18.66
160027	1.0851	15.74

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
160028	1.2328	20.54
160029	1.5330	20.40
160030	1.3897	17.99
160031	1.1173	15.28
160032	1.1540	16.18
160033	1.9249	18.37
160034	1.1538	14.51
160035	0.8486	15.92
160036	1.0544	19.20
160037	1.0575	18.40
160039	1.0380	17.63
160040	1.2725	16.83
160041	1.0640	15.47
160043	0.9958	15.63
160044	1.2165	16.04
160045	1.8190	20.12
160046	1.0270	14.77
160047	1.3715	16.69
160048	1.2473	13.14
160049	0.9271	13.36
160050	1.0702	16.42
160051	0.8978	14.27
160052	0.9917	17.55
160054	1.0301	15.71
160055	0.9883	14.06
160056	1.0674	15.38
160057	1.2430	17.41
160058	1.8366	20.34
160060	1.0432	15.95
160061	1.0830	17.57
160062	0.9941	14.44
160063	1.1620	16.30
160064	1.5338	19.91
160065	1.0522	16.51
160066	1.1019	16.26
160067	1.4239	17.85
160068	1.0224	15.85
160069	1.5367	18.49
160070	0.9958	15.66
160072	1.0345	14.19
160073	0.9972	15.05
160074	1.0388	16.48
160075	1.0778	17.89
160076	1.0989	17.31
160077	1.1087	11.40
160079	1.4119	17.71
160080	1.2114	17.81
160081	1.1520	16.51
160082	1.9236	18.76
160083	1.6706	18.41
160085	0.9972	18.55
160086	0.9601	16.46
160088	1.1561	17.53
160089	1.1911	16.74
160090	1.0139	16.60
160091	1.0383	12.19
160092	1.0120	15.80
160093	1.0155	15.95
160094	1.1043	16.56
160095	1.0299	14.26
160097	1.0774	15.21
160098	0.9466	15.54
160099	0.9654	13.79
160101	1.0851	17.87

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
160102	1.3432	18.36
160103	0.9416	17.15
160104	1.2969	19.74
160106	1.1113	16.66
160107	1.1505	16.56
160108	1.0215	15.42
160109	1.0167	16.49
160110	1.5105	18.81
160111	0.9969	13.17
160112	1.3695	16.28
160113	1.0947	14.58
160114	0.9776	15.58
160115	0.9770	15.76
160116	1.1196	16.69
160117	1.4111	17.29
160118	0.9954	15.84
160120	0.9721	12.56
160122	1.1137	18.52
160124	1.2998	17.16
160126	0.9700	17.74
160129	0.9742	15.89
160130	1.1286	15.45
160131	1.0437	14.69
160134	0.9459	13.32
160135	1.0163	16.33
160138	1.0146	15.71
160140	1.1321	18.80
160142	1.0188	16.14
160143	1.1242	15.92
160145	1.0697	15.17
160146	1.4411	16.35
160147	1.2764	18.39
160151	1.0545	15.74
160152	0.9425	15.22
160153	1.7595	19.69
170001	1.2073	17.44
170004	1.0739	13.06
170006	1.1966	19.31
170008	1.0034	13.90
170009	1.1479	19.59
170010	1.3585	17.90
170012	1.4135	16.79
170013	1.2818	17.89
170014	1.0342	17.34
170015	0.9809	15.89
170016	1.7098	19.64
170017	1.1985	17.87
170018	1.1014	14.28
170019	1.2400	16.66
170020	1.4076	16.15
170022	1.0506	17.94
170023	1.4694	19.36
170024	1.0663	13.06
170025	1.1917	16.37
170026	1.0821	13.31
170027	1.3182	16.39
170030	1.0600	15.24
170031	0.8926	13.47
170032	1.0154	14.48
170033	1.4154	16.05
170034	1.0335	14.63
170035	0.8974	15.62
170036	.....	14.17
170038	0.9007	14.21

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
170039	1.0924	14.30
170040	1.5839	20.14
170041	1.0515	11.47
170044	0.9951	14.78
170045	1.0889	12.11
170049	1.3513	18.58
170051	0.9883	14.16
170052	1.0435	14.62
170053	0.9379	9.04
170054	1.0385	12.77
170055	0.9812	14.99
170056	0.8854	14.87
170057	.....	15.09
170058	1.1560	18.34
170060	1.0207	17.23
170061	1.1617	14.14
170063	0.8974	11.33
170064	.....	12.42
170066	0.9451	14.48
170067	0.9987	12.78
170068	1.2647	15.82
170070	1.0611	12.82
170072	0.9119	13.34
170073	1.0417	16.47
170074	1.2029	14.40
170075	0.9266	11.26
170076	1.0180	13.58
170077	0.9138	12.72
170079	1.0029	14.29
170080	0.9644	12.20
170081	0.9118	12.51
170082	0.9387	12.39
170084	0.8978	12.16
170085	0.8894	14.51
170086	1.6767	19.85
170088	0.9319	11.75
170089	0.9744	18.08
170090	0.9652	11.27
170092	.....	12.85
170093	0.8902	12.78
170094	0.9571	17.71
170095	1.0123	15.75
170097	0.9087	15.85
170098	1.1360	14.10
170099	1.1529	13.55
170100	.....	14.47
170101	0.9694	12.88
170102	0.9678	13.24
170103	1.3272	16.66
170104	1.4805	19.76
170105	1.0590	15.93
170106	0.9336	14.68
170109	0.9346	16.94
170110	0.9857	15.55
170112	1.1452	13.39
170113	1.0746	13.39
170114	0.9511	14.51
170115	0.9977	12.68
170116	1.0599	15.76
170117	0.9782	15.28
170119	0.9657	13.97
170120	1.2725	16.21
170122	1.7569	20.13
170123	1.7222	21.42

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
170124	0.9948	10.21
170126	0.9316	12.13
170128	0.9613	14.99
170131	.....	13.10
170133	1.1278	17.11
170134	0.8746	14.23
170137	1.1825	17.42
170139	1.0034	13.39
170142	1.3143	17.32
170143	1.1142	15.88
170144	1.5081	16.09
170145	1.1137	16.75
170146	1.4464	19.97
170147	1.1950	16.28
170148	1.3683	17.25
170150	1.1491	15.43
170151	0.9386	13.37
170152	1.0039	13.68
170160	0.9948	13.31
170164	0.9849	15.56
170166	1.1213	17.57
170171	1.0545	13.81
170175	1.3044	17.88
170176	1.6757	20.32
170182	1.4288	14.20
170183	1.9802	19.09
170184	.....	27.01
180001	1.3845	19.52
180002	1.0807	18.13
180004	1.1145	15.99
180005	1.1967	20.63
180006	0.9088	11.23
180007	1.4605	17.20
180009	1.3630	20.81
180010	1.9352	17.55
180011	1.3149	16.93
180012	1.4399	18.74
180013	1.4516	17.45
180014	1.6962	20.80
180016	1.3326	18.84
180017	1.3055	15.17
180018	1.2972	18.90
180019	1.1916	16.76
180020	1.1096	17.78
180021	1.0498	15.16
180023	0.9502	15.22
180024	1.4071	15.33
180025	1.2007	17.17
180026	1.2061	14.16
180027	1.2508	14.89
180028	1.0896	19.35
180029	1.2291	18.02
180030	1.1690	17.02
180031	1.1171	13.79
180032	1.0592	16.09
180033	1.0969	13.77
180034	1.0876	17.32
180035	1.6449	19.45
180036	1.1569	19.19
180037	1.3120	18.81
180038	1.4617	17.16
180040	1.9294	19.44
180041	1.1888	15.17
180042	1.1678	16.29

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
180043	1.1248	16.61
180044	1.1967	17.82
180045	1.3993	17.73
180046	1.0431	17.91
180047	1.0016	15.04
180048	1.2482	19.57
180049	1.3489	16.08
180050	1.2187	18.48
180051	1.3876	15.68
180053	1.0545	14.63
180054	1.0894	16.39
180055	1.2204	14.64
180056	1.1028	16.62
180058	1.0446	14.36
180059	0.8725	14.26
180060	.....	7.21
180063	1.0690	11.91
180064	1.1791	14.49
180065	1.0777	20.03
180066	1.0801	18.56
180067	1.8973	18.53
180069	1.1243	17.30
180070	1.1056	13.84
180072	1.1200	17.85
180075	.....	15.07
180078	1.0782	19.16
180079	1.1816	13.41
180080	1.0820	15.83
180087	1.2278	14.97
180088	1.6070	22.53
180092	1.2232	16.31
180093	1.4180	16.83
180094	1.0265	12.51
180095	1.1312	13.40
180099	1.0423	13.70
180101	1.1766	19.56
180102	1.4368	17.88
180103	2.3182	19.22
180104	1.5485	18.87
180105	0.8828	14.08
180106	0.8754	13.61
180108	0.8268	14.62
180115	0.9601	17.11
180116	1.2335	16.94
180117	1.1154	18.38
180118	0.9648	12.15
180120	1.0190	17.81
180121	1.1698	14.51
180122	1.0646	16.97
180123	1.3537	19.00
180124	1.3291	18.41
180125	1.1248	19.73
180126	1.1140	12.40
180127	1.2901	17.35
180128	1.0665	17.05
180129	0.9823	17.86
180130	1.4358	19.01
180132	1.2696	17.26
180133	1.3414	22.23
180134	1.0880	13.63
180136	1.8166	17.71
180138	1.2012	18.61
180139	1.0562	18.77
180140	0.9802	20.40

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
180141	1.8686	20.01
180142	1.7788	.....
190001	0.8863	17.01
190002	1.6872	18.84
190003	1.3293	22.15
190004	1.4227	17.54
190005	1.5108	16.71
190006	1.4657	17.73
190007	1.0554	13.60
190008	1.6184	16.89
190009	1.2835	14.21
190010	1.2068	17.02
190011	1.1462	15.17
190013	1.3006	16.57
190014	1.1871	17.02
190015	1.2674	18.19
190017	1.3423	15.79
190018	1.1075	16.98
190019	1.7884	17.40
190020	1.1993	17.31
190025	1.3078	16.07
190026	1.5549	17.22
190027	1.5154	16.19
190029	1.1492	17.11
190033	0.9722	10.74
190034	1.1721	16.51
190036	1.6846	19.94
190037	0.9642	12.02
190039	1.4096	17.17
190040	1.3336	20.32
190041	1.6062	17.90
190043	1.0448	12.57
190044	1.1671	17.20
190045	1.4154	21.69
190046	1.4275	19.35
190048	1.2068	16.34
190049	0.9395	16.42
190050	1.0788	15.38
190053	1.1493	12.50
190054	1.2992	16.47
190059	0.8878	15.84
190060	1.3886	18.37
190064	1.5235	19.90
190065	1.4997	19.39
190071	0.8370	13.59
190077	0.8845	12.83
190078	1.1084	13.50
190079	1.3543	17.29
190081	0.8862	12.02
190083	1.0663	16.14
190086	1.3280	14.93
190088	1.2140	19.63
190089	1.1095	12.79
190090	1.0412	16.56
190092	.....	18.07
190095	0.9939	15.73
190098	1.5467	19.22
190099	1.1795	18.92
190102	1.6260	19.05
190103	0.9068	15.57
190106	1.1248	17.75
190109	1.2488	14.53
190110	0.9773	12.99
190111	1.5936	20.04

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
190112	1.6944	19.21
190113	1.3926	18.99
190114	1.0180	12.91
190115	1.2776	20.49
190116	1.1970	12.59
190118	0.9984	12.95
190120	0.9918	13.69
190122	1.2902	14.83
190124	1.6262	22.38
190125	1.4998	18.63
190128	1.1960	19.71
190130	1.0021	12.43
190131	1.2634	19.60
190133	1.0829	13.48
190134	1.0010	12.68
190135	1.4336	21.35
190136	0.9974	11.33
190138	.....	22.71
190140	0.9506	12.03
190142	0.9173	14.98
190144	1.1852	16.84
190145	0.9756	13.99
190146	1.5254	20.09
190147	0.9772	14.32
190148	0.9409	14.02
190149	0.9956	15.19
190151	1.0763	11.92
190152	1.5099	20.40
190155	.....	11.08
190156	0.9523	12.48
190158	1.2658	19.62
190160	1.2656	18.47
190161	1.0796	14.63
190162	1.2953	19.50
190164	1.1850	16.33
190167	1.1283	16.29
190170	0.9051	13.58
190173	1.3386	19.64
190175	1.4211	20.69
190176	1.6017	18.82
190177	1.7127	20.32
190178	0.9284	10.49
190182	1.3004	20.03
190183	1.1900	16.11
190184	0.9948	14.86
190185	1.3089	19.37
190186	0.9392	16.36
190189	.....	26.54
190190	0.9164	18.67
190191	1.1467	18.14
190196	0.9433	14.87
190197	1.1821	17.92
190199	1.1077	13.42
190200	1.4896	19.41
190201	1.0997	19.14
190202	1.1257	17.90
190203	1.4077	21.31
190204	1.4949	21.21
190205	1.9200	18.10
190206	1.6311	20.06
190207	1.2616	17.67
190208	0.8087	14.61
190218	1.0606	18.16
190223	.....	19.26

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
190227	1.0049	12.11
190231	1.5630	16.89
190235	.....	18.27
190236	1.4200	22.18
190237	2.6647	.....
190238	1.6631	.....
190239	1.1565	.....
190240	0.9574	.....
200001	1.3477	17.49
200002	1.1150	18.77
200003	1.0964	16.74
200006	1.0846	19.80
200007	1.0259	17.89
200008	1.2221	20.50
200009	1.8810	20.64
200012	1.1802	17.01
200013	1.1132	16.49
200015	.....	20.11
200016	1.0407	17.66
200017	.....	19.65
200018	1.2100	17.24
200019	1.2510	18.64
200020	1.1517	20.60
200021	1.1958	19.41
200023	0.8393	14.92
200024	1.4795	18.65
200025	1.2498	19.07
200026	0.9907	17.28
200027	1.2361	18.28
200028	0.9208	16.93
200031	1.2276	15.90
200032	1.3282	17.92
200033	1.7827	21.40
200034	1.2767	19.24
200037	1.2288	18.24
200038	1.1403	19.21
200039	1.2567	20.29
200040	1.1161	19.30
200041	1.1251	17.66
200043	0.8011	16.54
200050	1.2048	18.08
200051	0.9887	19.59
200052	0.9951	15.12
200055	1.0880	17.17
200062	0.9532	16.51
200063	1.2440	19.67
200066	1.1429	16.34
210001	1.4433	18.73
210002	2.0494	22.84
210003	1.6842	25.37
210004	1.3603	23.59
210005	1.2944	19.62
210006	1.1143	17.77
210007	1.8010	21.54
210008	1.3067	19.50
210009	1.8608	21.81
210010	1.1389	14.38
210011	1.3616	21.24
210012	1.6214	23.43
210013	1.3595	18.85
210015	1.3058	16.69
210016	1.8547	22.15
210017	1.2502	17.17
210018	1.2626	21.41

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
210019	1.6155	19.09
210022	1.4895	21.82
210023	1.4521	21.80
210024	1.6929	19.56
210025	1.3269	19.57
210026	1.3215	11.64
210027	1.2849	18.49
210028	1.1685	18.86
210029	1.2770	22.39
210030	1.2555	21.02
210031	1.3110	15.59
210032	1.1818	18.50
210033	1.2403	19.91
210034	1.3179	16.12
210035	1.3496	20.61
210037	1.2643	18.74
210038	1.4168	23.26
210039	1.1908	20.73
210040	1.3185	25.08
210043	1.2817	18.59
210044	1.3636	22.24
210045	1.0866	9.69
210048	1.2884	22.39
210049	1.1698	17.67
210051	1.4028	20.76
210054	1.3672	23.51
210055	1.3640	20.10
210056	1.3926	20.94
210057	1.3578	22.57
210058	1.5015	21.50
210059	1.1916	23.13
210060	1.2744	.....
210061	1.1312	20.02
220001	1.2885	26.32
220002	1.4675	22.58
220003	1.1126	19.14
220004	.....	20.01
220006	1.3858	22.12
220008	1.2978	21.89
220010	1.3476	21.92
220011	1.0966	28.57
220012	1.3138	29.51
220015	1.1694	21.78
220016	1.3440	23.14
220017	1.3512	25.26
220019	1.1553	19.13
220020	1.2443	19.99
220021	.....	23.63
220023	0.6351	18.76
220024	1.2152	21.59
220025	1.1428	19.94
220028	1.4561	22.07
220029	1.1597	21.87
220030	1.1060	14.54
220031	1.9047	28.16
220033	1.2607	20.41
220035	1.3065	22.00
220036	1.6250	24.16
220038	1.3105	22.35
220041	1.1892	23.15
220042	1.2714	25.28
220046	1.3199	22.47
220049	1.2818	23.03
220050	1.1650	20.83

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
220051	1.1795	20.48
220052	1.2991	23.14
220053	1.1633	21.27
220055	1.2850	21.57
220057	1.3594	23.00
220058	1.1555	20.19
220060	1.2301	26.17
220062	0.5637	20.06
220063	1.2667	20.95
220064	1.2836	22.18
220065	1.3716	20.20
220066	1.3505	20.46
220067	1.2871	25.74
220068	.....	6.45
220070	1.2178	19.77
220071	1.9238	24.65
220073	1.3020	25.87
220074	1.3357	24.05
220075	1.7963	21.54
220076	1.2498	24.78
220077	1.8273	24.80
220079	1.1002	21.01
220080	1.3051	20.50
220081	0.9211	25.34
220082	1.2653	20.02
220083	1.1883	23.08
220084	1.2499	24.66
220086	1.7929	30.46
220088	1.6454	23.38
220089	1.2586	21.79
220090	1.2248	21.64
220092	1.1846	17.04
220094	.....	21.99
220095	1.1895	21.45
220098	1.3182	20.86
220100	1.3672	25.35
220101	1.4445	24.33
220104	1.4751	27.53
220105	1.2705	21.69
220106	1.2167	24.55
220107	.....	20.27
220108	1.1918	22.64
220110	2.1062	29.19
220111	1.2452	23.05
220116	1.9074	24.97
220118	.....	30.52
220119	1.2606	22.86
220123	1.0333	27.31
220126	1.2501	20.96
220128	.....	20.56
220133	0.6976	35.27
220135	1.2820	25.08
220153	1.0071	23.90
220154	0.9026	22.13
220162	1.5209	.....
220163	2.0316	27.35
220171	1.6823	23.43
230001	1.1547	19.20
230002	1.2729	21.91
230003	1.1440	19.61
230004	1.6897	22.03
230005	1.2524	19.40
230006	1.0497	18.47
230007	.....	19.43

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
230012	0.9628	18.67
230013	1.3746	20.63
230015	1.1422	20.43
230017	1.6115	20.40
230019	1.5321	21.32
230020	1.7453	21.32
230021	1.5006	18.57
230022	1.2699	19.76
230024	1.4264	27.96
230027	1.0344	18.03
230029	1.5752	21.06
230030	1.3412	17.70
230031	1.4268	17.53
230032	1.7439	20.68
230034	1.2703	17.23
230035	1.0782	17.56
230036	1.2543	21.76
230037	1.1759	19.07
230038	1.7538	23.39
230040	1.1335	20.39
230041	1.2547	19.03
230042	1.2347	19.49
230046	1.9274	25.95
230047	1.3582	20.64
230053	1.5879	22.18
230054	1.8393	19.54
230055	1.1717	19.84
230056	0.9022	16.41
230058	1.1008	18.23
230059	1.4590	19.51
230060	1.3289	17.87
230062	0.9642	16.30
230063	1.2580	20.22
230065	1.3189	21.15
230066	1.3680	21.51
230069	1.1982	21.79
230070	1.6482	20.06
230071	1.1143	22.16
230072	1.2345	20.43
230075	1.5088	19.43
230076	1.4056	23.82
230077	2.0633	20.39
230078	1.1156	16.25
230080	1.2475	18.91
230081	1.2085	17.95
230082	1.1156	17.74
230085	1.2336	17.54
230086	0.9507	16.98
230087	1.0836	15.77
230089	1.2845	21.39
230092	1.3584	18.96
230093	1.2332	20.19
230095	1.1754	16.78
230096	1.1056	22.56
230097	1.6198	20.10
230099	1.1227	20.25
230100	1.1434	13.11
230101	1.0673	18.61
230103	1.0518	19.60
230104	1.5580	23.47
230105	1.8005	20.88
230106	1.1850	18.35
230107	0.9423	14.67
230108	1.2110	17.42

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
230110	1.3149	17.80
230113	0.8490	11.17
230115	1.0569	16.47
230116	0.8683	16.36
230117	1.9017	23.94
230118	1.1392	21.71
230119	1.3553	23.96
230120	1.1300	19.64
230121	1.2281	20.08
230122	1.3510	18.09
230124	1.1665	18.89
230125	.....	15.35
230128	1.4062	23.58
230130	1.6919	22.52
230132	1.3454	26.17
230133	1.2277	17.57
230134	.....	15.32
230135	1.2335	22.74
230137	.....	18.34
230141	1.6286	23.05
230142	1.2833	20.12
230143	1.2819	16.45
230144	1.1235	20.99
230145	1.1243	16.60
230146	1.2623	18.63
230147	1.4122	20.51
230149	1.1319	14.17
230151	1.4152	20.89
230153	1.0656	17.33
230154	0.8898	14.58
230155	1.0291	16.99
230156	1.7492	23.61
230157	1.1708	19.72
230159	1.0227	18.84
230162	0.9486	17.77
230165	1.9365	23.31
230167	1.7523	20.32
230169	1.3609	22.86
230171	1.0638	14.96
230172	1.1814	20.22
230174	1.3724	20.85
230175	2.3801	21.81
230176	1.2161	21.86
230178	0.9470	16.08
230180	1.1228	15.48
230184	1.2506	17.29
230186	1.1355	.....
230188	1.1192	15.56
230189	0.9459	15.91
230190	0.8855	23.71
230191	0.9307	17.12
230193	1.3034	20.18
230195	1.3593	22.37
230197	1.4069	21.62
230199	1.1010	18.40
230201	1.2559	15.32
230204	1.3711	22.95
230205	0.9890	13.89
230207	1.2528	20.35
230208	1.2993	17.15
230211	0.9109	17.51
230212	1.0548	22.14
230213	0.9300	15.32
230216	1.5720	19.59

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
230217	1.2676	20.95
230219	0.8629	20.70
230221*	.....	21.50
230222	1.3905	20.84
230223	1.2683	21.50
230227	1.4220	21.38
230230	1.5842	22.53
230232	.....	12.64
230235	1.0983	15.95
230236	1.3279	23.22
230239	1.1721	19.23
230241	1.1923	18.85
230244	1.4096	21.08
230253	0.9601	21.95
230254	1.2941	21.28
230257	0.9124	20.47
230259	1.1378	21.15
230264	1.6854	15.18
230269	1.3102	22.81
230270	1.2083	20.08
230273	1.5194	23.40
230275	0.5244	17.60
230276	0.5657	18.58
230277	1.2485	22.50
230278	.....	16.66
230279	0.6550	16.04
230280	1.0995	14.22
230283	2.2592	.....
240001	1.5332	22.85
240002	1.7586	23.02
240004	1.5987	23.92
240005	0.8865	16.98
240006	1.1679	27.11
240007	1.0673	16.98
240008	1.1473	21.81
240009	0.9476	16.69
240010	1.9899	23.63
240011	1.1456	18.96
240013	1.2868	18.97
240014	1.0965	21.86
240016	1.3894	19.86
240017	1.1545	17.23
240018	1.2702	19.07
240019	1.1855	20.99
240020	1.1176	19.57
240021	0.9884	17.40
240022	1.1043	19.16
240023	0.9797	20.39
240025	1.0961	17.25
240027	1.0734	16.25
240028	1.1427	19.38
240029	1.1507	17.99
240030	1.2812	18.44
240031	0.9279	18.07
240036	1.5882	20.33
240037	1.0148	18.46
240038	1.5017	26.35
240040	1.2710	19.90
240041	1.1727	19.21
240043	1.2209	17.31
240044	1.1345	18.92
240045	1.1610	20.99
240047*	1.5761	21.86
240048	.....	23.31

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
240049	.....	22.13
240050	1.2090	24.50
240051	0.9678	18.23
240052	1.3021	19.22
240053	1.4864	21.20
240056	1.2521	22.29
240057	1.8388	23.24
240058	0.9316	14.91
240059	1.0446	21.96
240061	1.7835	25.56
240063	1.4484	23.54
240064	1.3231	20.76
240065	1.1449	12.55
240066	1.3065	22.05
240069	1.1937	19.18
240071	1.1063	19.19
240072	1.0228	18.00
240073	0.8981	15.63
240075	1.2006	21.19
240076	1.0723	21.07
240077	0.8989	14.95
240078	1.5437	22.71
240079	0.9531	17.82
240080*	1.6136	23.73
240082	1.1218	18.03
240083	1.2912	19.29
240084	1.3307	19.61
240085	1.0393	18.02
240086	1.0475	15.33
240087	1.1670	17.06
240088	1.4004	21.02
240089	0.9225	18.42
240090	1.1253	18.05
240093	1.2993	18.68
240094	0.9638	20.57
240096	0.9927	18.34
240097	1.1145	23.62
240098	0.9306	20.60
240099	1.0713	14.38
240100	1.2877	19.19
240101	1.2098	17.75
240102	0.9288	15.56
240103	1.2084	16.88
240104	1.1678	24.02
240105	.....	14.79
240106	1.3974	23.78
240107	0.9782	19.03
240108	0.9821	16.46
240109	0.9815	13.15
240110	0.9379	17.28
240111	0.9930	17.04
240112	0.9784	15.32
240114	0.9362	15.49
240115	1.6103	22.16
240116	0.9259	15.18
240117	1.1442	17.57
240119	0.8629	22.50
240121	0.9090	21.37
240122	1.0827	18.04
240123	1.0155	15.60
240124	0.9602	19.05
240125	0.9736	13.15
240127	1.0148	14.77
240128	1.1120	16.08

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
240129	0.9953	15.42
240130	0.9313	15.65
240132	1.2720	24.50
240133	1.2168	18.52
240135	0.9183	13.60
240137	1.1747	19.18
240138	0.9423	13.74
240139	0.9616	17.02
240141	1.1570	21.99
240142	1.0110	20.61
240143	0.9629	14.28
240144	1.0633	15.87
240145	0.9100	15.00
240146*	0.9093	16.75
240148	1.0294	11.34
240150	0.8795	12.83
240152	1.0247	20.20
240153	1.0013	15.61
240154	1.0226	17.06
240155	0.9164	20.42
240157	1.0213	14.69
240160	1.0612	16.60
240161	1.0365	15.42
240162	1.0748	19.04
240163	0.9730	17.87
240166	1.1543	16.39
240169	0.9599	18.62
240170	1.1064	17.65
240171	1.0064	16.72
240172	0.9741	16.07
240173	0.9970	16.74
240179	1.0360	16.65
240184	0.9619	14.40
240187	1.2498	17.51
240193	1.0038	16.30
240196	0.6772	23.27
240200	0.9005	14.73
240205	0.9227	.....
240206	0.8330	.....
240207	1.2623	23.33
240210	1.2530	23.84
240211	0.9634	20.55
250001	1.6314	18.14
250002	0.8836	15.60
250003	0.9911	15.66
250004	1.5373	17.12
250005	0.9463	12.00
250006	0.9631	15.70
250007	1.2281	19.16
250008	1.0321	13.32
250009	1.2665	16.18
250010	1.0095	13.34
250012	0.9332	18.48
250015	1.0380	11.07
250017	1.0279	17.30
250018	0.9334	13.47
250019	1.4828	17.15
250020	0.9516	14.06
250021	0.8435	9.08
250023	0.8955	13.54
250024	0.8985	11.59
250025	1.1484	17.89
250027	0.9764	12.42
250029	0.8697	14.85

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
250030	0.9198	13.63
250031	1.2472	18.77
250032	1.2183	17.30
250033	1.0130	15.76
250034	1.5442	18.13
250035	0.8342	17.41
250036	0.9965	13.79
250037	0.8826	10.32
250038	0.9386	13.62
250039	0.9969	16.51
250040	1.3140	15.64
250042	1.2627	16.47
250043	0.9006	13.65
250044	0.9882	16.75
250045	1.2709	19.48
250047	0.9058	12.10
250048	1.5287	15.71
250049	0.8842	10.76
250050	1.2687	13.92
250051	0.9276	9.60
250057	1.1769	14.29
250058	1.1854	15.42
250059	1.0826	14.30
250060	0.7514	7.99
250061	0.8571	13.97
250063	0.8309	14.97
250065	0.8940	12.68
250066	0.9147	14.33
250067	1.1605	15.29
250068	0.8225	11.43
250069	1.2675	15.77
250071	0.9001	11.21
250072	1.4320	16.93
250077	0.9344	11.41
250078	1.5476	15.46
250079	0.8556	19.06
250081	1.2710	16.14
250082	1.4184	14.02
250083	0.9424	9.20
250084	1.0972	19.74
250085	0.9906	13.85
250088	0.9812	16.75
250089	1.0895	13.05
250093	1.1743	15.09
250094	1.3417	17.85
250095	0.9930	16.36
250096	1.2105	17.07
250097	1.2839	18.41
250098	0.9397	14.30
250099	1.2925	14.41
250100	1.2679	16.60
250101	0.8835	16.31
250102	1.5198	20.02
250104	1.4479	17.54
250105	0.9368	14.60
250107	0.8802	13.63
250109	0.8898	14.55
250112	0.9928	14.20
250117	1.0623	14.52
250119	1.0646	12.74
250120	1.0648	14.41
250122	1.1767	17.71
250123	1.2182	17.41
250124	0.9343	12.67

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
250125	1.2795	14.49
250126	0.9354	14.71
250127	0.9230	.....
250128	1.0364	13.00
250131	1.0826	10.28
250134	0.9628	17.98
250136	0.9183	18.05
250138	1.2050	17.60
250141	1.2056	17.12
250145	0.8696	11.40
250146	0.9386	13.28
250148	1.2354	14.82
250149	0.9692	12.98
250150	1.2560	.....
260001	1.6540	17.55
260002	1.4391	20.59
260003	1.1323	14.35
260004	0.9723	13.75
260005	1.6472	19.71
260006	1.5189	18.94
260008	1.0522	16.25
260009	1.2922	17.94
260011	1.5359	18.34
260012	1.0022	14.46
260013	1.1867	15.54
260015	1.1785	21.33
260017	1.1731	15.80
260018	0.8870	12.23
260019	1.1516	23.67
260020	1.8132	21.86
260021	1.4382	17.57
260022	1.2554	19.35
260023	1.4184	15.82
260024	0.9715	13.47
260025	1.3027	14.94
260027	1.6141	21.01
260029	1.1888	17.47
260030	1.1362	11.24
260031	1.5369	18.30
260032	1.7266	20.81
260034	1.0233	17.90
260035	1.0041	12.59
260036	1.0016	18.31
260039	1.0672	14.20
260040	1.6822	15.39
260042	1.2519	17.44
260044	1.0069	17.12
260047	1.6386	17.28
260048	1.2523	21.43
260050	1.0553	18.74
260052	1.3718	17.75
260053	1.1217	12.01
260054	1.3547	17.37
260055	0.9682	13.80
260057	1.0095	15.33
260059	1.2434	15.79
260061	1.1184	15.01
260062	1.1843	20.26
260063	1.0723	16.85
260064	1.3324	16.50
260065	1.7738	18.47
260066	1.0120	14.42
260067	0.8925	12.16
260068	1.6794	19.83

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
260070	1.0404	21.69
260073	1.0809	13.01
260074	1.2969	15.45
260077	1.7295	18.26
260078	1.1807	15.48
260079	1.0611	14.83
260080	0.9884	12.56
260081	1.6614	18.96
260082	1.1528	15.79
260085	1.5832	19.51
260086	0.9274	14.87
260091	1.6930	19.61
260094	1.1892	15.87
260095	1.3659	19.77
260096	1.5590	21.72
260097	1.1452	15.79
260100	1.0130	15.73
260102	1.0038	16.37
260103	1.3185	17.35
260104	1.7110	19.12
260105	1.8654	20.80
260107	1.4527	18.46
260108	1.8537	19.24
260109	0.9906	13.44
260110	1.6721	17.00
260113	1.2263	14.90
260115	1.2279	17.90
260116	1.1041	14.57
260119	1.2152	16.20
260120	1.1948	17.13
260122	1.0917	14.54
260123	1.0487	14.00
260127	1.0634	15.95
260128	1.0338	11.27
260129	.....	14.64
260131	1.2601	19.75
260134	1.1698	16.58
260137	1.7102	15.22
260138	1.9094	21.39
260141	2.0004	17.96
260142	1.1233	16.03
260143	1.0016	11.94
260147	0.9530	13.66
260148	0.9021	10.34
260158	1.0574	12.40
260159	1.0116	18.22
260160	1.1472	16.19
260162	1.5667	20.71
260163	1.2567	14.81
260164	0.9190	14.31
260166	1.2194	19.53
260172	0.9615	12.49
260173	1.0048	11.98
260175	1.1265	16.29
260176	1.7233	19.54
260177	1.3369	20.75
260178	1.4649	21.41
260179	1.6106	20.74
260180	1.6586	18.54
260183	1.6585	20.19
260186	1.5839	18.06
260188	1.2743	18.58
260189	0.9387	10.75
260190	1.1980	18.16

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
260191	1.2861	19.34
260193	1.2221	20.51
260195	1.2459	15.95
260197	1.0938	16.46
260198	1.2956	17.64
260200	1.2113	18.88
260205	1.1124	.....
260206	2.6705	.....
270002	1.2833	17.19
270003	1.2141	22.13
270004	1.6968	21.34
270006	0.8808	16.19
270007	1.0011	13.17
270009	1.0256	17.70
270011	1.0498	19.82
270012	1.6001	22.88
270013	.....	20.40
270014	1.8500	18.56
270016	0.9247	19.77
270017	1.2639	19.58
270019	1.0268	12.78
270021	1.1669	16.65
270023	1.2640	20.36
270026	0.9053	15.64
270027	1.0596	9.78
270028	1.1731	17.21
270029	0.9212	17.89
270032	1.1264	17.03
270033	0.8642	16.46
270035	1.0021	17.65
270036	0.9187	14.08
270039	1.0483	15.35
270040	1.1242	19.19
270041	1.0440	16.78
270044	1.1390	13.46
270046	.....	17.10
270048	1.0158	15.84
270049	1.7683	21.17
270050	0.9929	18.04
270051	1.3159	18.95
270052	1.0056	14.80
270057	1.3060	20.01
270058	0.9229	14.07
270059	0.7506	15.60
270060	0.9519	14.02
270063	0.9338	14.23
270073	1.0809	15.53
270074	0.8781	.....
270075	0.8274	.....
270079	0.9373	15.03
270080	1.1414	14.04
270081	0.9580	15.52
270082	1.1019	16.13
270083	1.0075	20.82
270084	0.9157	16.21
280001	1.0653	17.89
280003	2.1221	22.00
280005	1.3612	18.75
280009	1.7670	18.75
280010	0.8073	16.54
280011	0.8552	13.96
280012	.....	16.41
280013	1.7273	22.18
280014	0.9006	15.24

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
280015	1.0732	14.64
280017	1.0728	14.19
280018	1.0539	14.85
280020	1.8150	19.40
280021	1.1771	16.69
280022	0.9681	15.71
280023	1.3944	21.24
280024	0.9612	13.91
280025	0.9712	14.27
280026	1.0404	16.06
280028	1.0763	15.89
280029	1.2096	19.05
280030	1.7625	28.71
280031	0.9956	13.22
280032	1.3462	19.39
280033	1.0807	14.93
280034	.....	15.28
280035	0.9131	15.33
280037	1.0308	16.17
280038	1.0606	16.47
280039	1.0660	15.19
280040	1.7369	18.97
280041	0.9646	13.39
280042	1.0402	15.30
280043	0.9786	15.79
280045	1.0415	14.27
280046	1.0475	13.72
280047	1.1206	18.37
280048	1.1174	14.07
280049	1.0856	15.63
280050	0.8884	15.34
280051	1.1386	15.85
280052	1.0615	13.65
280054	1.2474	17.58
280055	0.9142	12.99
280056	0.9322	14.02
280057	0.9649	15.76
280058	1.2501	17.88
280060	1.6246	28.60
280061	1.4157	17.95
280062	1.1769	13.67
280064	1.0166	15.51
280065	1.2679	18.53
280066	1.0165	11.64
280068	0.9402	10.13
280070	0.9894	13.74
280073	0.9850	17.06
280074	0.9716	15.22
280075	1.1012	13.79
280076	1.0276	13.92
280077	1.2963	19.01
280079	1.0819	9.91
280080	1.0562	14.35
280081	1.7212	20.92
280082	1.0739	13.13
280083	1.0628	17.55
280084	0.9626	11.69
280085	0.8210	21.58
280088	1.2613	22.11
280089	0.8817	17.47
280090	0.8499	14.72
280091	1.0928	15.22
280092	0.9078	14.20
280094	0.9941	15.88

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
280097	1.0876	14.30
280098	0.8785	10.17
280101	1.0046	17.42
280102	.....	12.94
280104	0.9207	13.38
280105	1.2342	18.78
280106	1.0160	15.54
280107	1.1351	13.46
280108	1.0616	17.22
280109	0.9496	11.06
280110	0.9845	12.30
280111	1.2649	23.08
280114	0.9211	13.56
280115	0.9774	16.43
280117	1.0941	16.82
280118	0.9071	16.92
280119	0.9530	.....
280123	.....	20.77
280125	1.2264	.....
290001	1.6989	22.42
290002	0.9461	20.94
290003	1.6712	25.01
290005	1.3324	17.86
290006	1.2261	19.88
290007	1.6901	29.69
290008	1.2555	20.25
290009	1.6203	22.74
290010	1.1253	14.48
290011	1.0959	16.44
290012	1.3503	21.51
290013	0.9996	17.09
290014	1.0332	18.38
290015	0.9724	17.83
290016	1.1412	12.79
290019	1.3301	20.93
290020	0.9828	26.15
290021	1.6748	21.13
290022	1.5940	24.08
290027	0.8902	16.43
290029	0.9227	.....
290032	1.4060	22.79
290036	0.5760	18.61
290038	0.9361	23.14
290039	1.3330	25.80
290041	1.2649	.....
290043	1.5247	.....
300001	1.4811	21.42
300003	1.9992	23.38
300005	1.3421	19.99
300006	1.1762	18.93
300007	1.0898	19.34
300008	1.2459	16.46
300009	1.0636	20.01
300010	1.2614	19.38
300011	1.3223	21.24
300012	1.3247	23.89
300013	1.1162	18.97
300014	1.2417	19.80
300015	1.1328	19.93
300016	1.2146	18.50
300017	1.3266	22.34
300018	1.3652	20.89
300019	1.2381	20.61
300020	1.3828	21.97

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
300021	1.0721	17.35
300022	1.1269	17.19
300023	1.3992	20.39
300024	1.2667	17.95
300028	1.2841	18.05
300029	1.3193	20.90
300033	1.0937	19.85
300034	2.1599	23.52
310001	1.7867	27.60
310002	1.8508	27.87
310003	1.2979	27.42
310005	1.2978	23.05
310006	1.2138	21.56
310008	1.3295	24.95
310009	1.3238	23.19
310010	1.2493	21.11
310011	1.2567	23.40
310012	1.6481	26.32
310013	1.3716	22.11
310014	1.6717	28.70
310015	2.0397	26.76
310016	1.2889	26.05
310017	1.3516	26.07
310018	1.0776	24.53
310019	1.6759	23.09
310020	1.3978	19.27
310021	1.5405	22.65
310022	1.3233	20.73
310024	1.3299	22.78
310025	1.1918	22.81
310026	1.2343	23.87
310027	1.3202	21.77
310028	1.2507	23.52
310029	1.9457	23.38
310031	2.7809	25.18
310032	1.3227	23.30
310034	1.2856	21.69
310036	1.1393	19.82
310037	1.4029	27.44
310038	2.0126	25.38
310039	1.2557	22.03
310040	1.2028	23.99
310041	1.3458	23.78
310042	1.2925	24.33
310043	1.1863	22.09
310044	1.3355	20.43
310045	1.4863	28.16
310047	1.3368	24.52
310048	1.2892	23.33
310049	1.2327	24.76
310050	1.2135	22.59
310051	1.3946	25.28
310052	1.3043	22.58
310054	1.3470	24.74
310057	1.3024	20.45
310058	1.1475	26.22
310060	1.1966	19.11
310061	1.2040	20.80
310062	.....	19.27
310063*	1.3463	21.85
310064	1.3574	24.21
310067	1.3006	22.27
310069	1.2634	24.17
310070	1.4210	25.04

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
310072	1.3713	22.22
310073	1.6775	25.63
310074	1.3809	24.46
310075	1.4097	26.46
310076	1.4991	28.90
310077	1.6678	25.06
310078	1.4298	23.48
310081	1.3501	23.89
310083	1.2768	23.68
310084	1.3292	24.09
310086	1.2175	21.44
310087	1.3344	20.89
310088	1.2069	22.34
310090	1.3904	24.24
310091	1.2672	22.01
310092	1.3248	22.34
310093	1.2003	21.23
310096	1.9959	26.30
310105	1.2465	24.49
310108	1.4314	22.88
310110	1.2678	20.14
310111	1.2705	21.72
310112	1.3062	22.52
310113	1.2906	22.95
310115	1.3002	20.07
310116	1.2884	25.24
310118	1.2517	24.54
310119	1.7352	29.48
310120	1.2046	21.69
310121	.....	18.74
320001	1.5262	17.85
320002	1.3456	22.46
320003	1.0767	15.35
320004	1.2930	17.24
320005	1.3126	19.87
320006	1.3526	18.65
320009	1.5990	17.64
320011	1.1443	16.55
320012	1.0529	16.00
320013	1.1406	23.84
320014	1.0812	15.97
320016	1.1821	18.93
320017	1.1290	18.15
320018	1.5139	18.19
320019	1.5059	19.26
320021	1.8101	17.16
320022	1.2310	15.84
320023	1.0211	16.42
320030	1.1556	16.53
320031	0.9386	13.99
320032	0.8993	18.75
320033	1.1749	20.31
320035	1.0245	25.74
320037	1.1621	17.08
320038	1.2322	16.29
320046	1.4424	19.00
320048	1.4140	19.17
320056	1.1122	.....
320057	0.9720	.....
320058	0.8862	.....
320059	1.0597	.....
320060	0.9253	.....
320061	1.1311	.....
320062	0.8525	.....

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
320063	1.2513	19.83
320065	1.2154	16.10
320067	0.8614	57.48
320068	0.8969	18.18
320069	0.9807	11.31
320070	0.9556	.....
320074	1.0870	18.65
320079	1.2126	17.07
330001	1.1862	25.21
330002	1.4469	26.39
330003	1.3432	18.05
330004	1.3046	19.96
330005	1.6831	24.28
330006	1.3374	25.92
330007	1.3674	18.80
330008	1.1788	18.07
330009	1.3298	30.42
330010	1.2856	14.74
330011	1.3008	18.04
330012	1.7199	31.51
330013	2.0374	19.99
330014	1.3839	27.57
330016	0.9911	17.41
330019	1.3601	32.45
330020	1.0286	14.55
330023	1.3009	24.27
330024	1.8309	33.62
330025	1.1220	16.03
330027	1.4693	32.50
330028	1.4098	27.08
330029	1.1581	16.56
330030	1.4112	15.06
330033	1.3199	16.75
330034	0.5292	30.78
330036	1.2759	24.32
330037	1.2233	16.00
330038	1.1832	16.01
330039	.....	12.47
330041	1.2880	30.42
330043	1.3066	27.63
330044	1.2646	18.70
330045	1.3781	27.17
330046	1.4593	31.98
330047	1.1968	17.69
330048	1.2630	17.62
330049	1.2706	19.31
330053	1.2225	15.67
330055	1.5732	30.73
330056	1.4694	30.22
330057	1.6858	18.69
330058	1.3130	16.98
330059	1.6062	32.23
330061	1.2760	25.07
330062	1.0970	15.28
330064	1.4280	32.87
330065	1.2350	18.37
330066	1.2659	19.94
330067	1.3299	21.29
330072	1.4098	29.31
330073	1.1707	15.88
330074	1.2820	18.16
330075	1.0916	17.43
330078	1.4535	17.49
330079	1.2806	16.76

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
330080	1.2173	26.88
330084	1.0649	23.03
330085	1.2898	18.78
330086	1.2276	30.69
330088	1.0486	25.62
330090	1.5583	18.68
330091	1.3777	18.53
330092	1.0002	12.65
330094	1.2368	17.72
330095	1.3283	18.55
330096	1.1192	16.60
330097	1.2475	16.96
330100	0.9953	28.11
330101	1.7932	31.31
330102	1.3020	17.52
330103	1.2013	16.52
330104	1.4136	28.77
330106	1.7013	35.87
330107	1.2670	28.08
330108	1.2378	17.08
330111	1.0739	15.20
330114	0.9034	18.24
330115	1.1307	16.56
330116	0.8479	24.23
330118	1.6335	20.76
330119	1.7050	34.75
330121	1.0145	15.85
330122	1.0108	21.20
330125	1.8904	19.75
330126	1.1356	22.70
330127	1.3751	29.33
330128	1.3130	27.87
330132	1.2002	14.70
330133	1.3616	32.38
330135	1.1987	18.33
330136	1.3304	17.60
330140	1.8211	19.50
330141	1.3368	25.14
330144	0.9874	15.51
330148	1.0682	15.04
330151	1.0931	13.97
330152	1.4635	29.48
330153	1.7143	17.50
330154	1.7631	.....
330157	1.3782	20.82
330158	1.4535	26.05
330159	1.2598	18.02
330160	1.4258	30.57
330162	1.2112	27.72
330163	1.2668	20.46
330164	1.3673	19.48
330166	1.0666	14.18
330167	1.7231	31.18
330169	1.4422	33.45
330171	1.3081	25.43
330175	1.1866	16.69
330177	0.9536	14.54
330179	0.8480	12.69
330180	1.2149	15.53
330181	1.3246	32.47
330182	2.5278	30.93
330183	1.4710	20.00
330184	1.3687	27.49
330185	1.2683	26.95

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
330188	1.2749	18.72
330189	1.1706	17.66
330191	1.3142	18.86
330193	1.3094	29.80
330194	1.8144	35.57
330195	1.6168	31.39
330196	1.2584	28.45
330197	1.1217	17.00
330198	1.3910	23.81
330199	1.3867	27.66
330201	1.6595	30.33
330202	1.3321	30.79
330203*	1.3921	19.24
330204	1.3626	29.37
330205	1.2157	19.46
330208	1.2524	25.82
330209	1.2116	24.88
330211	1.1008	19.10
330212	1.1242	21.18
330213	1.1317	18.51
330214	1.8270	32.20
330215	1.2136	17.58
330218	1.0783	21.71
330219	1.6448	22.15
330221	1.2958	32.21
330222	1.2727	17.81
330223	1.0436	17.28
330224	1.2609	21.97
330225	1.1997	25.80
330226	1.2800	17.67
330229	1.3032	16.25
330230	1.3323	28.86
330231	1.0181	29.09
330232	1.2621	19.50
330233	1.4710	33.30
330234	2.3453	33.33
330235	1.1654	19.45
330236	1.3908	30.70
330238	1.2201	14.80
330239	1.2099	17.28
330240	1.3684	30.48
330241	2.0212	22.60
330242	1.2840	24.74
330245	1.4695	17.28
330246	1.3231	26.66
330247	0.8484	27.62
330249	1.1958	16.48
330250	1.2389	19.56
330252	.....	17.04
330254	1.1711	16.73
330258	1.2652	30.47
330259	1.4799	25.25
330261	1.3017	26.17
330263	1.0017	19.64
330264	1.1961	23.14
330265	1.3299	15.62
330267	1.3394	23.56
330268	0.9564	14.62
330270	2.0232	28.24
330273	1.2930	25.89
330275	1.3094	17.42
330276	1.1580	17.75
330277	1.1064	17.16
330279	1.2946	19.91

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
330285	1.8724	22.47
330286	1.3300	25.09
330290	1.7078	32.58
330293	1.1263	15.38
330304	1.2300	29.37
330306	1.3461	27.62
330307	1.3055	20.74
330308	.....	36.84
330314	1.3296	24.74
330316	1.2613	28.79
330327	0.8785	16.97
330331	1.3605	31.04
330332	1.2161	27.16
330333	1.2122	.....
330336	1.3033	30.17
330338	1.2486	23.01
330339	0.9024	19.67
330340	1.1804	26.92
330350	1.7352	30.38
330353	1.2745	33.55
330354	1.5861	.....
330357	1.3424	34.75
330359	.....	29.29
330372	1.2139	22.50
330381	1.2974	29.24
330385	1.1317	28.84
330386	1.1738	24.67
330387	0.7617	.....
330389	1.7654	32.42
330390	1.3622	29.79
330393	1.7228	27.99
330394	1.5602	18.77
330395	1.3551	37.68
330396	1.1225	30.72
330397	1.3731	31.00
330398	1.3883	30.32
330399	1.2650	35.52
330400	0.8755	.....
340001	1.4550	19.01
340002	1.8335	18.78
340003	1.1380	21.97
340004	1.5053	17.89
340005	1.1327	14.09
340006	1.0448	17.81
340007	1.1625	17.17
340008	1.1063	18.38
340009	.....	20.50
340010	1.3066	17.65
340011	1.1010	14.92
340012	1.1766	16.66
340013	1.2440	17.43
340014	1.5360	19.92
340015	1.2395	19.01
340016	1.1721	16.40
340017	1.2566	19.22
340018	1.1435	15.16
340019	0.9975	13.59
340020	1.2389	16.75
340021	1.2577	19.67
340022	1.1225	16.72
340023	1.3395	17.21
340024	1.1417	16.64
340025	1.2484	16.82
340027	1.2085	17.30

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
340028	1.5314	17.72
340030	2.0552	20.05
340031	0.9565	12.39
340032	1.3524	20.47
340035	1.0956	18.10
340036	1.1292	16.97
340037	1.0029	15.53
340038	1.1014	17.01
340039	1.2603	20.15
340040	1.7863	20.12
340041	1.2563	17.76
340042	1.1906	16.63
340044	1.1019	16.37
340045	1.0204	12.42
340047	1.8911	19.60
340048	0.6134	.....
340049	0.7590	16.50
340050	1.1658	18.56
340051	1.2890	18.60
340052	0.9879	21.37
340053	1.6306	19.49
340054	1.1743	14.47
340055	1.2601	18.18
340060	1.0858	17.92
340061	1.7102	20.85
340063	1.0122	16.92
340064	1.1554	17.26
340065	1.3341	18.32
340067	1.0091	18.61
340068	1.2353	16.70
340069	1.8140	19.99
340070	1.2558	18.63
340071	1.1412	16.37
340072	1.1342	15.60
340073	1.3877	20.69
340075	1.2374	18.21
340080	0.9827	16.85
340084	1.1280	21.78
340085	1.1684	16.24
340087	1.1121	16.70
340088	1.2483	19.83
340089	0.9798	13.86
340090	1.1715	17.85
340091	1.6767	19.40
340093	1.0384	15.16
340094	1.3871	15.96
340096	1.1735	17.98
340097	1.1300	21.37
340098	1.5807	20.17
340099	1.1289	15.09
340101	1.0689	15.36
340104	0.8681	15.87
340105	1.3487	18.90
340106	1.1391	18.08
340107	1.2312	16.95
340109	1.3520	17.96
340111	1.1185	14.92
340112	0.9997	14.60
340113	1.8588	20.88
340114	1.6123	20.82
340115	1.5468	18.67
340116	1.8562	19.48
340119	1.2136	16.85
340120	1.1373	14.38

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
340121	1.0483	15.97
340123	1.1257	16.22
340124	1.1103	14.05
340125	1.4571	19.63
340126	1.3214	17.72
340127	1.3040	17.38
340129	1.2333	19.73
340130	1.3605	19.44
340131	1.5410	18.94
340132	1.2906	16.94
340133	1.0718	14.35
340137	1.2697	.....
340138	1.0653	19.28
340141	1.7096	22.22
340142	1.1906	16.09
340143	1.4510	20.95
340144	1.2510	19.19
340145	1.3190	19.20
340146	1.0415	13.01
340147	1.2389	19.11
340148	1.3628	18.42
340151	1.2111	16.57
340153	1.8460	20.66
340155	1.3964	20.42
340156	0.7271	.....
340158	1.0716	17.26
340159	1.1780	16.80
340160	1.1654	15.53
340162	.....	16.64
340164	1.3637	19.68
340166	1.3042	19.17
340168	0.4833	14.75
340171	1.1348	20.05
340173	1.2020	20.21
350001	0.9646	11.73
350002	1.8448	17.28
350003	1.2042	17.43
350004	1.9290	17.90
350005	1.0889	16.03
350006	1.3866	16.62
350007	0.9036	13.28
350008	0.9709	21.70
350009	1.1851	18.28
350010	1.1308	15.28
350011	1.9286	18.49
350012	1.0793	12.73
350013	1.0590	16.68
350014	1.0326	15.79
350015	1.7240	15.87
350016	.....	11.63
350017	1.3378	17.78
350018	1.0325	13.64
350019	1.7209	19.40
350021	0.9859	12.69
350023	0.9505	12.80
350024	1.0053	14.37
350025	0.9820	16.24
350027	1.0099	17.12
350029	0.8409	12.80
350030	1.0653	17.35
350033	0.9296	14.90
350034	0.9296	18.32
350035	0.8734	10.16
350038	1.0783	18.74

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
350039	1.0442	17.31
350041	0.9447	14.68
350042	1.0586	16.75
350043	1.6076	17.16
350044	0.9014	10.53
350047	1.1414	17.93
350049	1.2037	14.53
350050	0.9242	10.57
350051	0.9872	17.53
350053	1.0048	13.94
350055	0.9884	12.37
350056	0.9227	14.74
350058	0.9550	14.35
350060	0.8626	9.60
350061	1.0451	14.59
350063	0.8913	.....
350064	0.8650	.....
350068	2.4777	.....
350069	1.2467	.....
360001	1.3010	17.39
360002	1.1805	17.40
360003	1.7521	22.03
360006	1.9102	22.09
360007	1.0878	17.10
360008	1.2553	17.82
360009	1.5416	17.53
360010	1.2807	18.09
360011	1.2954	18.95
360012	1.2982	19.22
360013	1.1484	20.81
360014	1.1318	19.88
360016	1.6655	18.77
360017	1.9312	22.50
360018	1.6955	21.34
360019	1.2255	20.17
360020	1.4599	22.95
360024	1.3135	18.54
360025	1.3536	19.29
360026	1.3128	17.04
360027	1.4745	20.36
360028	1.4934	17.27
360029	1.1928	18.22
360030	1.3464	15.35
360031	1.1973	19.90
360032	1.1566	17.93
360034	1.3261	15.56
360035*	1.6492	20.33
360036	1.3101	19.18
360037	2.1402	22.52
360038	1.6231	19.89
360039	1.2936	17.40
360040	1.2903	18.12
360041	1.2883	18.42
360042	1.1662	16.12
360044	1.1577	16.79
360045	1.4251	21.18
360046	1.1457	19.32
360047	1.1301	15.34
360048	1.8831	21.17
360049	1.2259	18.81
360050	1.2304	12.89
360051	1.6202	20.95
360052	1.6991	20.02
360054	1.2488	16.19

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
360055	1.3169	23.27
360056	1.3944	18.76
360057	1.0590	13.81
360058	1.1920	17.92
360059	1.6176	21.97
360062	1.4095	20.31
360063	1.1426	22.79
360064	1.6125	20.64
360065	1.2530	19.45
360066	1.6379	20.03
360067	1.1487	14.57
360068	1.7961	21.22
360069	1.1401	17.83
360070	1.7813	17.53
360071	1.4168	23.80
360072	1.2698	17.97
360074	1.2995	18.26
360075	1.3458	18.47
360076	1.3578	19.59
360077	1.6203	20.82
360078	1.2481	20.79
360079	1.8424	22.00
360080	1.1428	16.64
360081	1.3443	19.64
360082	1.2775	22.86
360083	.....	18.46
360084	1.6064	20.09
360085	1.8845	21.67
360086	1.4307	17.04
360087	1.4307	20.04
360088	1.3186	22.31
360089	1.1340	20.56
360090	1.2673	20.40
360091	1.3221	21.03
360092	1.1368	15.91
360093	1.1664	18.57
360094	1.3406	18.31
360095	1.2602	18.71
360096	1.0740	17.16
360098	1.4616	18.34
360099	1.0145	18.55
360100	1.2435	17.66
360101	1.3302	22.31
360102	1.2047	19.77
360103	.....	22.62
360104	1.1889	.....
360106	1.2012	16.18
360107	1.2436	18.62
360108	1.0496	16.51
360109	1.0898	19.52
360112	1.9109	22.57
360113	1.3312	22.46
360114	1.0862	16.33
360115	1.3561	18.19
360116	1.1098	18.08
360118	1.3482	18.61
360121	1.2089	21.10
360123	1.2389	19.13
360125	1.1466	18.17
360126	1.2114	20.46
360127	1.1478	16.92
360128	1.1562	15.58
360129	0.9412	15.52
360130	1.0130	15.34

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
360131	1.3306	18.29
360132	1.4151	18.27
360133	1.6452	19.03
360134	1.7555	20.24
360136	1.0165	17.85
360137	1.7409	20.26
360140	0.9460	19.13
360141	1.6436	22.85
360142	1.0518	17.32
360143	1.3319	20.44
360144	1.2938	21.92
360145	1.6950	19.39
360147	1.2418	16.59
360148	1.1492	18.89
360149	1.2611	18.79
360150	1.3013	20.63
360151	1.3912	17.49
360152	1.5355	22.00
360153	1.1316	14.89
360154	1.0439	13.78
360155	1.3700	20.90
360156	1.2856	17.92
360159	1.1775	20.71
360161	1.3543	19.41
360162	1.0718	18.61
360163	1.8529	20.38
360164	.....	16.16
360165	1.1711	19.48
360166	.....	16.98
360170	1.4463	17.18
360172	1.3447	18.47
360174	1.2444	19.09
360175	1.1884	20.41
360176	1.1409	15.47
360177	1.3262	19.41
360178	1.3137	17.40
360179	1.4139	19.14
360180	2.1661	22.09
360184	0.5560	19.35
360185	1.2339	18.67
360186	1.0606	20.86
360187	1.4030	18.02
360188	0.9307	17.53
360189	1.1003	17.37
360192	1.3355	21.00
360193	.....	17.69
360194	1.1609	17.69
360195	1.1446	19.02
360197	1.1573	19.42
360200	0.9129	17.76
360203	1.1658	15.62
360204	1.2012	19.35
360210	1.1911	20.28
360211	1.2583	19.58
360212	1.3505	20.23
360213	1.2574	18.33
360218	1.3249	18.41
360230	1.5283	21.44
360231	1.1689	13.56
360234	1.3667	22.43
360236	1.2668	19.49
360239	1.2640	19.86
360241	0.4070	22.08
360242	1.8361	.....

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
360243	0.6859	13.58
360244	.....	10.55
360245	0.7433	15.06
360247	0.4015	18.11
360248	.....	21.65
370001	1.7346	21.27
370002	1.2288	14.08
370004	1.1872	16.77
370005	0.9385	17.38
370006	1.1884	12.95
370007	1.1457	17.15
370008	1.3742	17.30
370011	1.0371	14.64
370012	0.8381	10.80
370013	1.8493	18.04
370014	1.1887	19.65
370015	1.1904	17.82
370016	1.3340	16.64
370017	1.1216	12.98
370018	1.3475	14.24
370019	1.3147	16.88
370020	1.2736	13.48
370021	0.8600	11.26
370022	1.3152	17.90
370023	1.2592	16.82
370025	1.3103	16.40
370026	1.4917	16.90
370028	1.8963	19.71
370029	1.1600	13.89
370030	1.1994	15.47
370032	1.6025	16.64
370033	1.0433	12.39
370034	1.2299	14.51
370035	1.7120	18.96
370036	1.0585	11.46
370037	1.7309	17.75
370038	0.9615	12.81
370039	1.1544	16.27
370040	1.0110	14.26
370041	0.9415	17.41
370042	0.8612	14.61
370043	0.9299	16.08
370045	1.0224	12.44
370046	0.9794	18.15
370047	1.4234	15.67
370048	1.2065	17.44
370049	1.3139	19.84
370051	0.9449	12.18
370054	1.3637	16.56
370056	1.5690	18.88
370057	1.0262	14.66
370059	1.1239	16.46
370060	1.0608	15.12
370063	1.1026	17.06
370064	0.9372	8.75
370065	0.9995	16.56
370071	1.0270	14.95
370072	0.8663	14.65
370076	1.2551	12.86
370077	.....	17.62
370078	1.6865	17.24
370079	0.9319	13.60
370080	0.9519	14.34
370082	0.8529	13.54

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
370083	0.9651	11.49
370084	1.0188	21.75
370085	0.8885	11.88
370086	1.1192	13.56
370089	1.2148	14.50
370091	1.6636	17.58
370092	0.9955	14.68
370093	1.7971	18.57
370094	1.4454	18.38
370095	0.9872	14.13
370097	1.3459	23.31
370099	1.1217	16.26
370100	0.9773	17.10
370103	0.9111	15.90
370105	1.9566	17.68
370106	1.5308	18.62
370108	0.9670	12.24
370112	1.0270	15.25
370113	1.2331	16.20
370114	1.6454	15.98
370121	1.0409	19.55
370122	1.0456	12.15
370123	1.4493	16.36
370125	0.8954	13.55
370126	0.9646	18.24
370131	0.9766	16.24
370133	1.0621	10.02
370138	1.0502	15.94
370139	1.0969	13.30
370140	1.0458	15.23
370141	1.3710	12.14
370146	1.0935	12.56
370148	1.4517	16.41
370149	1.3477	16.72
370153	1.1156	15.32
370154	1.0477	15.91
370156	1.1036	13.64
370158	1.0207	15.09
370159	1.2557	17.83
370163	0.9854	14.56
370165	1.2557	13.22
370166	1.0448	17.82
370169	1.0466	9.48
370170	1.0201	.....
370171	1.0333	.....
370172	0.8953	.....
370173	1.0677	.....
370174	0.7213	.....
370176	1.2191	16.03
370177	0.9826	11.88
370178	0.9826	11.64
370179	0.9491	19.27
370180	0.9918	.....
370183	1.0386	7.62
370186	0.9783	13.35
370190	1.4695	13.70
370192	1.4803	16.74
370196	0.8822	.....
370197	.....	21.57
370198	1.4366	.....
370199	1.0710	.....
370200	1.1757	.....
380001	1.3054	22.03
380002	1.2171	19.48

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
380003	1.1769	24.74
380004	1.7367	23.14
380005	1.1722	23.24
380006	1.2239	20.54
380007	1.6506	24.29
380008	1.0693	21.19
380009	1.7994	25.17
380010	1.0403	19.75
380011	1.1050	21.14
380013	1.1851	20.10
380014	1.6519	23.48
380017	1.9289	23.82
380018	1.8307	22.08
380019	1.2451	20.77
380020	1.4521	21.35
380021	1.2078	20.64
380022	1.1103	21.61
380023	1.1371	19.24
380025	1.2975	24.67
380026	1.1401	19.27
380027	1.2810	20.16
380029	1.1435	18.57
380031	0.9408	22.83
380033	1.7943	23.29
380035	1.3526	21.65
380036	1.0855	19.33
380037	1.2290	21.23
380038	1.2487	25.58
380039	1.2583	22.12
380040	1.2936	21.64
380042	1.0177	19.81
380047	1.6722	21.95
380048	1.0388	18.38
380050	1.4293	18.25
380051	1.6373	21.24
380052	1.2518	17.87
380055	.....	21.25
380056	1.1058	17.16
380060	1.4643	23.29
380061	1.5204	22.60
380062	1.2219	18.52
380063	.....	19.36
380064	1.3264	19.87
380065	1.3064	22.17
380066	1.3262	20.42
380068	.....	22.76
380069	1.0690	19.58
380070	1.3461	24.71
380071	1.2354	20.47
380072	0.9961	16.32
380075	1.4230	22.17
380078	1.1344	19.10
380081	1.0229	20.59
380082	1.2605	22.58
380083	1.1703	21.81
380084	1.2427	23.64
380087	1.2284	14.10
380088	1.0722	19.52
380089	1.2782	23.74
380090	1.2985	27.09
380091	1.2615	22.83
390001	1.5197	18.64
390002	1.3161	18.08
390003	1.2413	17.24

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
390004	1.3985	18.89
390005	1.0952	16.44
390006	1.8485	19.60
390007	1.2517	21.41
390008	1.1995	16.74
390009	1.7387	20.12
390010	1.2493	17.23
390011	1.2786	18.07
390012	1.2224	20.02
390013	1.2401	19.33
390015	1.1327	12.94
390016	1.2481	17.07
390017	1.1841	16.22
390018	1.2421	19.12
390019	1.0759	16.40
390022	1.3526	22.90
390023	1.2272	19.56
390024	1.1811	25.03
390025	0.4279	15.71
390026	1.2761	22.76
390027	1.8053	27.69
390028	1.8916	20.11
390029	2.0498	19.69
390030	1.2190	18.40
390031	1.2148	19.52
390032	1.2612	18.15
390035	1.2648	18.51
390036	1.5398	18.87
390037	1.3709	22.24
390039	1.1436	16.54
390040	0.9484	15.12
390041	1.2688	19.58
390042	1.5854	21.13
390043	1.1832	16.36
390044	1.6421	19.54
390045	1.7159	18.46
390046	1.6104	20.46
390047*	1.7392	24.58
390048	1.1549	18.38
390049	1.6110	21.13
390050	2.1144	20.92
390051	2.1338	26.05
390052	1.1515	17.10
390054	1.2341	17.44
390055	1.8882	25.90
390056	1.1205	17.17
390057	1.3152	19.75
390058	1.2858	19.25
390060	1.2088	13.63
390061	1.4942	20.48
390062	1.2444	16.45
390063	1.8378	19.64
390065	1.2322	20.00
390066	1.2608	18.71
390067	1.8018	20.65
390068	1.3033	17.55
390069	1.2663	19.28
390070	1.4159	20.19
390071	1.1073	16.23
390072	1.0501	15.56
390073	1.6671	20.69
390074	1.2469	16.60
390075	1.3924	17.27
390076	1.2799	21.43

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
390078	1.1498	18.23
390079	1.7562	18.20
390080	1.2916	19.52
390081	1.2972	23.99
390083	1.2031	20.59
390084	1.2677	16.35
390086	1.1360	17.25
390088	1.3689	23.49
390090	1.8001	20.65
390091	1.1280	18.37
390093	1.1551	16.63
390095	1.2033	13.05
390096	1.4914	19.31
390097	1.2750	21.41
390100	1.6552	20.30
390101	1.2029	17.05
390102	1.3959	19.49
390103	1.0911	17.71
390104	1.0664	15.96
390106	1.1156	16.28
390107	1.3308	19.18
390108	1.4026	21.29
390109	1.2009	14.66
390110	1.5954	21.32
390111	1.9491	28.79
390112	1.2904	14.04
390113	1.2508	17.94
390114	1.2348	22.97
390115	1.3965	24.72
390116	1.3025	20.60
390117	1.1716	16.90
390118	1.2155	16.90
390119*	1.3896	18.59
390121	1.3960	18.64
390122	1.0609	17.46
390123	1.2758	20.84
390125	1.2088	15.94
390126	1.2888	20.94
390127	1.2287	21.88
390128	1.2209	19.41
390130	1.1335	17.33
390131	1.3299	16.83
390132	1.2842	20.55
390133	1.7977	24.61
390135	1.2393	21.25
390136	1.1430	17.61
390137	1.5156	16.56
390138	1.3213	18.86
390139	1.5077	22.94
390142	1.6076	26.80
390145	1.3889	20.34
390146	1.2155	17.70
390147	1.2656	21.11
390150	1.1805	19.66
390151	1.2299	20.51
390152	1.1121	19.15
390153	1.2219	23.12
390154	1.2679	15.85
390156	1.4108	21.16
390157	1.3940	19.83
390158	.....	21.60
390160	1.2390	20.77
390161	1.1929	12.37
390162	1.5211	21.02

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
390163	1.2276	15.62
390164	2.1736	21.59
390166	1.1138	19.96
390167	.....	22.91
390168	1.2592	18.99
390169	1.3390	18.99
390170	1.8476	22.99
390173	1.2211	17.86
390174	1.6855	25.24
390176	1.1814	17.36
390178	1.3114	17.70
390179	1.3111	21.41
390180	1.4575	25.12
390181	1.0728	17.09
390183	1.1617	19.08
390184	1.1308	20.75
390185	1.2169	17.65
390189	1.1404	18.67
390191	1.1721	16.20
390192	1.1726	16.37
390193	1.1915	16.47
390194	1.1396	20.15
390195	1.8300	23.69
390196	1.5787	.....
390197	1.2829	18.99
390198	1.2778	15.45
390199	1.2683	16.66
390200	0.9687	13.59
390201	1.2641	20.50
390203	1.3610	21.19
390204	1.2735	20.85
390206	1.3965	18.57
390209	1.0811	16.96
390211	1.2188	17.91
390213	1.1371	17.44
390215	1.2554	21.43
390217	1.2220	19.29
390219	1.3081	21.63
390220	1.1645	18.52
390222	1.3169	20.91
390223	1.7259	22.65
390224	0.8838	15.91
390225	1.1965	18.17
390226	1.6019	23.16
390228	1.2988	19.81
390231	1.5687	24.49
390233	1.3518	18.77
390235	1.4228	24.60
390236	1.2240	17.03
390237	1.5705	21.75
390238	1.2725	.....
390242	.....	18.09
390244	0.9246	14.41
390245	1.3207	20.15
390246	1.1923	17.92
390247	1.0508	20.67
390249	0.9293	10.73
390256	1.8873	23.78
390258	1.4564	21.36
390260	1.0990	21.19
390262	1.9277	18.67
390263	1.4217	20.09
390265	1.2937	19.51
390266	1.2120	16.24

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
390267	1.2587	20.51
390268	1.3361	21.02
390270	1.3866	17.83
390272	0.4775	.....
390277	0.4015	27.10
390278	0.6656	19.20
390279	1.0539	13.70
390283	1.2887	.....
390284	1.2825	.....
400001	1.2244	9.86
400002	1.6964	9.31
400003	1.3598	9.99
400004	1.1415	8.48
400005	1.1222	7.85
400006	1.1587	10.53
400007	1.1989	7.86
400009	1.0514	8.37
400010	0.8930	11.66
400011	1.0733	5.68
400012	1.3553	7.81
400013	1.2614	8.21
400014	1.3933	9.54
400015	1.3572	10.33
400016	1.3661	12.07
400017	1.1566	8.57
400018	1.2826	9.45
400019	1.6564	10.15
400021	1.4420	9.91
400022	1.3356	11.12
400024	0.9529	7.56
400026	0.9627	7.12
400027	1.1026	8.49
400028	1.2378	8.40
400031	1.2515	9.78
400032	1.2192	9.73
400044	1.2602	11.75
400048	1.0437	8.92
400061	1.7071	12.28
400079	1.2218	7.08
400087	1.4146	10.40
400094	0.9953	7.82
400098	1.3997	7.21
400102	1.1587	7.73
400103	1.3967	10.73
400104	1.2587	9.94
400105	1.2156	10.17
400106	1.2572	8.51
400109	1.4778	10.18
400110	1.1266	10.53
400111	1.1973	9.56
400112	1.0576	12.85
400113	1.1558	9.48
400114	1.0813	6.41
400115	1.0388	9.13
400117	1.1552	10.04
400118	1.2390	8.70
400120	1.2553	9.74
400121	0.9964	7.11
400122	1.0235	8.48
400123	1.2032	9.02
400124	2.8388	11.48
400125	1.0258	.....
410001	1.3403	22.53
410004	1.2575	22.32

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
410005	1.3736	21.24
410006	1.3072	21.98
410007	1.6369	20.95
410008	1.2134	22.61
410009	1.2947	24.08
410010	1.1607	27.14
410011	1.2718	24.37
410012	1.9093	21.33
410013	1.2981	25.01
420002	1.5001	20.20
420004	1.8174	19.41
420005	1.1360	15.99
420006	1.2057	18.24
420007	1.5723	17.58
420009	1.1691	17.25
420010	1.1771	17.91
420011	1.2447	14.99
420014	1.0205	16.72
420015	1.3354	17.18
420016	0.9537	18.15
420018	1.8084	19.73
420019	1.2188	15.55
420020	1.1847	17.90
420023	1.4285	20.97
420026	1.8906	21.90
420027	1.3311	18.08
420029	.....	18.35
420030	1.2089	17.82
420031	0.8604	13.07
420033	1.1644	21.09
420036	1.2900	19.74
420037	1.1933	21.96
420038	1.3150	16.15
420039	1.0732	16.96
420042	.....	14.66
420043	1.1871	18.36
420048	1.2367	18.03
420049	1.1990	19.23
420051	1.6460	18.25
420053	1.1431	16.55
420054	1.2387	16.55
420055	1.0582	16.18
420056	1.1140	15.60
420057	1.1152	14.50
420059	0.9721	19.13
420061	1.1775	16.13
420062	1.1898	18.95
420064	1.1047	15.45
420065	1.3888	19.06
420066	0.9829	15.50
420067	1.2167	18.31
420068	1.3841	17.21
420069	1.0603	16.32
420070	1.2337	17.45
420071	1.3506	18.29
420072	0.9129	12.60
420073	1.2811	19.20
420074	1.0309	13.80
420075	0.9395	16.29
420078	1.8574	20.68
420079	1.5169	18.77
420080	1.3719	24.83
420081	.....	20.42
420082	1.5862	18.88

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
420083	1.3552	23.34
420085	1.4126	18.55
420086	1.4345	19.31
420087	1.5936	18.40
420088	1.0874	17.91
420089	1.2957	21.66
420091	1.2752	18.57
420093	1.0331	16.77
420094	.....	32.68
430004	0.9951	17.84
430005	1.3596	15.84
430007	1.0895	14.06
430008	1.0961	16.76
430010	1.1568	16.11
430011	1.2924	16.42
430012	1.3190	17.78
430013	1.2075	17.24
430014	1.3645	18.44
430015	1.2102	16.41
430016	1.8688	18.97
430018	0.8830	14.91
430022	0.8600	12.95
430023	0.8726	11.64
430024	0.9383	13.99
430026	.....	10.85
430027	1.7702	18.64
430028	1.0723	16.72
430029	0.9695	15.10
430031	0.9138	12.46
430033	0.9911	14.64
430034	0.9542	12.85
430036	0.9551	13.78
430037	0.9633	15.95
430038	1.0095	11.94
430040	1.0562	13.37
430041	0.9146	12.62
430043	1.1343	13.43
430044	0.9084	16.45
430047	1.0290	15.62
430048	1.2374	17.26
430049	0.8800	14.44
430051	0.9313	17.21
430054	0.9661	13.50
430056	0.8354	11.41
430057	0.8972	15.15
430060	1.0902	8.64
430062	.....	10.89
430064	1.0315	12.74
430065	.....	12.77
430066	0.9635	13.44
430073	1.0645	14.98
430076	0.9498	12.25
430077	1.6674	17.71
430079	0.9893	12.98
430081	0.8927	.....
430082	0.8557	.....
430083	0.9273	.....
430084	0.8292	.....
430085	0.7951	.....
430087	.....	10.45
430089	0.8333	17.01
430090	1.3132	.....
430091	1.4508	.....
430092	2.2027	.....

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
430093	0.9944	.....
440001	1.1723	15.31
440002	1.6655	18.54
440003	1.2107	17.47
440006	1.4049	20.66
440007	1.0023	7.76
440008	0.9789	15.47
440009	1.1546	15.46
440010	0.9316	13.51
440011	1.3825	17.16
440012	1.7212	19.06
440014	1.0054	14.61
440015	1.8026	21.09
440016	1.0329	14.94
440017	1.7407	21.13
440018	1.2959	18.21
440019	1.7380	28.22
440020	1.1314	15.59
440022	.....	19.02
440023	1.1026	14.14
440024	1.2941	18.10
440025	1.1546	15.28
440026	0.8073	22.92
440029	1.2571	18.52
440030	1.2081	15.57
440031	1.0313	14.30
440032	1.0042	13.60
440033	1.1597	14.04
440034	1.5624	17.93
440035	1.2300	18.16
440039	1.8880	19.37
440040	0.9695	17.50
440041	1.0284	13.63
440046	1.2340	16.88
440047	0.9232	17.00
440048	1.8759	18.14
440049	1.6647	16.71
440050	1.3886	16.76
440051	0.9140	14.91
440052	1.0635	16.27
440053	1.3256	17.69
440054	1.1374	12.31
440056	1.1442	14.25
440057	1.0332	12.72
440058	1.2111	18.74
440059	1.4218	17.53
440060	1.1643	15.86
440061	1.1488	16.84
440063	1.6723	18.29
440064	1.0849	17.62
440065	1.2815	18.69
440067	1.2417	22.07
440068	1.2254	17.45
440070	1.0048	15.04
440071	1.3484	16.27
440072	1.3554	16.77
440073	1.2784	18.56
440078	1.0266	13.09
440081	1.0930	17.97
440082	2.0510	23.08
440083	0.9673	35.10
440084	1.2069	13.37
440091	1.6378	19.73
440100	1.0065	13.95

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
440102	1.1291	13.96
440103	1.1144	19.21
440104	1.7467	22.39
440105	1.7762	16.03
440109	1.0850	14.25
440110	1.1007	15.92
440111	1.4511	21.07
440114	1.0554	13.61
440115	1.0675	12.97
440120	1.6383	18.30
440125	1.5580	16.11
440130	1.1358	16.67
440131	1.1191	14.68
440132	1.1320	15.91
440133	1.5497	21.51
440135	1.2187	20.90
440137	1.0853	14.70
440141	0.9707	12.48
440142	1.0003	13.01
440143	1.0458	17.84
440144	1.2153	16.67
440145	0.9558	13.66
440147	1.7028	22.01
440148	1.1231	17.64
440149	1.0963	17.15
440150	1.3332	13.08
440151	1.1150	15.43
440152	2.0217	17.84
440153	1.1545	16.10
440156	1.5019	19.61
440157	1.0816	11.40
440159	1.1206	17.62
440161	1.8695	20.76
440162	.....	14.41
440166	1.6850	18.14
440168	1.0595	15.95
440173	1.6016	18.47
440174	1.0343	17.01
440175	1.0711	17.61
440176	1.3789	18.75
440180	1.2237	17.34
440181	0.9669	11.85
440182	0.9559	20.32
440183	1.5916	19.44
440184	1.2535	18.06
440185	1.1857	18.73
440186	1.0484	18.53
440187	1.1034	16.25
440189	1.4919	16.19
440192	1.0808	19.97
440193	1.2258	18.40
440194	1.2517	20.33
440197	1.3608	23.11
440200	1.0409	16.06
440203	0.9731	16.61
440206	0.9468	15.55
440209	.....	14.75
440210	0.8584	12.33
440211	0.7028	.....
440212	1.3679	.....
440213	2.6309	.....
440214	1.3295	.....
440215	3.2594	.....
450002*	1.5331	19.92

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
450004	1.1460	15.28
450005	1.1874	15.59
450007	1.2676	15.75
450008	1.2574	15.75
450010	1.4353	16.08
450011	1.5196	18.01
450014	1.1164	18.22
450015	1.6333	18.44
450016	1.6642	17.31
450018	1.4440	20.41
450020	0.9574	16.97
450021	1.8603	22.69
450023	1.4538	16.64
450024	1.4522	16.56
450025	1.7316	16.44
450028	1.4999	18.43
450029	1.6790	17.69
450031	1.4813	20.90
450032	1.3572	15.24
450033	1.7147	20.86
450034	1.5646	18.91
450035	1.4767	16.81
450037	1.5593	18.65
450039	1.4220	22.08
450040	1.5467	17.52
450042	1.7755	17.59
450044	1.6190	21.04
450046	1.3229	17.09
450047	1.1484	13.90
450050	0.9409	13.00
450051	1.5732	20.08
450052	1.0005	13.53
450053	1.1017	17.31
450054	1.6336	21.98
450055	1.1134	14.81
450056	1.6266	20.00
450058	1.6320	16.98
450059	1.3025	14.21
450063	0.9080	13.81
450064	1.4194	16.42
450065	1.0265	19.61
450068	1.9340	22.69
450072	1.1756	17.38
450073	1.1201	16.62
450076	1.7324	.....
450078	0.8770	13.49
450079	1.5304	19.49
450080	1.1737	16.31
450081	1.0574	16.17
450082	0.9662	13.30
450083	1.8059	20.18
450085	1.0594	14.22
450087	1.4462	21.48
450090	1.1225	13.91
450092	1.2258	15.73
450094	1.3312	19.42
450096	1.4157	16.63
450097	1.3386	18.27
450098	1.0981	15.48
450099	1.1520	22.88
450101	1.4857	16.96
450102	1.7293	18.85
450104	1.1823	15.98
450107	1.5327	20.74

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
450108	1.0390	16.15
450109	0.9217	12.77
450110	.....	21.44
450111	1.2307	19.27
450112	1.2575	14.76
450113	1.3243	18.53
450118	1.6605	15.83
450119	1.4078	18.32
450121	1.5371	18.23
450123	1.1890	19.19
450124	1.6617	21.09
450126	1.3281	17.45
450128	1.1958	15.89
450130	1.5002	17.87
450131	1.2654	17.62
450132	1.6202	18.07
450133	1.6004	19.92
450135	1.6151	20.81
450137	1.5720	23.96
450140	0.9268	18.07
450143	1.0303	14.46
450144	1.1036	16.30
450145	0.8681	14.84
450146	0.9514	14.20
450147	1.3107	18.07
450148	1.2211	22.03
450149	1.4919	24.00
450150	0.9050	15.21
450151	1.1068	14.84
450152	1.2314	17.38
450153	1.5422	19.94
450154	1.1797	13.18
450155	1.0303	23.77
450157	1.0679	14.66
450160	0.9603	8.75
450162	1.2180	22.20
450163	1.0045	16.98
450164	1.1806	20.04
450165	1.0378	15.16
450166	0.9271	10.28
450169	.....	15.88
450170	0.9642	14.81
450176	1.2922	16.30
450177	1.2048	14.73
450178	1.0236	16.76
450181	1.0155	14.02
450184	1.4598	19.97
450185	1.0280	13.06
450187	1.1970	17.57
450188	0.9951	13.78
450191	1.0175	18.80
450192	1.1761	19.33
450193	2.0418	22.73
450194	1.3020	19.15
450196	1.4363	16.49
450200	1.4435	17.38
450201	1.0156	17.05
450203	1.1610	18.66
450209	1.5661	18.66
450210	1.0520	14.23
450211	1.3657	17.14
450213	1.7239	18.45
450214	1.3278	17.25
450217	0.9404	11.69

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
450219	1.0827	15.42
450221	1.1951	16.99
450222	1.4958	18.45
450224	1.3659	22.83
450229	1.5753	16.41
450231	1.6275	17.70
450234	1.0446	13.30
450235	1.0697	13.42
450236	1.1450	15.68
450237	1.5270	17.40
450239	1.0085	13.64
450241	0.9610	14.87
450243	0.9422	12.36
450246	1.0263	17.97
450249	1.0666	11.63
450250	0.9906	14.91
450253	1.1245	15.35
450258	1.0358	13.23
450259	.....	17.85
450264	0.8807	13.89
450269	0.9970	14.93
450270	1.0799	12.70
450271	1.2418	15.50
450272	1.2621	17.95
450276	1.0970	12.71
450278	0.8254	13.79
450280	1.5817	19.49
450283	1.0456	13.89
450286	.....	12.12
450288	1.1566	15.99
450289	1.4628	18.35
450292	1.1880	19.51
450293	0.9416	14.43
450296	1.3456	20.66
450299	1.5391	17.97
450303	0.9610	12.67
450306	1.0915	13.32
450307	0.8064	16.68
450309	1.0981	16.21
450315	0.9782	20.80
450320	1.2433	19.63
450321	0.9220	13.39
450322	0.5973	12.46
450324	1.5321	17.87
450327	0.9680	16.09
450330	1.1273	18.42
450334	0.9752	12.27
450337	0.9914	17.42
450340	1.4515	15.85
450341	1.0145	19.18
450346	1.4978	17.10
450347	1.2191	17.69
450348	1.1295	12.94
450351	1.2160	15.98
450352	1.1896	17.85
450353	1.1368	15.00
450355	1.0439	14.32
450358	2.0749	21.28
450362	1.0930	15.35
450369	1.0526	15.19
450370	1.2091	15.44
450371	1.2416	11.90
450372	1.2361	19.86
450373	1.1050	17.60

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
450374	0.8698	12.83
450378	1.2110	23.16
450379	1.5565	20.28
450381	0.9516	15.62
450388	1.7788	17.56
450389	1.2896	18.15
450393	1.2509	18.74
450395	1.0405	16.67
450399	0.9427	16.31
450400	1.3730	14.08
450403	1.2446	21.37
450411	0.9314	14.05
450417	1.0243	13.85
450418	1.3882	20.58
450419	1.2157	21.82
450422	1.0412	24.53
450423	1.5370	19.44
450424	1.2472	17.57
450429	1.1166	11.38
450431	1.5621	16.27
450438	1.1335	16.55
450446	0.7614	21.97
450447	1.3915	16.61
450451	1.1857	19.64
450457	1.8458	19.77
450460	1.0022	14.22
450462	1.7379	20.13
450464	0.9349	13.47
450465	1.3025	15.22
450467	1.0721	15.60
450469	1.3893	22.10
450473	1.0194	14.19
450475	1.0898	16.25
450484	1.4878	19.59
450488	1.3277	18.68
450489	0.9699	14.57
450497	1.1185	11.92
450498	0.9726	12.02
450508	1.3869	19.87
450514	1.0763	22.28
450517	0.9630	12.87
450518	1.5221	19.01
450523	1.4824	20.26
450530	1.1935	22.91
450534	0.9667	24.08
450535	1.2294	21.26
450537	1.3395	21.74
450538	.....	19.69
450539	1.2636	14.25
450544	1.1451	19.38
450545	1.3921	16.97
450547	1.0630	13.81
450551	1.1015	13.91
450558	1.7932	20.02
450559	.....	13.46
450561	.....	16.82
450563	1.2612	30.37
450565	1.2556	16.45
450570	1.1337	17.71
450571	1.4934	16.97
450573	0.9884	15.67
450574	0.9302	14.24
450575	1.1417	19.06
450578	0.9369	16.87

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
450580	1.1529	15.36
450583	1.0313	15.50
450584	1.1775	13.37
450586	1.0568	12.84
450587	1.1748	17.11
450591	1.1439	17.92
450596	1.2187	14.82
450597	0.9686	16.18
450603	0.7880	12.77
450604	1.3018	15.48
450605	1.1881	20.15
450609	0.8938	10.73
450610	1.4658	16.75
450614	0.9889	13.83
450615	1.0752	14.75
450617	1.3304	19.54
450620	1.1230	13.71
450623	1.1370	21.83
450626	1.0095	19.79
450628	1.0152	16.83
450630	1.5196	19.19
450631	1.6627	17.56
450632	0.9391	12.73
450633	1.5491	20.72
450634	1.6032	20.29
450638	1.5279	19.70
450639	1.4801	20.31
450641	1.0503	13.50
450643	1.2187	17.43
450644	1.4341	20.79
450646	1.4580	19.99
450647	1.8895	22.42
450648	1.0047	14.75
450649	1.0310	15.82
450651	1.6794	20.73
450652	0.9055	16.65
450653	1.0887	19.28
450654	0.9509	13.88
450656	1.3892	18.73
450658	0.9617	15.15
450659	1.4870	20.56
450661	1.1054	20.22
450662	1.4695	18.68
450665	0.8670	15.44
450666	1.3171	19.35
450668	1.6278	18.72
450669	1.3458	22.28
450670	1.3452	18.20
450672	1.5856	21.21
450673	1.0157	13.84
450674	1.1487	20.62
450675	1.3667	23.26
450677	1.3315	18.79
450678	1.4770	20.75
450681	1.3177	.....
450683	1.2748	21.17
450684	1.2383	22.85
450686	1.5942	15.01
450688	1.3164	20.90
450690	1.3880	22.41
450694	1.1399	18.49
450696	1.3358	17.57
450697	1.3675	15.93
450698	0.9133	14.40

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
450700	0.9460	15.12
450702	1.5056	21.01
450703	1.1321	18.80
450704	1.2429	21.62
450705	0.8800	22.32
450706	1.1954	21.38
450709	1.1866	19.77
450711	1.6330	18.24
450712	0.5453	16.89
450713	1.4858	23.60
450715	1.4308	19.77
450716	1.2691	19.99
450717	1.2889	19.45
450718	1.2002	19.07
450723	1.4188	19.70
450724	1.2574	20.07
450725	.....	19.56
450727	1.0500	17.75
450728	0.8255	12.93
450730	1.3987	20.91
450733	1.4696	20.37
450735	0.8297	8.00
450742	1.2714	20.78
450743	1.4590	15.95
450746	0.9207	20.75
450747	1.3342	17.38
450749	1.0361	12.95
450750	1.0162	14.72
450751	1.2134	22.25
450754	0.9408	14.89
450755	1.1073	14.71
450757	0.8766	13.96
450758	1.9447	18.65
450760	1.2078	18.07
450761	0.9462	11.14
450763	1.0029	17.56
450766	2.0818	21.81
450769	0.8516	13.62
450770	0.9940	16.83
450771	1.9082	21.58
450774	1.6697	16.52
450775	1.3660	19.97
450776	1.0045	10.20
450777	0.9770	19.59
450779	1.2931	22.97
450780	1.7380	15.28
450785	0.9897	18.55
450788	1.5021	20.98
450794	.....	18.40
450795	0.9879	14.17
450796	3.3883	17.45
450797	0.7701	18.59
450798	0.7662	9.22
450801	1.4581	16.61
450802	1.4444	18.90
450803	1.0992	16.20
450804	1.7531	20.22
450807	0.8919	13.23
450808	1.9250	45.47
450809	1.5460	19.03
450810	0.9739	.....
450811	2.3971	18.38
450812	.....	20.74
450813	0.9718	.....

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
450815	2.5623	.....
450817	0.6826	.....
450818	1.2025	.....
450819	1.5000	.....
450820	1.0411	.....
450822	1.2110	.....
460001	1.7793	20.63
460003	1.6046	20.60
460004	1.7755	20.82
460005	1.6581	17.58
460006	1.3373	19.65
460007	1.3076	20.57
460008	1.3677	21.03
460009	1.8478	21.11
460010	2.0972	21.25
460011	1.3205	16.71
460013	1.4303	20.33
460014	1.2254	19.55
460015	1.2396	20.10
460016	0.9953	18.08
460017	1.3888	26.03
460018	0.9230	16.86
460019	1.0510	17.37
460020	0.9556	17.03
460021	1.3848	20.26
460022	0.9569	18.21
460023	1.1785	21.33
460024	.....	13.03
460025	0.8243	12.51
460026	1.0605	17.34
460027	0.9545	20.83
460029	1.0958	17.25
460030	1.1918	17.22
460032	0.9792	19.55
460033	0.9753	15.72
460035	0.9477	14.28
460036	1.0005	22.38
460037	0.9080	18.77
460039	1.0603	24.48
460041	1.3072	21.69
460042	1.3714	17.85
460043	0.9896	23.90
460044	1.1363	20.69
460046	.....	17.11
460047	1.6723	21.38
460049	1.9825	18.82
460050	.....	26.25
460051	1.1552	20.98
460052	1.4619	.....
470001	1.3011	19.61
470003	1.8338	22.59
470004	1.0674	18.10
470005	1.2285	21.51
470006	1.2408	18.39
470008	1.2590	19.41
470010	1.0678	19.47
470011	1.1504	21.20
470012	1.2780	18.52
470015	1.1985	19.26
470018	1.2252	20.42
470020	0.9900	18.99
470023	1.3197	20.64
470024	1.1528	20.41
490001	1.1931	24.76

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
490002	1.0751	12.99
490003	0.6419	18.00
490004	1.2740	18.77
490005	1.5963	16.91
490006	1.2147	15.23
490007	2.0919	18.43
490009	1.9489	22.95
490010	1.0335	18.58
490011	1.4655	18.75
490012	1.1933	13.78
490013	1.2476	16.93
490014	1.5333	24.56
490015	1.5161	19.36
490017	1.3895	17.32
490018	1.3002	17.94
490019	1.1951	17.53
490020	1.2248	17.67
490021	1.3810	19.45
490022	1.5532	20.72
490023	1.2186	18.96
490024	1.6762	16.89
490027	1.1131	14.42
490030	1.1907	10.50
490031	1.0734	15.82
490032	1.7204	21.56
490033	1.1999	18.33
490037	1.1999	15.97
490038	1.2143	15.71
490040	1.4733	22.52
490041	1.2747	16.55
490042	1.2324	15.27
490043	1.3532	20.68
490044	1.3213	17.63
490045	1.2161	19.63
490046	1.5370	18.61
490047	1.1078	17.16
490048	1.5688	17.89
490050	1.4272	22.71
490052	1.6372	16.94
490053	1.3233	15.69
490054	1.0319	15.55
490057	1.5739	19.07
490059	1.5941	20.37
490060	1.0645	19.20
490063	1.7721	28.25
490066	1.3274	16.50
490067	1.2535	17.19
490069	1.4182	15.70
490071	1.4083	19.47
490073	1.5076	26.14
490074	.....	19.34
490075	1.3785	19.19
490077	1.2263	19.79
490079	1.3128	16.44
490083	.....	16.64
490084	1.1308	16.38
490085	1.1582	16.40
490088	1.1286	15.60
490089	1.0694	15.86
490090	1.1220	16.28
490091	1.2330	19.99
490092	1.2219	15.69
490093	1.4339	16.48
490094	1.0922	16.79

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
490095	.....	18.25
490097	1.2096	15.86
490098	1.2068	14.70
490099	0.9555	16.87
490100	.....	17.22
490101	1.2286	25.09
490104	0.7018	28.49
490105	0.5822	18.25
490106	0.8713	16.91
490107	1.3326	22.41
490108	0.8935	19.75
490109	0.8779	21.16
490110	1.2994	15.84
490111	1.2000	17.35
490112	1.6550	20.52
490113	1.3249	23.08
490114	1.1582	16.91
490115	1.1600	17.10
490116	1.1704	16.44
490117	1.1543	13.84
490118	1.7091	20.87
490119	1.3367	17.87
490120	1.3095	19.98
490122	1.3605	23.97
490123	1.1355	16.85
490124	1.0893	19.36
490126	1.3233	18.23
490127	1.0410	14.48
490129	1.0746	27.47
490130	1.3119	16.28
490132	1.0183	17.02
500001	1.4869	21.35
500002	1.4055	21.04
500003	1.4016	24.31
500005	1.7533	23.48
500007	1.3352	22.43
500008	1.9490	24.19
500011	1.3373	25.18
500012	1.5530	22.28
500014	1.5641	23.93
500015	1.3293	23.24
500016	1.4955	23.90
500019	1.3833	22.37
500021	1.4802	24.46
500023	1.2073	27.19
500024	1.6886	24.05
500025	1.9090	23.96
500026	1.4529	23.35
500027	1.6832	25.05
500028	1.0717	18.86
500029	0.9086	16.81
500030	1.4513	24.13
500031	1.2483	23.37
500033	1.3309	21.39
500036	1.3911	21.90
500037	1.1389	19.68
500039	1.3828	23.32
500041	1.3244	24.85
500042	1.4121	22.13
500043	1.0107	20.25
500044	1.9371	23.11
500045	1.0116	22.10
500048	0.9601	19.30
500049	1.4695	22.95

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
500050	1.3489	20.94
500051	1.6736	24.48
500052	1.1621	.....
500053	1.3284	22.05
500054	1.8781	22.90
500055	1.1284	22.88
500057	1.3026	18.04
500058	1.4834	23.40
500059	1.0767	22.54
500060	1.3712	23.54
500061	1.0000	20.40
500062	1.0655	19.46
500064	1.6382	24.53
500065	1.2532	21.42
500068	1.0543	18.70
500069	1.1155	20.63
500071	1.2837	19.38
500072	1.2021	24.46
500073	0.9531	21.43
500074	1.1055	18.65
500077	1.3298	23.21
500079	1.3220	22.98
500080	0.8180	13.80
500084	1.2784	22.22
500085	0.9302	28.61
500086	1.2601	22.31
500088	1.2967	23.70
500089	1.0515	17.94
500090	0.8380	16.33
500092	1.0165	17.29
500094	0.8803	18.11
500096	0.9394	20.96
500097	1.0798	20.80
500098	1.0464	12.99
500101	1.0108	19.45
500102	0.9022	20.33
500104	1.2616	22.58
500106	0.9351	18.71
500107	1.2053	17.30
500108	1.7383	27.21
500110	1.2107	21.41
500118	1.1490	22.92
500119	1.3555	21.57
500122	1.2755	21.91
500123	0.9495	19.58
500124	1.3681	24.15
500125	1.0521	16.63
500129	1.6409	23.60
500132	0.9686	19.36
500134	0.6491	20.96
500138	3.6799	.....
500139	1.4682	20.88
500141	1.3726	22.94
500143	0.5954	17.60
500146	.....	17.85
510001	1.9499	17.83
510002	1.2866	17.34
510005	1.0198	14.43
510006	1.2719	17.88
510007	1.5729	20.25
510008	1.2172	17.37
510012	1.0087	16.50
510013	1.1012	16.62
510015	0.9677	14.79

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
510016	.....	12.03
510018	1.0741	16.48
510020	1.0848	12.65
510022	1.8970	19.84
510023	1.2380	15.94
510024	1.5836	18.80
510026	1.0574	13.46
510027	0.9600	17.58
510028	1.0520	20.73
510029	1.2855	17.05
510030	1.0520	18.31
510031	1.4131	18.49
510033	1.2904	18.81
510035	1.2311	18.65
510036	0.9839	13.20
510038	1.0640	14.34
510039	1.3990	16.06
510043	0.9349	14.29
510046	1.2735	17.73
510047	1.2611	19.12
510048	1.1332	20.37
510050	1.7457	16.57
510053	1.0811	15.59
510055	1.2306	22.84
510058	1.2795	17.98
510059	2.0210	16.77
510060	1.0503	15.66
510061	1.0243	14.22
510062	1.2784	17.63
510065	.....	14.59
510066	.....	12.72
510067	1.2058	18.11
510068	1.2058	16.29
510070	1.2966	16.36
510071	1.3297	16.24
510072	1.0573	17.66
510077	1.1370	16.41
510080	1.1479	14.80
510081	1.0787	13.00
510082	1.1597	13.69
510084	1.0361	12.48
510085	1.2771	18.64
510086	1.1035	13.79
510088	1.0389	.....
520002	1.2721	18.35
520003	1.0869	16.43
520004	1.1778	18.17
520006	1.0164	20.44
520007	1.0508	13.11
520008	1.6392	22.80
520009	1.6949	18.51
520010	1.1559	20.34
520011	1.1930	20.38
520013	1.3680	21.63
520014	1.1066	16.40
520015	1.1978	18.32
520016	0.9703	13.29
520017	1.1930	19.32
520018	1.1211	18.64
520019	1.3095	18.31
520021	1.4596	20.03
520024	1.0420	14.61
520025	1.0654	18.11
520026	1.0296	19.81

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
520027	1.2626	18.91
520028	1.3294	19.14
520029	0.8917	16.75
520030	1.7395	20.00
520031	1.0756	18.71
520032	1.2622	17.90
520033	1.2388	18.89
520034	1.1058	16.69
520035	1.3246	17.10
520037	1.7026	20.05
520038	1.3352	17.71
520039	0.9990	19.60
520040	1.5261	20.74
520041	1.1567	15.37
520042	1.1256	17.66
520044	1.4143	17.79
520045	1.6556	19.67
520047	0.9397	17.87
520048	1.4958	19.17
520049	2.0506	19.57
520051	1.8466	19.74
520053	1.1884	16.49
520054	1.0542	15.99
520057	1.1944	18.32
520058	1.1077	18.13
520059	1.4368	19.85
520060	1.4770	17.17
520062	1.2487	17.80
520063	1.1864	20.77
520064	1.5707	21.46
520066	1.4671	22.44
520068	0.9618	18.08
520069	1.2293	17.91
520070	1.5249	17.82
520071	1.2525	18.79
520074	1.0559	18.69
520075	1.4866	19.09
520076	1.1796	16.51
520077	0.9312	15.54
520078	1.6373	20.56
520082	1.1943	16.74
520083	1.7219	22.57
520084	1.0804	18.95
520087	1.6992	19.39
520088	1.2752	20.15
520089	1.4733	20.61
520090	1.2604	18.00
520091	1.2778	20.07
520092	1.0845	17.56
520094	0.7818	19.78
520095	1.2908	18.51
520096	1.3848	19.30
520097	1.3197	19.65
520098	1.7723	20.03
520100	1.2561	18.38
520101	1.0650	17.85
520102	1.1753	19.83
520103	1.3285	21.23
520107	1.2649	20.54
520109	1.0080	18.63
520110	1.2429	20.03
520111	1.0771	17.24
520112	1.1382	18.18
520113	1.2755	20.59

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
520114	1.0706	17.38
520115	1.2453	17.38
520116	1.2751	18.57
520117	1.0083	17.42
520118	0.9267	12.44
520120	0.9639	15.62
520121	0.9801	17.58
520122	0.9988	16.76
520123	0.9687	17.41
520124	1.0567	16.39
520130	1.0645	15.16
520131	1.0215	18.80
520132	1.2140	17.28
520134	1.1056	17.61
520135	0.9686	14.47
520136*	1.5183	19.99
520138	1.8827	20.89
520139	1.2600	21.28
520140	1.6650	21.42
520141	.....	16.95
520142	0.8577	17.70
520144	1.0177	16.62
520145	0.9103	17.24
520146	1.0606	15.73
520148	1.1737	16.93
520149	0.8651	13.30
520151	1.0561	18.08
520152	1.1273	21.33
520153	0.9014	15.45
520154	1.1283	17.92
520156	1.1278	19.84
520157	1.1408	17.28
520159	0.9357	18.74
520160	1.7939	18.84
520161	0.9978	18.57
520170	1.1960	22.50
520171	0.9558	15.73
520173	1.1310	20.14
520177	1.7178	21.76
520178	1.0401	17.04
520187	0.6853	.....
520188	1.9479	.....
530002	1.1799	17.59
530003	0.8696	15.78
530004	0.9388	16.19
530005	1.1268	15.15
530006	1.1073	19.34
530007	1.0673	18.06
530008	1.2158	22.96
530009	0.9826	19.45
530010	1.2456	18.93
530011	1.1585	17.44
530012	1.6198	19.48
530014	1.4187	17.32
530015	1.2855	22.65
530016	1.2279	17.71
530017	0.9404	13.71
530018	0.9876	17.87
530019	0.9171	16.76
530022	1.1504	17.88
530023	0.8235	20.75
530025	1.3737	20.32
530026	1.1260	18.92
530027	0.8284	29.77

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
530029	0.9986	17.80
530031	0.8242	13.38
530032	1.1799	20.21

*Asterisk denotes teaching physician costs removed based on costs reported on Worksheet A, Col. 1, Line 23 of FY 1996 cost report.

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS

Urban area (constituent counties)	Wage index	GAF
0040 Abilene, TX	0.8179	0.8714
Taylor, TX		
0060 Aguadilla, PR [2]	0.4249	0.5565
Aguada, PR		
Aguadilla, PR		
Moca, PR		
0080 Akron, OH	1.0163	1.0111
Portage, OH		
Summit, OH		
0120 Albany, GA	1.0372	1.0253
Dougherty, GA		
Lee, GA		
0160 Albany-Schenectady-Troy, NY	0.8754	0.9129
Albany, NY		
Montgomery, NY		
Rensselaer, NY		
Saratoga, NY		
Schenectady, NY		
Schoharie, NY		
0200 Albuquerque, NM	0.8499	0.8946
Bernalillo, NM		
Sandoval, NM		
Valencia, NM		
0220 Alexandria, LA	0.7910	0.8517
Rapides, LA		
0240 Allentown-Bethlehem-Easton, PA	0.9550	o.9690
Carbon, PA		
LeHigh, PA		
Northampton, PA		
0280 Altoona, PA	0.9342	0.9545
Blair, PA		
0320 Amarillo, TX	0.8435	0.8900
Potter, TX		
Randall, TX		
0380 Anchorage, AK	1.3009	1.1974
Anchorage, AK		
0440 Ann Arbor, MI	1.1483	1.0993
Lenawee, MI		
Livingston, MI		
Washtenaw, MI		
0450 Anniston, AL	0.8462	0.8919
Calhoun, AL		
0460 Appleton-Oshkosh-Neenah, WI	0.8913	0.9242

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
Calumet, WI		
Outagamie, WI		
Winnebago,WI		
0470 Arecibo, PR	0.4815	0.6062
Arecibo, PR		
Camuy, PR		
Hatillo, PR		
0480 Asheville, NC	0.8884	0.9222
Buncombe, NC		
Madison, NC		
0500 Athens, GA	0.9800	0.9863
Clarke, GA		
Madison, GA		
Oconee, GA		
0520 Atlanta, GA	1.0050	1.0034
Barrow, GA		
Bartow, GA		
Carroll, GA		
Cherokee, GA		
Clayton, GA		
Cobb, GA		
Coweta, GA		
DeKalb, GA		
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	1.1050	1.0708
Atlantic, NJ		
Cape May, NJ		
0580 Auburn-Opelika, AL	0.7748	0.8397
Lee, AL		
0600 Augusta-Aiken, GA–SC	0.9013	0.9313
Columbia, GA		
McDuffie, GA		
Richmond, GA		
Aiken, SC		
Edgefield, SC		
0640 Austin-San Marcos, TX [1]	0.9081	0.9361
Bastrop, TX		
Caldwell, TX		
Hays, TX		
Travis, TX		
Williamson, TX		
0680 Bakersfield, CA [2]	0.9951	0.9966
Kern, CA		
0720 Baltimore, MD [1]	0.9891	0.9925
Anne Arundel, MD		
Baltimore, MD		
Baltimore, City, MD		
Carroll, MD		
Harford, MD		
Howard, MD		
Queen Anne's, MD		
0733 Bangor, ME	0.9609	0.9731

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
Penobscot, ME		
0743 Barnstable-Yarmouth, MA	1.3302	1.2158
Barnstable, MA		
0760 Baton Rouge, LA	0.8707	0.9095
Ascension, LA		
East Baton Rouge, LA		
Livingston, LA		
West Baton Rouge, LA		
0840 Beaumont-Port Arthur, TX	0.8624	0.9036
Hardin, TX		
Jefferson, TX		
Orange, TX		
0860 Bellingham, WA	1.1394	1.0935
Whatcom, WA		
0870 Benton Harbor, MI [2]	0.8831	0.9184
Berrien, MI		
0875 Bergen-Passaic, NJ [1]	1.1833	1.1222
Bergen, NJ		
Passaic, NJ		
0880 Billings, MT	1.0038	1.0026
Yellowstone, MT		
0920 Biloxi-Gulfport-Pascagoula, MS	0.7949	0.8545
Hancock, MS		
Harrison, MS		
Jackson, MS		
0960 Binghamton, NY	0.8750	0.9126
Broome, NY		
Tioga, NY		
1000 Birmingham, AL	0.8994	0.9300
Blount, AL		
Jefferson, AL		
St. Clair, AL		
Shelby, AL		
1010 Bismarck, ND	0.7893	0.8504
Burleigh, ND		
Morton, ND		
1020 Bloomington, IN	0.8593	0.9014
Monroe, IN		
1040 Bloomington-Normal, IL	0.8993	0.9299
McLean, IL		
1080 Boise City, ID	0.9086	0.9365
Ada, ID		
Canyon, ID		
1123 Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH (MA Hospitals) [1 2]	1.1369	1.0918
Bristol, MA		
Essex, MA		
Middlesex, MA		
Norfolk, MA		
Plymouth, MA		
Suffolk, MA		
Worcester, MA		
Hillsborough, NH		
Merrimack, NH		
Rockingham, NH		
Strafford, NH		
1123 Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH (NH Hospitals) [1]	1.1358	1.0911
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	0.9944	0.9962
Boulder, CO		
1145 Brazoria, TX	0.8516	0.8958
Brazoria, TX		
1150 Bremerton, WA	1.1011	1.0682
Kitsap, WA		
1240 Brownsville-Harlingen-San Benito, TX	0.9212	0.9453
Cameron, TX		
1260 Bryan-College Station, TX	0.8501	0.8947
Brazos, TX		
1280 [1] Buffalo-Niagara Falls, NY	0.9604	0.9727
Erie, NY		
Niagara, NY		
1303 Burlington, VT	1.0558	1.0379
Chittenden, VT		
Franklin, VT		
Grand Isle, VT		
1310 Caguas, PR	0.4561	0.5842
Caguas, PR		
Cayey, PR		
Cidra, PR		
Gurabo, PR		
San Lorenzo, PR		
1320 Canton-Massillon, OH [2]	0.8649	0.9054
Carrll, OH		
Stark, OH		
1350 Casper, WY	0.9199	0.9444
Natrona, WY		
1360 Cedar Rapids, IA	0.9018	0.9317
Linn, IA		
1400 Champaign-Urbana, IL	0.9163	0.9419
Champaign, IL		
1440 Charleston-North Charleston, SC	0.8988	0.9295
Berkeley, SC		
Charleston, SC		
Dorchester, SC		
1480 Charleston, WV	0.9095	0.9371
Kanawha, WV		
Putnam, WV		
1520 Charlotte-Gastonia-Rock Hill, NC–SC [1]	0.9433	0.9608
Cabarrus, NC		
Gaston, NC		
Lincoln, NC		
Mecklenburg, NC		
Rowan, NC		
Stanly, NC		
Union, NC		
York, SC		
1540 Charlottesville, VA	1.0573	1.0389
Albermarle, VA		
Charlottesville City, VA		
Fluvanna, VA		
Greene, VA		
1560 Chattanooga, TN–GA	0.9731	0.9815
Catoosa, GA		
Dade, GA		
Walker, GA		
Hamilton, TN		
Marion, TN		
1580 Cheyenne, WY [2]	0.8859	0.9204
Laramie, WY		
1600 Chicago, IL [1]	1.0872	1.0589
Cook, IL		
DeKalb, IL		
DuPage, IL		
Grundy, IL		
Kane, IL		
Kendall, IL		
Lake, IL		
McHenry, IL		
Will, IL		
1620 Chico-Paradise, CA	1.0390	1.0265
Butte, CA		
1640 Cincinnati, OH–KY–IN [1]	0.9434	0.9609
Dearborn, IN		
Ohio, IN		
Boone, KY		
Campbell, KY		
Gallatin, KY		
Grant, KY		
Kenton, KY		
Pendleton, KY		
Brown, OH		
Clermont, OH		
Hamilton, OH		
Warren, OH		
1660 Clarksville-Hopkinsville, TN–KY	0.8283	0.8790
Christian, KY		
Montgomery, TN		
1680 Cleveland-Lorain-Elyria, OH [1]	0.9688	0.9785

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
Ashtabula, OH		
Cuyahoga, OH		
Geauga, OH		
Lake, OH		
Lorain, OH		
Medina, OH		
1720 Colorado Springs, CO	0.9218	0.9458
El Paso, CO		
1740 Columbia, MO	0.8904	0.9236
Boone, MO		
1760 Columbia, SC	0.9357	0.9555
Lexington, SC		
Richland, SC		
1800 Columbus, GA–AL	0.8510	0.8954
Russell, AL		
Chattahoochee, GA		
Harris, GA		
Muscogee, GA		
1840 Columbus, OH	0.9907	0.9936
Delaware, OH		
Fairfield, OH		
Franklin, OH		
Licking, OH		
Madison, OH		
Pickaway, OH		
1880 Corpus Christi, TX	0.8702	0.9092
Nueces, TX		
San Patricio, TX		
1890 Crovallis, OR	1.1087	1.0732
Benton, OR		
1900 Cumberland, MD–WV (Maryland Hospitals)	0.8801	0.9163
Allegany, MD		
Mineral, WV		
1920 Dallas, TX [1]	0.9589	0.9717
Collin, TX		
Dallas, TX		
Denton, TX		
Ellis, TX		
Henderson, TX		
Hunt, TX		
Kaufman, TX		
Rockwall, TX		
1950 Danville, VA	0.9061	0.9347
Danville City, VA		
Pittsylvania, VA		
1960 Davenport-Moline-Rock Island, IA–IL	0.8706	0.9095
Scott, IA		
Henry, IL		
Rock Island, IL		
2000 Dayton-Springfield, OH	0.9336	0.9540
Clark, OH		
Greene, OH		
Miami, OH		
Montgomery, OH		
2020 Daytona Beach, FL [2]	0.8986	0.9294
Flagler, FL		
Volusia, FL		
2030 Decatur, AL	0.8679	0.9075
Lawrence, AL		
Morgan, AL		
2040 Decatur, IL	0.8321	0.8817
Macon, IL		
2080 Danver, CO [1]	1.0197	1.0134
Adams, CO		
Arapahoe, CO		
Denver, CO		
Douglas, CO		
Jefferson, CO		
2120 Des Moines, IA	0.8754	0.9129
Dallas, IA		
Polk, IA		
Warren, IA		
2160 Detroit, MI [1]	1.0421	1.0286
Lapeer, MI		
Macomb, MI		
Monroe, MI		
Oakland, MI		
St. Clair, MI		
Wayne, MI		
2180 Dothan, AL	0.7836	0.8462
Dale, AL		
Houston, AL		
2190 Dover, DE	0.9335	0.9540
Kent, DE		
2200 Dubuque, IA	0.8520	0.8961
Dubuque, IA		
2240 Duluth-Superior, MN–WI	1.0165	1.0113
St. Louis, MN		
Douglas, WI		
2281 Dutchess County, NY	0.9872	0.9912
Dutchess, NY		
2290 Eau Claire, WI	0.8957	0.9273
Chippewa, WI		
Eau Claire, WI		
2320 El Paso, TX	0.8947	0.9266
El Paso, TX		
2330 Elkhart-Goshen, IN	0.9379	0.9570
Elkhart, IN		
2335 Elmira, NY [2]	0.8636	0.9045
Chemung, NY		
2340 Enid, OK	0.7953	0.8548
Garfield, OK		
2360 Erie, PA	0.9023	0.9320
Erie, PA		
2400 Eugene-Springfield, OR	1.0765	1.0518
Lane, OR		
2440 Evansville-Henderson, IN–KY (IN Hospitals) [2]	0.8396	0.8872
Posey, IN		
Vanderburgh, IN		
Warrick, IN		
Henderson, KY		
2440 Evansville-Henderson, IN–KY (KY Hospitals)	0.8303	0.8804
Posey, IN		
Vanderburgh, IN		
Warrick, IN		
Henderson, KY		
2520 Fargo-Moorhead, ND–MN	0.8620	0.9033
Clay, MN		
Cass, ND		
2560 Fayetteville, NC	0.8494	0.8942
Cumberland, NC		
2580 Fayetteville-Springdale-Rogers, AR	0.7773	0.8415
Benton, AR		
Washington, AR		
2620 Flagstaff, AZ–UT	1.0348	1.0237
Coconino, AZ		
Kane, UT		
2640 Flint, MI	1.1020	1.0688
Genesee, MI		
2650 Florence, AL	0.7927	0.8529
Colbert, AL		
Lauderdale, AL		
2655 Florence, SC	0.8618	0.9032
Florence, SC		
2670 Fort Collins-Loveland, CO	1.0302	1.0206
Larimer, CO		
2680 Ft. Lauderdale, FL [1]	1.0172	1.0117
Broward, FL		
2700 Fort Myers-Cape Coral, FL [2]	0.8986	0.9294
Lee, FL		
2710 Fort Pierce-Port St. Lucie, FL	1.0109	1.0075
Martin, FL		
St. Lucie, FL		
2720 Fort Smith, AR–OK	0.7844	0.8468
Crawford, AR		
Sebastian, AR		
Sequoyah, OK		
2750 Fort Walton Beach, FL [2]	0.8986	0.9294
Okaloosa, FL		
2760 Fort Wayne, IN	0.9096	0.9372
Adams, IN		
Allen, IN		
De Kalb, IN		
Huntington, IN		
Wells, IN		
Whitley, IN		
2800 Forth Worth-Arlington, TX [1]	0.9835	0.9887
Hood, TX		
Johnson, TX		
Parker, TX		
Tarrant, TX		
2840 Fresno, CA	1.0262	1.0179
Fresno, CA		
Madera, CA		
2880 Gadsden, AL	0.8754	0.9129
Etowah, AL		
2900 Gainesville, FL	1.0102	1.0070
Alachua, FL		
2920 Galveston-Texas City, TX	0.9732	0.9816
Galveston, TX		
2960 Gary, IN	0.9369	0.9563
Lake, IN		
Porter, IN		
2975 Glens Falls, NY [2]	0.8636	0.9045

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
Warren, NY		
Washington, NY		
2980 Goldsboro, NC	0.8333	0.8826
Wayne, NC		
2985 Grand Forks, ND–MN	0.9097	0.9372
Polk, MN		
Grand Forks, ND		
2995 Grand Junction, CO	0.9188	0.9437
Mesa, CO		
3000 Grand Rapids-Muskegon-Holland, MI [1]	1.0135	1.0092
Allegan, MI		
Kent, MI		
Muskegon, MI		
Ottawa, MI		
3040 Great Falls, MT	1.0459	1.0312
Cascade, MT		
3060 Greeley, CO	0.9722	0.9809
Weld, CO		
3080 Green Bay, WI	0.9215	0.9456
Brown, WI		
3120 Greensboro-Winston-Salem-High Point, NC [1]	0.9037	0.9330
Alamance, NC		
Davidson, NC		
Davie, NC		
Forsyth, NC		
Guilford, NC		
Randolph, NC		
Stokes, NC		
Yadkin, NC		
3150 Greenville, NC	0.9500	0.9655
Pitt, NC		
3160 Greenville-Spartanburg-Anderson, SC	0.9188	0.9437
Anderson, SC		
Cherokee, SC		
Greenville, SC		
Pickens, SC		
Spartanburg, SC		
3180 Hagerstown, MD	0.8853	0.9200
Washington, MD		
3200 Hamilton-Middletown, OH	0.8989	0.9296
Butler, OH		
3240 Harrisburg-Lebanon-Carlisle, PA	0.9917	0.9943
Cumberland, PA		
Dauphin, PA		
Lebanon, PA		
Perry, PA		
3283 Hartford, CT [1 2]	1.2413	1.1595
Hartford, CT		
Litchfield, CT		
Middlesex, CT		
Tolland, CT		
3285 Hattiesburg, MS [2]	0.7306	0.806
Forrest, MS		
Lamar, MS		
3290 Hickory-Morganton-Lenoir, NC	0.9148	0.940
Alexander, NC		
Burke, NC		
Caldwell, NC		
Catawba, NC		
3320 Honolulu, HI	1.1479	1.099
Honolulu, HI		
3350 Houma, LA	0.7837	0.8463
Lafourche, LA		
Terrebonne, LA		
3360 Houston, TX [1]	0.9387	0.9576
Chambers, TX		
Fort Bend, TX		
Harris, TX		
Liberty, TX		
Montgomery, TX		
Waller, TX		
3400 Huntington-Ashland, WV–KY–OH	0.9757	0.9833
Boyd, KY		
Carter, KY		
Greenup, KY		
Lawrence, OH		
Cabell, WV		
Wayne, WV		
3440 Huntsville, AL	0.8822	0.9178
Limestone, AL		
Madison, AL		
3480 Indianapolis, IN [1]	0.9792	0.9857
Boone, IN		
Hamilton, IN		
Hancock, IN		
Hendricks, IN		
Johnson, IN		
Madison, IN		
Marion, IN		
Morgan, IN		
Shelby, IN		
3500 Iowa City, IA	0.9607	0.9729
Johnson, IA		
3520 Jackson, MI	0.8840	0.9190
Jackson, MI		
3560 Jackson, MS	0.8387	0.8865
Hinds, MS		
Madison, MS		
Rankin, MS		
3580 Jackson, TN	0.8600	0.9019
Madison, TN		
Chester, TN		
3600 Jacksonville, FL [1 2]	0.8986	0.9294
Clay, FL		
Duval, FL		
Nassau, FL		
St. Johns, FL		
3605 Jacksonville, NC [2]	0.8290	0.8795
Onslow, NC		
3610 Jamestown, NY [2]	0.8636	0.9045
Chautauqua, NY		
3620 Janesville-Beloit, WI	0.9656	0.9763
Rock, WI		
3640 Jersey City, NJ	1.1674	1.1118
Hudson, NJ		
3660 Johson City-Kingsport-Bristol, TN–VA	0.8894	0.9229
Carter, TN		
Hawkins, TN		
Sullivan, TN		
Unicoi, TN		
Washington, TN		
Bristol City, VA		
Scott, VA		
Washington, VA		
3680 Johnstown, PA [2]	0.8524	0.8964
Cambria, PA		
Somerset, PA		
3700 Jonesboro, AR	0.7251	0.8024
Craighead, AR		
3710 Joplin, MO [2]	0.7723	0.8378
Jasper, MO		
Newton, MO		
3720 Kalamazoo-Battlecreek, MI	0.9981	0.9987
Calhoun, MI		
Kalamazoo, MI		
Van Buren, MI		
3740 Kankakee, IL	0.8598	0.9017
Kankakee, IL		
3760 Kansas City, KS–MO [1]	0.9322	0.9531
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	0.9033	0.9327
Kenosha, WI		
3810 Killeen-Temple, TX	0.9932	0.9953
Bell, TX		
Coryell, TX		
3840 Knoxville, TN	0.9199	0.9444
Anderson, TN		
Blount, TN		
Knox, TN		
Loudon, TN		
Sevier, TN		
Union, TN		
3850 Kokomo, IN	0.8984	0.9293
Howard, IN		
Tipton, IN		
3870 LaCrosse, WI–MN	0.8933	0.9256
Houston, MN		
La Crosse, WI		
3880 Lafayette, LA	0.8397	0.8872
Acadia, LA		
Lafayette, LA		
St. Landry, LA		
St. Martin, LA		
3920 Lafayette, IN	0.8809	0.9168
Clinton, IN		
Tippecanoa, IN		
3960 Lake Charles, LA	0.7966	0.8558

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
Calcasieu, LA		
3980 Lakeland-Winter Haven, FL [2]	0.8986	0.9294
Polk, FL		
4000 Lancaster, PA	0.9255	0.9484
Lancaster, PA		
4040 Lansing-East Lansing, MI	0.9977	0.9984
Clinton, MI		
Eaton, MI		
Ingham, MI		
4080 Laredo, TX	0.8323	0.8819
Webb, TX		
4100 Las Cruces, NM	0.8590	0.9012
Dona Anam, NM		
4120 Las Vegas, NV–AZ [1]	1.1258	1.0845
Mohave, AZ		
Clark, NV		
Nye, NV		
4150 Lawrence, KS	0.8222	0.8745
Douglas, KS		
4200 Lawton, OK	0.9532	0.9677
Comanche, OK		
4243 Lewiston-Auburn, ME	0.8899	0.9232
Androscoggin, ME		
4280 Lexington, KY	0.8552	0.8984
Bourbon, KY		
Clark, KY		
Fayette, KY		
Jessamine, KY		
Madison, KY		
Scott, KY		
Woodford, KY		
4320 Lima, OH	0.9108	0.938
Allen, OH		
Auglaize, OH		
4360 Lincoln, NE	0.9670	0.977
Lancaster, NE		
4400 Little Rock-North Little Rock, AR	0.8614	0.9029
Faulkner, AR		
Lonoke, AR		
Pulaski, AR		
Saline, AR		
4420 Longview, Marshall, TX	0.8738	0.9118
Gregg, TX		
Harrison, TX		
Upshur, TX		
4480 Los Angeles-Long Beach, CA [1]	1.2085	1.1385
Los Angeles, CA		
4520 Louisville, KY–IN	0.9381	0.9572
Clark, IN		
Floyd, IN		
Harrison, IN		
Scott, IN		
Bullitt, KY		
Jefferson, KY		
Oldham, KY		
4600 Lubbock, TX	0.8411	0.8883
Lubbock, TX		
4640 Lynchburg, VA	0.8814	0.9172
Amherst, VA		
Bedford, VA		
Bedford City, VA		
Campbell, VA		
Lynchburg City, VA		
4680 Macon, GA	0.8530	0.8968
Bibb, GA		
Houston, GA		
Jones, GA		
Peach, GA		
Twiggs, GA		
4720 Madison, WI	0.9729	0.981
Dane, WI		
4800 Mansfield, OH [2]	0.8649	0.905
Crawford, OH		
Richland, OH		
4840 Mayaguez, PR	0.4674	0.5940
Anasco, PR		
Cabo Rojo, PR		
Hormigueros, PR		
Mayaguez, PR		
Sabana Grande, PR		
San German, PR		
4880 McAllen-Edinburg-Mission, TX	0.8120	0.8671
Hidalgo, TX		
4890 Medford-Ashland, OR	1.0492	1.0334
Jackson, OR		
4900 Melbourne-Titusville-Palm Bay, FL	0.9296	0.9512
Brevard, FL		
4920 Memphis, TN–AR–MS [1]	0.8244	0.8761
Crittenden, AR		
DeSoto, MS		
Fayette, TN		
Shelby, TN		
Tipton, TN		
4940 Merced, CA	1.0509	1.0346
Merced, CA		
5000 Miami, FL [1]	1.0233	1.0159
Dade, FL		
5015 Middlesex-Somerset-Hunterdon, NJ [1]	1.0876	1.0592
Hunterdon, NJ		
Middlesex, NJ		
Somerset, NJ		
5080 Milwaukee-Waukesha, WI [1]	0.9845	0.9894
Milwaukee, WI		
Ozaukee, WI		
Washington, WI		
Waukesha, WI		
5120 Minneapolis-St. Paul, MN–WI [1]	1.0929	1.0627
Anoka, MN		
Carver, MN		
Chisago, MN		
Dakota, MN		
Hennepin, MN		
Isanti, MN		
Ramsey, MN		
Scott, MN		
Sherburne, MN		
Washington, MN		
Wright, MN		
Pierce, WI		
St. Croix, WI		
5140 Missoula, MT	0.9085	0.9364
Missoula, MT		
5160 Mobile, AL	0.8267	0.8778
Baldwin, AL		
Mobile, AL		
5170 Modesto, CA	1.0111	1.0076
Stanislaus, CA		
5190 Monmouth-Ocean, NJ [1]	1.1258	1.0845
Monmouth, NJ		
Ocean, NJ		
5200 Monroe, LA	0.8221	0.8745
Quachita, LA		
5240 Montgomery, AL	0.7724	0.8379
Autauga, AL		
Elmore, AL		
Mongomery, AL		
5280 Muncie, IN	1.0834	1.0564
Delaware, IN		
5330 Myrtle Beach, SC	0.8529	0.8968
Horry, SC		
5345 Naples, FL	0.9839	0.9889
Collier, FL		
5360 Nashville, TN [1]	0.9449	0.9619
Cheatham, TN		
Davidson, TN		
Dickson, TN		
Robertson, TN		
Rutherford TN		
Sumner, TN		
Williamson, TN		
Wilson, TN		
5380 Nassau-Suffolk, NY [1]	1.4074	1.2637
Nassau, NY		
Suffolk, NY		
5483 New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT [1]	1.2417	1.1598
Fairfield, CT		
New Haven, CT		
5523 New London-Norwich, CT	1.2428	1.1605
New London, CT		
5560 New Orleans, LA [1]	0.9089	0.9367

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
Jefferson, LA		
Orleans, LA		
Plaquemines, LA		
St. Bernard, LA		
St. Charles, LA		
St. James, LA		
St. John The Baptist, LA		
St. Tammany, LA		
5600 New York, NY [1]	1.4517	1.2908
Bronx, NY		
Kings, NY		
New York, NY		
Putnam, NY		
Queens, NY		
Richmond, NY		
Rockland, NY		
Westchester, NY		
5640 Newark, NY [1]	1.0772	1.0522
Essex, NJ		
Morris, NJ		
Sussex, NJ		
Union, NJ		
Warren, NJ		
5660 Newburgh, NY–PA	1.0908	1.0613
Orange, NY		
Pike, PA		
5720 Norfolk-Virginia Beach-Newport News, VA–NC [1]	0.8442	0.8905
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 Oakland, CA	1.5095	1.3258
Alameda, CA		
Contra Costa, CA		
5790 Ocala, FL	0.9615	0.9735
Marion, FL		
5800 Odessa-Midland, TX	0.8873	0.9214
Ector, TX		
Midland, TX		
5880 Oklahoma City, OK [1]	0.8589	0.9011
Candian, OK		
Cleveland, OK		
Logan, OK		
McClain, OK		
Oklahoma, OK		
Pottawatomie, OK		
5910 Olympia, WA	1.0932	1.0629
Thurston, WA		
5920 Omaha, NE–IA	1.0455	1.0309
Pottawattamie, IA		
Cass, NE		
Douglas, NE		
Sarpy, NE		
Washington, NE		
5945 Orange County, CA [1]	1.1592	1.1065
Orange, CA		
5660 Orlando, FL	0.9806	0.9867
Lake, FL		
Orange, FL		
Osceola, FL		
Seminole, FL		
5990 Owensboro, KY	0.8104	0.8659
Daviess, KY		
6015 Panama City, FL	0.9169	0.9423
6020 Parkersburg-Marietta, WV–OH (WV Hospitals)	0.8414	0.8885
Washington, OH		
Wood, WV		
6020 Parkersburg-Marietta, WV–OH (OH Hospitals) [2]	0.8649	0.9054
Washington, OH		
Wood, WV		
6080 Pensacola, FL [2]	0.8986	0.9294
Escambia, FL		
Santa Rosa, FL		
6120 Peoria-Perkin, IL	0.8399	0.8874
Peoria, IL		
Tazewell, IL		
Woodford, IL		
6160 Philadelphia, PA–NJ	1.1186	1.0798
Burlington, NJ		
Camden, NJ		
Gloucester, NJ		
Salem, NJ		
Bucks, PA		
Chester, PA		
Delaware, PA		
Montgomery, PA		
Philadelphia, PA		
6200 Phoenix-Messa, AZ [1]	0.9464	0.9630
Maricopa, AZ		
Pinal, AZ		
6240 Pine Bluff, AR	0.7697	0.8359
Jefferson, AR		
6280 Pittsburgh, PA [1]	0.9634	0.9748
Allegheny, PA		
Beaver, PA		
Butler, PA		
Fayette, PA		
Washington, PA		
Westmoreland, PA		
6323 Pittsfield, MA [2]	1.1369	1.0918
Berkshire, MA		
6340 Pocatello, ID	0.8973	0.9285
Bannock, ID		
6360 Ponce, PR	0.4971	0.6196
Guayanilla, PR		
Juana Diaz, PR		
Penuelas, PR		
Ponce, PR		
Villalba, PR		
Yauco, PR		
6403 Portland, ME	0.9487	0.9646
Cumberland, ME		
Sagadahoc, ME		
York, ME		
6440 Portland-Vancouver, OR–WA [1]	1.0996	1.0672
Clackamas, OR		
Columbia, OR		
Multnomah, OR		
Washington, OR		
Yamhill, OR		
Clark, WA		
6483 Providence-Warwick-Pawtucket, RI [1]	1.0690	1.0468
Bristol, RI		
Kent, RI		
Newport, RI		
Providence, RI		
Washington, RI		
6520 Provo-Orem, UT	0.9818	0.9875
Utah, UT		
6560 Pueblo, CO	0.8853	0.9200
Pueblo, CO		
6580 Punta Gorda, FL	0.9508	0.9660
Charalotte, FL		
6600 Racine, WI	0.9216	0.9456
Racine, WI		
6640 Raleigh-Durham-Chapel Hill, NC [1]	0.9544	0.9685
Chatham, NC		
Durham, NC		
Franklin, NC		
Johnston, NC		
Orange, NC		
Wake, NC		
6660 Rapid City, SD	0.8363	0.8848
Pennington, SD		
6680 Reading, PA	0.9436	0.9610
Berks, PA		
6690 Redding, CA	1.1263	1.0849
Shasta, CA		
6720 Reno, NV	1.0655	1.0444
Washoe, NV		
6740 Richland-Kennewick-Pasco, WA	1.1224	1.0823
Benton, WA		
Franklin, WA		
6760 Richmond-Petersburg, VA	0.9545	0.9686

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
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 Riverside-San Bernardino, CA [1]	1.1061	1.0715
Riverside, CA		
San Bernardino, CA		
6800 Roanoke, VA	0.8142	0.8687
Botetourt, VA		
Roanoke, VA		
Roanoke City, VA		
Salem City, VA		
6820 Rochester, MN	1.1429	1.0958
Olmsted, MN		
6840 Rochester, NY [1]	0.9184	0.9434
Genesee, NY		
Livingston, NY		
Monroe, NY		
Ontario, NY		
Orleans, NY		
Wayne, NY		
6880 Rockford, IL	0.8783	0.9150
Boone, IL		
Ogle, IL		
Winnebago, IL		
6895 Rocky Mount, NC	0.8735	0.9115
Edgecombe, NC		
Nash, NC		
6920 Sacramento, CA [1]	1.2284	1.1513
El Dorado, CA		
Placer, CA		
Sacramento, CA		
6960 Saginaw-Bay City-Midland, MI	0.9294	0.9511
Bay, MI		
Midland, MI		
Saginaw, MI		
6980 St. Cloud, MN	0.9608	0.9730
Benton, MN		
Stearns, MN		
7000 St. Joseph, MO	0.8943	0.9264
Andrew, MO		
Buchanan, MO		
7040 St. Louis, MO–IL [1]	0.9052	0.9341
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 Salem, OR	0.9949	0.9965
Marion, OR		
Polk, OR		
7120 Salinas, CA	1.4710	1.3025
Monterey, CA		
7160 Salt Lake City-Ogden, UT [1]	0.9854	0.9900
Davis, UT		
Salt Lake, UT		
Weber, UT		
7200 San Angelo, TX	0.7845	0.8469
Tom Green, TX		
7240 San Antonio, TX [1]	0.8318	0.8815
Bexar, TX		
Comal, TX		
Guadalupe, TX		
Wilson, TX		
7320 San Diego, CA [1]	1.1955	1.1301
San Diego, CA		
7360 San Francisco, CA [1]	1.3784	1.2458
Marin, CA		
San Francisco, CA		
San Mateo, CA		
7400 San Jose, CA [1]	1.3492	1.2277
Santa Clara, CA		
7440 San Juan-Bayamon, PR [1]	0.4657	0.5925
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	1.0470	1.0320
San Luis Obispo, CA		
7480 Santa Barbara-Santa Maria-Lompoc, CA	1.0819	1.0554
Santa Barbara, CA		
7485 Santa Cruz-Watsonville, CA	1.3927	1.2546
Santa Cruz, CA		
7490 Santa Fe, NM	1.0437	1.0297
Los Alamos, NM		
Santa Fe, NM		
7500 Santa Rosa, CA	1.3000	1.1968
Sonoma, CA		
7510 Sarasota-Bradenton, FL	0.9905	0.9935
Manatee, FL		
Sarasota, FL		
7520 Savannah, GA	0.9953	0.9968
Bryan, GA		
Chatham, GA		
Effington, GA		
7560 Scranton—Wilkes-Barre—Hazleton, PA [2]	0.8524	0.8964
Columbia, PA		
Lackawanna, PA		
Luzerne, PA		
Wyoming, PA		
7600 Seattle-Bellevue-Everett, WA [1]	1.1289	1.0866
Island, WA		
King, WA		
Snohomish, WA		
7610 Sharon, PA [2]	0.8524	0.8964

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
Mercer, PA		
7620 Sheboygan, WI [2]	0.8759	0.9133
Sheboygan, WI		
7640 Sherman-Denison, TX	0.9329	0.9535
Grayson, TX		
7680 Shreveport-Bossier City, LA	0.9049	0.9339
Bossier, LA		
Caddo, LA		
Webster, LA		
7720 Sioux City, IA–NE	0.8549	0.8982
Woodbury, IA		
Dakota, NE		
7760 Sioux Falls, SD	0.8776	0.9145
Lincoln, SD		
Minnehaha, SD		
7800 South Bend, IN	0.9793	0.9858
St. Joseph, IN		
7840 Spokane, WA	1.0799	1.0541
Spokane, WA		
7880 Springfield, IL	0.8684	0.9079
Menard, IL		
Sangamon, IL		
7920 Springfield, MO	0.7991	0.8576
Christian, MO		
Greene, MO		
Webster, MO		
8003 Springfield, MA [2]	1.1369	1.0918
Hampden, MA		
Hampshire, MA		
8050 State College, PA	0.9138	0.9401
Centre, PA		
8080 Steubenville-Weirton, OH–WV (OH Hospitals) [2]	0.8649	0.9054
Jefferson, OH		
Brooke, WV		
Hancock, WV		
8080 Steubenville-Weirton, OH–WV (OH Hospitals) [2]	0.8614	0.9029
Jefferson, OH		
Brooke, WV		
Hancock, WV		
8120 Stockton-Lodi, CA	1.0518	1.0352
San Joaquin, CA		
8140 Sumter, SC [2]	0.8264	0.8776
Sumter, SC		
8160 Syracuse, NY	0.9441	0.9614
Cayuga, NY		
Madison, NY		
Onondaga, NY		
Oswego, NY		
8200 Tacoma, WA	1.1631	1.1090
Pierce, WA		
8240 Tallahassee, FL [2]	0.8986	0.9294
Gadsden, FL		
Leon, FL		
8280 Tampa-St. Petersburg-Clearwater, FL [1]	0.9119	0.9388
Hernando, FL		
Hillsborough, FL		
Pasco, FL		
Pinellas, FL		
8320 Terre Haute, IN	0.8570	0.8997
Clay, IN		
Vermillion, IN		
Vigo, IN		
8360 Texarkana, AR-Texarkana, TX	0.8174	0.8710
Miller, AR		
Bowie, TX		
8400 Toledo, OH	0.9593	0.9719
Fulton, OH		
Lucas, OH		
Wood, OH		
8440 Topeka, KS	0.9326	0.9533
Shawnee, KS		
8480 Trenton, NJ	0.9955	0.9969
Mercer, NJ		
8520 Tucson, AZ	0.8742	0.9120
Pima, AZ		
8560 Tulsa, OK	0.8086	0.8646
Creek, OK		
Osage, OK		
Rogers, OK		
Tulsa, OK		
Wagoner, OK		
8600 Tuscaloosa, AL	0.8064	0.8630
Tuscaloosa, AL		
8640 Tyler, TX	0.9369	0.9563
Smith, TX		
8680 Utica-Rome, NY [2]	0.8636	0.9045
Herkimer, NY		
Oneida, NY		
8720 Vallejo-Fairfield-Napa, CA	1.2655	1.1750
Napa, CA		
Solano, CA		
8735 Ventura, CA	1.0952	1.0643
Ventura, CA		
8750 Victoria, TX	0.8378	0.8859
Victoria, TX		
8760 Vineland-Millville-Bridgeton, NJ	1.0517	1.0351
Cumberland, NJ		
8780 Visalia-Tulare-Porterville, CA	1.0411	1.0280
Tulare, CA		
8800 Waco, TX	0.8075	0.8638
McLennan, TX		
8840 Washington, DC–MD–VA–WV [1]	1.1053	1.0710
District of Columbia, DC		
Calvert, MD		
Charles, MD		
Frederick, MD		
Montgomery, MD		
Prince Georges, MD		
Alexandria City, VA		
Arlington, VA		
Clarke, VA		
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	0.8841	0.9191
Black Hawk, IA		
8940 Wausau, WI	0.9445	0.9617
Marathon, WI		
8960 West Palm Beach-Boca Raton, FL [1,2]	0.9951	0.9966
Palm Beach, FL		
9000 Wheeling, WV–OH (WV Hospitals) [2]	0.8068	0.8633
Belmont, OH		
Marshall, WV		
Ohio, WV		
9000 Wheeling, WV–OH (OH Hospitals) [2]	0.8649	0.9054
Belmont, OH		
Marshall, WV		
Ohio, WV		
9040 Wichita, KS	0.9421	0.09600
Butler, KS		
Harvey, KS		
Sedgwick, KS		
9080 Wichita Falls, TX	0.7652	0.8325
Archer, TX		
Wichita, TX		
9140 Williamsport, PA [2]	0.8524	0.8964
Lycoming, PA		
9160 Wilmington-Newark, DE–MD	1.1274	1.0856
New Castle, DE		
Cecil, MD		
9200 Wilmington, NC	0.9707	0.9798
New Hanover, NC		
Brunswick, NC		
9260 [2] Yakima, WA	1.0446	1.0303

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
Yakima, WA		
9270 Yolo, CA	1.0485	1.0330
Yolo, CA		
9280 York, PA	0.9309	0.9521
York, PA		
9320 Youngstown-Warren, OH	0.9996	0.9997
Columbiana, OH		
Mahoning, OH		
Trumbull, OH		
9340 Yuba City, CA	1.0662	1.0449
Sutter, CA		
Yuba, CA		
9360 Yuma, AZ	0.9924	0.9948
Yuma, AZ		

[1] Large Urban Area.
[2] Hospitals geographically located in the area are assigned the statewide rural wage index for FY 2000.

TABLE 4B.—WAGE INDEX AND CAPITLA GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR RURAL AREAS

Nonurban area	Wage index	GAF
Alabama	0.7390	0.8129
Alaska	1.2057	1.1367
Arizona	0.8544	0.8978
Arkansas	0.7236	0.8013
California	0.9951	0.9966
Colorado	0.8813	0.9171
Connecticut	1.2413	1.1595
Delaware	0.9166	0.9421
Florida	0.8986	0.9294
Georgia	0.8094	0.8652
Hawaii	1.0726	1.0492
Idaho	0.8651	0.9055
Illinois	0.8047	0.8617
Indiana	0.8396	0.8872
Iowa	0.7926	0.8528
Kansas	0.7460	0.8182
Kentucky	0.8043	0.8615
Louisiana	0.7486	0.8201
Maine	0.8639	0.9047
Maryland	0.8631	0.9041
Massachusetts	1.1369	1.0918
Michigan	0.8831	0.9184
Minnesota	0.8669	0.9068
Mississippi	0.7306	0.8066
Missouri	0.7723	0.8378
Montana	0.8398	0.8873
Nebraska	0.8007	0.8588
Nevada	0.9097	0.9372
New Hampshire	0.9905	0.9935
New Jersey [1]	.....	.....
New Mexico	0.8378	0.8859
New York	0.8636	0.9045
North Carolina	0.8290	0.8795
North Dakota	0.7647	0.8322
Ohio	0.8649	0.9054
Oklahoma	0.7255	0.8027
Oregon	0.9873	0.9913
Pennsylvania	0.8524	0.8964
Puerto Rico	0.4249	0.5565

TABLE 4B.—WAGE INDEX AND CAPITLA GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR RURAL AREAS—Continued

Nonurban area	Wage index	GAF
Rhode Island [1]	.....	.....
South Carolina	0.8264	0.8776
South Dakota	0.7576	0.8269
Tennessee	0.7650	0.8324
Texas	0.7471	0.8190
Utah	0.8906	0.9237
Vermont	0.9427	0.9604
Virginia	0.7916	0.8521
Washington	1.0446	1.0303
West Virginia	0.8068	0.8633
Wisconsin	0.8759	0.9133
Wyoming	0.8859	0.9204

[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	0.8179	0.8714
Akron, OH	0.9981	0.9987
Albany, GA	0.9544	0.9685
Alexandria, LA	0.7910	0.8517
Amarillo, TX	0.8435	0.8900
Anchorage, AK	1.3009	1.1974
Ann Arbor, MI	1.1343	1.0901
Atlanta, GA	1.0050	1.0034
Austin-San Marcos, TX	0.9081	0.9361
Baltimore, MD	0.9891	0.9925
Baton Rouge, LA	0.8707	0.9095
Beaumont-Port Arthur, TX	0.8624	0.9036
Benton Harbor, MI	0.8831	0.9184
Bergen-Passaic, NJ	1.1833	1.1222
Billings, MT	1.0038	1.0026
Biloxi-Gulfport-Pascagoula, MS	0.7949	0.8545
Binghamton, NY	0.8750	0.9126
Birmingham, AL	0.8994	0.9300
Bismarck, ND	0.7893	0.8504
Boise City, ID	0.9086	0.9365
Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH	1.1358	1.0911
Burlington, VT	1.0122	1.0083
Caguas, PR	0.4561	0.5842
Champaign-Urbana, IL	0.9163	0.9419
Charleston-North Charleston, SC	0.8988	0.9295
Charleston, WV	0.8861	0.9205
Charlotte-Gastonia-Rock Hill, NC–SC	0.9433	0.9608
Chattanooga, TN–GA	0.9453	0.9622
Chicago, IL	1.0872	1.0589
Cincinnati, OH–KY–IN	0.9434	0.9609
Clarksville-Hopkinsville, TN–KY	0.8283	0.8790
Cleveland-Lorain-Elyria, OH	0.9688	0.9785
Columbia, MO	0.8736	0.9116
Columbia, SC	0.9215	0.9456
Columbus, GA–AL	0.8318	0.8815

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area	Wage index	GAF
Columbus, OH	0.9728	0.9813
Corpus Christi, TX	0.8599	0.9018
Dallas, TX	0.9589	0.9717
Danville, VA	0.8706	0.9095
Davenport-Moline-Rock Island, IA–IL	0.8606	0.9023
Dayton-Springfield, OH	0.9231	0.9467
Denver, CO	1.0197	1.0134
Des Moines, IA	0.8754	0.9129
Dothan, AL	0.7836	0.8462
Dover, DE	1.0511	1.0347
Duluth-Superior, MN–WI	1.0165	1.0113
Elkhart-Goshen, IN	0.9379	0.9570
Eugene-Springfield, OR	1.0765	1.0518
Evansville-Henderson, IN–KY	0.8396	0.8872
Fargo-Moorhead, ND–MN (ND and SD Hospitals)	0.8620	0.9033
Fargo-Moorhead, ND–MN (MN Hospital)	0.8669	0.9068
Fayetteville, NC	0.8494	0.8942
Flagstaff, AZ–UT	0.9860	0.9904
Flint, MI	1.0918	1.0620
Fort Collins-Loveland, CO	1.0197	1.0134
Fort Pierce-Port St. Lucie, FL	1.0109	1.0075
Fort Smith, AR–OK	0.7696	0.8358
Fort Walton Beach, FL	0.8713	0.9100
Forth Worth-Arlington, TX	0.9835	0.9887
Fresno, CA	1.0262	1.0179
Gadsden, AL	0.8754	0.9129
Gainesville, FL	0.9963	0.9975
Goldsboro, NC	0.8333	0.8826
Grand Forks, ND–MN	0.9097	0.9372
Grand Rapids-Muskegon-Holland, MI	1.0017	1.0012
Great Falls, MT	1.0459	1.0312
Greeley, CO	0.9449	0.9619
Green Bay, WI	0.9215	0.9456
Greensboro-Winston-Salem-High Point, NC	0.9037	0.9330
Greenville, NC	0.9237	0.9471
Greenville-Spartanburg-Anderson, SC	0.9188	0.9437
Hagerstown, MD	0.8853	0.9200
Harrisburg-Lebanon-Carlisle, PA	0.9793	0.9858
Hartford, CT	1.1715	1.1145
Hickory-Morganton-Lenoir, NC	0.9148	0.9408
Honolulu, HI	1.1479	1.0991
Houston, TX	0.9387	0.9576
Huntington-Ashland, WV–KY–OH	0.9436	0.9610
Huntsville, AL	0.8608	0.9024
Indianapolis, IN	0.9792	0.9857
Iowa City, IA	0.9460	0.9627
Jackson, MS	0.8268	0.8779
Jackson, TN	0.8447	0.8909
Jacksonville, FL	0.8957	0.9273
Johnson City-Kingsport-Bristol, TN–VA	0.8894	0.9229
Jonesboro, AR	0.7251	0.8024
Joplin, MO	0.7678	0.8345

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area	Wage index	GAF
Kalamazoo-Battlecreek, MI	0.9981	0.9987
Kansas City, KS–MO	0.9322	0.9531
Knoxville, TN	0.9199	0.9444
Kokomo, IN	0.8984	0.9293
Lafayette, LA	0.8397	0.8872
Lansing-East Lansing, MI	0.9834	0.9886
Las Vegas, NV–AZ	1.1258	1.0845
Lexington, KY	0.8552	0.8984
Lima, OH	0.9108	0.9380
Lincoln, NE	0.9451	0.9621
Little Rock-North Little Rock, AR	0.8432	0.8898
Longview-Marshall, TX	0.8541	0.8976
Los Angeles-Long Beach, CA	1.2085	1.1385
Louisville, KY–IN	0.9381	0.9572
Macon, GA	0.8530	0.8968
Madison, WI	0.9729	0.9814
Mansfield, OH	0.8649	0.9054
Memphis, TN–AR–MS	0.8244	0.8761
Merced, CA	1.0509	1.0346
Milwaukee-Waukesha, WI	0.9845	0.9894
Minneapolis-St. Paul, MN–WI	1.0929	1.0627
Missoula, MT	0.9085	0.9364
Monmouth-Ocean, NJ	1.1258	1.0845
Monroe, LA	0.8062	0.8628
Montgomery, AL	0.7724	0.8379
Myrtle Beach, SC	0.8357	0.8843
Nashville, TN	0.9254	0.9483
New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	1.2417	1.1598
New London-Norwich, CT	1.2328	1.1541
New Orleans, LA	0.9089	0.9367
New York, NY	1.4399	1.2836
Newark, NJ	1.0772	1.0522
Newburgh, NY–PA	1.0837	1.0566
Norfolk-Virginia Beach-Newport News, VA–NC	0.8442	0.8905
Oakland, CA	1.5095	1.3258
Oklahoma City, OK	0.8589	0.9011
Omaha, NE–IA	1.0455	1.0309
Orange County, CA	1.1592	1.1065
Orlando, FL	0.9806	0.9867
Peoria-Pekin, IL	0.8399	0.8874
Philadelphia, PA–NJ	1.1186	1.0798
Phoenix-Mesa, AZ	0.9464	0.9630
Pittsburgh, PA	0.9496	0.9652
Pocatello, ID	0.8651	0.9055
Portland, ME	0.9487	0.9646
Portland-Vancouver, OR–WA	1.0996	1.0672
Provo-Orem, UT	0.9818	0.9875
Raleigh-Durham-Chapel Hill, NC	0.9544	0.9685
Roanoke, VA	0.8142	0.8687
Rockford, IL	0.8783	0.9150
Sacramento, CA	1.2284	1.1513
Saginaw-Bay City-Midland, MI	0.9294	0.9511
St. Cloud, MN	0.9608	0.9730

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area	Wage index	GAF
St. Louis, MO–IL	0.9052	0.9341
Salt Lake City-Ogden, UT	0.9854	0.9900
San Diego, CA	1.1955	1.1301
Santa Fe, NM	0.9911	0.9939
Santa Rosa, CA	1.3000	1.1968
Seattle-Bellevue-Everett, WA	1.1289	1.0866
Sharon, PA	0.8524	0.8964
Sherman-Denison, TX	0.8833	0.9185
Sioux City, IA–NE	0.8549	0.8982
South Bend, IN	0.9692	0.9788
Springfield, IL	0.8684	0.9079
Springfield, MO	0.7991	0.8576
Syracuse, NY	0.9441	0.9614
Tallahassee, FL	0.8274	0.8783
Tampa-St. Petersburg-Clearwater, FL	0.9119	0.9388
Texarkana, AR-Texarkana, TX	0.8174	0.8710
Toledo, OH	0.9593	0.9719
Topeka, KS	0.9326	0.9533
Tulsa, OK	0.7931	0.8532
Tuscaloosa, AL	0.8064	0.8630
Tyler, TX	0.9199	0.9444
Vallejo-Fairfield-Napa, CA	1.2167	1.1438
Victoria, TX	0.8378	0.8859
Waco, TX	0.8075	0.8638
Washington, DC–MD–VA–WV	1.1053	1.0710
Waterloo-Cedar Falls, IA	0.8841	0.9191
Wausau, WI	0.9445	0.9617
Wichita, KS	0.9082	0.9362
Rural Colorado	0.8813	0.9171
Rural Florida	0.8986	0.9294
Rural Illinois	0.8047	0.8617
Rural Louisiana	0.7486	0.8201
Rural Michigan	0.8831	0.9184
Rural Minnesota	0.8669	0.9068
Rural Missouri	0.7723	0.8378
Rural Montana	0.8398	0.8873
Rural Oregon	0.9873	0.9913
Rural Tennessee	0.7650	0.8324
Rural Texas	0.7471	0.8190
Rural Virginia (KY Hospital)	0.8043	0.8615
Rural Washington	1.0333	1.0227
Rural Wyoming	0.8859	0.9204

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS

Urban area	Average hourly wage
Abilene, TX	17.3227
Aguadilla, PR	8.0776
Akron, OH	21.5248
Albany, GA	21.9678
Albany-Schenectady-Troy, NY	18.5415
Albuquerque, NM	18.0017
Alexandria, LA	16.6660
Allentown-Bethlehem-Easton, PA	21.6602
Altoona, PA	19.7859

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Amarillo, TX	17.7501
Anchorage, AK	27.2347
Ann Arbor, MI	24.3199
Anniston, AL	17.9235
Appleton-Oshkosh-Neenah, WI	18.8767
Arecibo, PR	10.1973
Asheville, NC	18.8155
Athens, GA	20.5536
Atlanta, GA	21.2868
Atlantic-Cape May, NJ	23.9544
Auburn-Opelika, AL	16.4103
Augusta-Aiken, GA–SC	19.0900
Austin-San Marcos, TX	19.2341
Bakersfield, CA	20.3699
Baltimore, MD	20.9485
Bangor, ME	20.3521
Barnstable-Yarmouth, MA	28.1731
Baton Rouge, LA	18.4424
Beaumont-Port Arthur, TX	18.2648
Bellingham, WA	24.1321
Benton Harbor, MI	17.9119
Bergen-Passaic, NJ	25.4749
Billings, MT	21.2596
Biloxi-Gulfport-Pascagoula, MS	16.6634
Binghamton, NY	18.5327
Birmingham, AL	19.0492
Bismarck, ND	16.4329
Bloomington,IN	18.1990
Bloomington-Normal, IL	19.0474
Boise City, ID	19.1895
Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH	24.0562
Boulder-Longmont, CO	21.0610
Brazoria, TX	18.0362
Bremerton, WA	23.3211
Brownsville-Harlingen-San Benito, TX	19.5103
Bryan-College Station, TX	18.0042
Buffalo-Niagara Falls, NY	20.3404
Burlington, VT	22.3616
Caguas, PR	9.6595
Canton-Massillon, OH	18.5769
Casper, WY	19.4829
Cedar Rapids, IA	19.1010
Champaign-Urbana, IL	19.4065
Charleston-North Charleston, SC	19.0373
Charleston, WV	19.2624
Charlotte-Gastonia-Rock Hill, NC–SC	19.9800
Charlottesville, VA	22.3946
Chattanooga, TN–GA	20.6102
Cheyenne, WY	17.3158
Chicago, IL	23.0278
Chico-Paradise, CA	22.0066
Cincinnati, OH–KY–IN	19.9480
Clarksville-Hopkinsville, TN–KY	17.1337
Cleveland-Lorain-Elyria, OH	20.5190
Colorado Springs, CO	19.5228
Columbia, MO	18.8596
Columbia, SC	19.8182
Columbus, GA–AL	18.0250
Columbus, OH	20.9839
Corpus Christi, TX	18.4298
Corvallis, OR	23.4819
Cumberland, MD–WV	18.6405
Dallas, TX	20.3455
Danville, VA	19.1906
Davenport-Moline-Rock Island, IA–IL	18.4403

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Dayton-Springfield, OH	20.0366
Daytona Beach, FL	19.0345
Decatur, AL	18.3823
Decatur, IL	17.6232
Denver, CO	21.5811
Des Moines, IA	18.5408
Detroit, MI	22.0711
Dothan, AL	16.5159
Dover, DE	19.7725
Dubuque, IA	18.0451
Duluth-Superior, MN–WI	21.5294
Dutchess County, NY	22.3487
Eau Claire, WI	18.9711
El Paso, TX	18.9500
Elkhart-Goshen, IN	19.8656
Elmira, NY	18.0730
Enid, OK	16.8452
Erie, PA	19.1114
Eugene-Springfield, OR	22.4571
Evansville, Henderson, IN–KY	17.5854
Fargo-Moorhead, ND–MN	18.2572
Fayetteville, NC	17.9896
Fayetteville-Springdale-Rogers, AR	16.4641
Flagstaff, AZ–UT	21.9164
Flint, MI	23.3401
Florence, AL	16.7894
Florence, SC	18.2536
Fort Collins-Loveland, CO	21.8189
Fort Lauderdale, FL	21.5452
Fort Myers-Cape Coral, FL	18.9574
Fort Pierce-Port St. Lucie, FL	21.1766
Fort Smith, AR–OK	16.6129
Fort Walton Beach, FL	18.4550
Fort Wayne, IN	19.2662
Fort Worth-Arlington, TX	20.8308
Fresno, CA	21.7350
Gadsden, AL	18.4020
Gainesville, FL	21.3966
Galveston-Texas City, TX	20.6131
Gary, IN	19.8884
Glens Falls, NY	18.2277
Goldsboro, NC	17.6500
Grand Forks, ND–MN	19.2683
Grand Junction, CO	19.4593
Grand Rapids-Muskegon-Holland, MI	21.4652
Great Falls, MT	22.1512
Greeley, CO	20.5908
Green Bay, WI	19.3420
Greensboro-Winston-Salem-High Point, NC	19.1402
Greenville, NC	20.1214
Greenville-Spartanburg-Anderson, SC	19.4594
Hagerstown, MD	18.7266
Hamilton-Middletown, OH	18.9474
Harrisburg-Lebanon-Carlisle, PA	21.0037
Hartford, CT	24.8124
Hattiesburg, MS	16.1679
Hickory-Morganton-Lenoir, NC	19.2995
Honolulu, HI	24.3050
Houma, LA	16.5978
Houston, TX	19.8810
Huntington-Ashland, WV–KY–OH	20.6646
Huntsville, AL	18.6860
Indianapolis, IN	20.7402
Iowa City, IA	20.3481
Jackson, MI	18.7230

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Jackson, MS	17.7627
Jackson, TN	18.2151
Jacksonville, FL	18.9712
Jacksonville, NC	16.6300
Jamestown, NY	16.6418
Janesville-Beloit, WI	20.4504
Jersey City, NJ	24.7265
Johnson City-Kingsport-Bristol, TN–VA	18.7506
Johnstown, PA	18.2989
Jonesboro, AR	15.3149
Joplin, MO	16.2618
Kalamazoo-Battlecreek, MI	21.1395
Kankakee, IL	18.2109
Kansas City, KS–MO	19.7430
Kenosha, WI	19.1315
Killeen-Temple, TX	21.0356
Knoxville, TN	19.4838
Kokomo, IN	18.8885
La Crosse, WI–MN	18.9205
Lafayette, LA	17.6615
Lafayette, IN	18.6572
Lake Charles, LA	16.8715
Lakeland-Winter Haven, FL	18.6713
Lancaster, PA	19.6017
Lansing-East Lansing, MI	21.1315
Laredo, TX	17.6272
Las Cruces, NM	18.1944
Las Vegas, NV–AZ	23.8445
Lawrence, KS	17.4151
Lawton, OK	20.1897
Lewiston-Auburn, ME	18.8489
Lexington, KY	18.0690
Lima, OH	18.8613
Lincoln, NE	20.4820
Little Rock-North Little Rock, AR	18.2444
Longview-Marshall, TX	18.5072
Los Angeles-Long Beach, CA	25.5235
Louisville, KY–IN	19.8685
Lubbock, TX	17.8142
Lynchburg, VA	18.6683
Macon, GA	18.0675
Madison, WI	20.6054
Mansfield, OH	17.9510
Mayaguez, PR	9.9005
McAllen-Edinburg-Mission, TX	17.1975
Medford-Ashland, OR	22.2214
Melbourne-Titusville-Palm Bay, FL	19.6889
Memphis, TN–AR–MS	17.4610
Merced, CA	21.7673
Miami, FL	21.6737
Middlesex-Somerset-Hunterdon, NJ	23.5556
Milwaukee-Waukesha, WI	20.8513
Minneapolis-St. Paul, MN–WI	23.1482
Missoula, MT	19.2420
Mobile, AL	17.5090
Modesto, CA	21.4157
Monmouth-Ocean, NJ	23.8439
Monroe, LA	17.4115
Montgomery, AL	16.3157
Muncie, IN	22.9458
Myrtle Beach, SC	18.0643
Naples, FL	20.8392
Nashville, TN	20.0138
Nassau-Suffolk, NY	29.8096
New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	26.1700
New London-Norwich, CT	26.3222

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
New Orleans, LA	19.2503
New York, NY	30.7475
Newark, NJ	24.6654
Newburgh, NY–PA	23.1041
Norfolk-Virginia Beach-Newport News, VA–NC	17.8754
Oakland, CA	31.8928
Ocala, FL	20.3639
Odessa-Midland, TX	18.7922
Oklahoma City, OK	18.1873
Olympia, WA	23.1536
Omaha, NE–IA	22.1432
Orange County, CA	24.5477
Orlando, FL	20.7465
Owensboro, KY	17.1643
Panama City, FL	19.4197
Parkersburg-Marietta, WV–OH	17.8217
Pensacola, FL	17.8801
Peoria-Pekin, IL	17.6840
Philadelphia, PA–NJ	23.6372
Phoenix-Mesa, AZ	20.0450
Pine Bluff, AR	16.3022
Pittsburgh, PA	20.4057
Pittsfield, MA	21.7194
Pocatello, ID	19.0047
Ponce, PR	10.5280
Portland, ME	20.0674
Portland-Vancouver, OR–WA	23.2438
Providence-Warwick, RI	22.6420
Provo-Orem, UT	20.7946
Pueblo, CO	18.7505
Punta Gorda, FL	20.1370
Racine, WI	19.5201
Raleigh-Durham-Chapel Hill, NC	20.2151
Rapid City, SD	17.7126
Reading, PA	19.9855
Redding, CA	23.8559
Reno, NV	22.5678
Richland-Kennewick-Pasco, WA	23.7721
Richmond-Petersburg, VA	20.2158
Riverside-San Bernardino, CA	23.7428
Roanoke, VA	17.2365
Rochester, MN	24.2072
Rochester, NY	19.4510
Rockford, IL	18.6017
Rocky Mount, NC	18.4997
Sacramento, CA	26.0168
Saginaw-Bay City-Midland, MI	19.6689
St. Cloud, MN	19.9529
St. Joseph, MO	18.9408
St. Louis, MO–IL	19.1725
Salem, OR	21.0721
Salinas, CA	31.1554
Salt Lake City-Ogden, UT	20.8711
San Angelo, TX	16.6166
San Antonio, TX	17.6168
San Diego, CA	25.2676
San Francisco, CA	29.6537
San Jose, CA	28.8225
San Juan-Bayamon, PR	9.8640
San Luis Obispo-Atascadero-Paso Robles, CA	22.1746
Santa Barbara-Santa Maria-Lompoc, CA	22.9137
Santa Cruz-Watsonville, CA	29.4979
Santa Fe, NM	22.1051
Santa Rosa, CA	27.5337
Sarasota-Bradenton, FL	20.9796
Savannah, GA	21.0803

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Scranton-Wilkes Barre-Hazleton, PA	17.7324
Seattle-Bellevue-Everett, WA	23.9115
Sharon, PA	17.5441
Sheboygan, WI	17.3719
Sherman-Denison, TX	19.7582
Shreveport-Bossier City, LA	19.1657
Sioux City, IA–NE	18.1059
Sioux Falls, SD	18.5874
South Bend, IN	20.7421
Spokane, WA	22.8719
Springfield, IL	18.3917
Springfield, MO	16.9245
Springfield, MA	22.6142
State College, PA	19.3540
Steubenville-Weirton, OH–WV	18.2449
Stockton-Lodi, CA	22.2772
Sumter, SC	17.4486
Syracuse, NY	19.9343
Tacoma, WA	24.3099
Tallahassee, FL	17.9690
Tampa-St. Petersburg-Clearwater, FL	19.1546
Terre Haute, IN	18.1515
Texarkana, AR-Texarkana, TX	17.2300
Toledo, OH	20.7884
Topeka, KS	19.7520
Trenton, NJ	21.3959
Tucson, AZ	18.5157
Tulsa, OK	17.1256
Tuscaloosa, AL	17.0793
Tyler, TX	19.8429
Utica-Rome, NY	17.5752
Vallejo-Fairfield-Napa, CA	28.2652
Ventura, CA	24.2606
Victoria, TX	17.7441
Vineland-Millville-Bridgeton, NJ	22.2740
Visalia-Tulare-Porterville, CA	22.0500
Waco, TX	17.1037
Washington, DC–MD–VA–WV	23.4111

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Waterloo-Cedar Falls, IA	18.0392
Wausau, WI	20.0043
West Palm Beach-Boca Raton, FL	21.2055
Wheeling, OH–WV	16.1892
Wichita, KS	19.9536
Wichita Falls, TX	16.2079
Williamsport, PA	17.8945
Wilmington-Newark, DE–MD	23.8786
Wilmington, NC	20.5594
Yakima, WA	21.8833
Yolo, CA	20.5840
York, PA	19.7168
Youngstown-Warren, OH	21.1707
Yuba City, CA	22.5818
Yuma, AZ	21.0182

TABLE 4E.—AVERAGE HOURLY WAGE FOR RURAL AREAS

Nonurban area	Average hourly wage
Alabama	15.6529
Alaska	25.5370
Arizona	18.0961
Arkansas	15.3250
California	21.0766
Colorado	18.6657
Connecticut	26.2903
Delaware	19.4135
Florida	19.0317
Georgia	17.1426
Hawaii	22.7187
Idaho	18.3238
Illinois	17.0445
Indiana	17.7834
Iowa	16.7882

TABLE 4E.—AVERAGE HOURLY WAGE FOR RURAL AREAS—Continued

Nonurban area	Average hourly wage
Kansas	15.8000
Kentucky	17.0342
Louisiana	15.6336
Maine	18.2971
Maryland	18.2815
Massachusetts	24.0785
Michigan	18.6693
Minnesota	18.3602
Mississippi	15.4749
Missouri	16.3576
Montana	17.7804
Nebraska	16.9591
Nevada	19.2681
New Hampshire	20.9790
New Jersey [1]	
New Mexico	17.7448
New York	18.2911
North Carolina	17.5573
North Dakota	16.1967
Ohio	18.3192
Oklahoma	15.3668
Oregon	20.8991
Pennsylvania	18.0541
Puerto Rico	8.9988
Rhode Island [1]	
South Carolina	17.5024
South Dakota	16.0465
Tennessee	16.2034
Texas	15.8229
Utah	18.8636
Vermont	19.9246
Virginia	16.7397
Washington	22.1244
West Virginia	17.0883
Wisconsin	18.5514
Wyoming	18.7641

[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	0.9120	0.9389		
Arecibo, PR	1.0334	1.0228		
Caguas, PR	0.9789	0.9855	0.9789	0.9855
Mayaguez, PR	1.0033	1.0023		
Ponce, PR	1.0669	1.0453		
San Juan-Bayamon, PR	0.9996	0.9997		
Rural Puerto Rico	0.9120	0.9389		

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	3.0957	6.5	9.3
2	01	SURG	CRANIOTOMY FOR TRAUMA AGE >17	3.1047	7.4	9.9
3	01	SURG	*CRANIOTOMY AGE 0–17	1.9619	12.7	12.7
4	01	SURG	SPINAL PROCEDURES	2.3205	4.9	7.5
5	01	SURG	EXTRACRANIAL VASCULAR PROCEDURES	1.4466	2.5	3.4
6	01	SURG	CARPAL TUNNEL RELEASE	.8119	2.2	3.1
7	01	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC	2.4986	6.9	10.4

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS
8	01	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC.	1.3426	2.2	3.1
9	01	MED	SPINAL DISORDERS & INJURIES	1.1917	4.6	6.3
10	01	MED	NERVOUS SYSTEM NEOPLASMS W CC	1.2036	4.9	6.6
11	01	MED	NERVOUS SYSTEM NEOPLASMS W/O CC	.8283	3.0	4.1
12	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS	.8904	4.6	6.3
13	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	.7599	4.2	5.2
14	01	MED	SPECIFIC CEREBROVASCULAR DISORDERS EXCEPT TIA	1.1914	4.7	6.1
15	01	MED	TRANSIENT ISCHEMIC ATTACK & PRECEREBRAL OCCLUSIONS	.7397	3.0	3.7
16	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	1.0985	4.6	5.9
17	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	.6399	2.6	3.4
18	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W CC	.9353	4.2	5.5
19	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	.6503	3.0	3.8
20	01	MED	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	2.6125	7.7	10.2
21	01	MED	VIRAL MENINGITIS	1.5032	5.0	6.8
22	01	MED	HYPERTENSIVE ENCEPHALOPATHY	.9621	3.8	4.9
23	01	MED	NONTRAUMATIC STUPOR & COMA	.7746	3.1	4.2
24	01	MED	SEIZURE & HEADACHE AGE >17 W CC	.9770	3.7	5.0
25	01	MED	SEIZURE & HEADACHE AGE >17 W/O CC	.5911	2.6	3.4
26	01	MED	SEIZURE & HEADACHE AGE 0–17	.6337	2.8	3.6
27	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR	1.3581	3.3	5.3
28	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC	1.2690	4.5	6.2
29	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR AGE <17 W/O CC	.6859	2.8	3.6
30	01	MED	*TRAUMATIC STUPOR & COMA, COMA >1 HR AGE 0–17	.3318	2.0	2.0
31	01	MED	CONCUSSION AGE >17 W CC	.8497	3.2	4.3
32	01	MED	CONCUSSION AGE >17 W/O CC	.5295	2.1	2.7
33	01	MED	*CONCUSSION AGE 0–17	.2085	1.6	1.6
34	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W CC	1.0275	3.9	5.3
35	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	.5937	2.7	3.5
36	02	SURG	RETINAL PROCEDURES	.6834	1.2	1.4
37	02	SURG	ORBITAL PROCEDURES	1.0318	2.6	3.8
38	02	SURG	PRIMARY IRIS PROCEDURES	.4875	1.9	2.6
39	02	SURG	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	.5704	1.4	1.9
40	02	SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	.8170	2.2	3.3
41	02	SURG	*EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0–17	.3378	1.6	1.6
42	02	SURG	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	.6236	1.6	2.1
43	02	MED	HYPHEMA	.4515	2.6	4.1
44	02	MED	ACUTE MAJOR EYE INFECTIONS	.6496	4.1	5.0
45	02	MED	NEUROLOGICAL EYE DISORDERS	.6941	2.7	3.4
46	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W CC	.7525	3.5	4.6
47	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W/O CC	.4784	2.5	3.2
48	02	MED	*OTHER DISORDERS OF THE EYE AGE 0–17	.2975	2.9	2.9
49	03	SURG	MAJOR HEAD & NECK PROCEDURES	1.8557	3.7	5.0
50	03	SURG	SIALOADENECTOMY	.8401	1.6	2.0
51	03	SURG	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	.8504	1.9	2.9
52	03	SURG	CLEFT LIP & PALATE REPAIR	.7696	1.5	1.9
53	03	SURG	SINUS & MASTOID PROCEDURES AGE >17	1.1784	2.3	3.6
54	03	SURG	*SINUS & MASTOID PROCEDURES AGE 0–17	.4823	3.2	3.2
55	03	SURG	MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES.	.8686	1.9	2.9
56	03	SURG	RHINOPLASTY	.8893	2.1	2.8
57	03	SURG	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17.	1.1589	2.8	4.5
58	03	SURG	*T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17.	.2739	1.5	1.5
59	03	SURG	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	.6720	1.9	2.5
60	03	SURG	*TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17	.2086	1.5	1.5
61	03	SURG	MYRINGOTOMY W TUBE INSERTION AGE >17	1.2597	2.9	4.8
62	03	SURG	*MYRINGOTOMY W TUBE INSERTION AGE 0–17	.2953	1.3	1.3
63	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES	1.3136	3.0	4.5
64	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.2464	4.3	6.6
65	03	MED	DYSEQUILIBRIUM	.5261	2.3	2.9
66	03	MED	EPISTAXIS	.5548	2.6	3.2
67	03	MED	EPIGLOTTITIS	.8031	2.9	3.7
68	03	MED	OTITIS MEDIA & URI AGE >17 W CC	.6758	3.4	4.2
69	03	MED	OTITIS MEDIA & URI AGE >17 W/O CC	.5191	2.7	3.3
70	03	MED	OTITIS MEDIA & URI AGE 0–17	.3985	2.3	2.7
71	03	MED	LARYNGOTRACHEITIS	.6136	2.7	3.4
72	03	MED	NASAL TRAUMA & DEFORMITY	.6462	2.6	3.4
73	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17	.7667	3.3	4.3

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS
74	03	MED	*OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0–17.	.3356	2.1	2.1
75	04	SURG	MAJOR CHEST PROCEDURES	3.1107	7.8	9.9
76	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.7208	8.3	11.1
77	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	1.2113	3.6	5.0
78	04	MED	PULMONARY EMBOLISM	1.3861	6.1	7.1
79	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	1.6439	6.6	8.4
80	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC.	.8980	4.5	5.6
81	04	MED	*RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0–17	1.5196	6.1	6.1
82	04	MED	RESPIRATORY NEOPLASMS	1.3656	5.2	7.0
83	04	MED	MAJOR CHEST TRAUMA W CC	.9796	4.3	5.5
84	04	MED	MAJOR CHEST TRAUMA W/O CC	.5278	2.6	3.2
85	04	MED	PLEURAL EFFUSION W CC	1.2421	5.0	6.5
86	04	MED	PLEURAL EFFUSION W/O CC	.6724	2.9	3.8
87	04	MED	PULMONARY EDEMA & RESPIRATORY FAILURE	1.3694	4.8	6.3
88	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	.9406	4.3	5.3
89	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	1.0855	5.1	6.1
90	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	.6734	3.7	4.3
91	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE 0–17	.6334	3.3	4.0
92	04	MED	INTERSTITIAL LUNG DISEASE W CC	1.1786	5.0	6.3
93	04	MED	INTERSTITIAL LUNG DISEASE W/O CC	.7644	3.5	4.3
94	04	MED	PNEUMOTHORAX W CC	1.1910	4.8	6.4
95	04	MED	PNEUMOTHORAX W/O CC	.5944	2.9	3.6
96	04	MED	BRONCHITIS & ASTHMA AGE >17 W CC	.7943	3.9	4.8
97	04	MED	BRONCHITIS & ASTHMA AGE >17 W/O CC	.5954	3.1	3.7
98	04	MED	BRONCHITIS & ASTHMA AGE 0–17	.6859	3.3	4.5
99	04	MED	RESPIRATORY SIGNS & SYMPTOMS W CC	.6817	2.4	3.1
100 ...	04	MED	RESPIRATORY SIGNS & SYMPTOMS W/O CC	.5268	1.8	2.2
101 ...	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	.8490	3.3	4.4
102 ...	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	.5349	2.1	2.7
103 ...	05	SURG	HEART TRANSPLANT	19.5100	35.7	56.5
104 ...	05	SURG	CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W CARDIAC CATH.	7.2361	9.3	11.9
105 ...	05	SURG	CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W/O CARDIAC CATH.	5.6607	7.6	9.4
106 ...	05	SURG	CORONARY BYPASS W PTCA	7.3334	9.1	10.9
107 ...	05	SURG	CORONARY BYPASS W CARDIAC CATH	5.4639	9.3	10.5
108 ...	05	SURG	OTHER CARDIOTHORACIC PROCEDURES	5.7715	8.3	11.0
109 ...	05	SURG	CORONARY BYPASS W/O PTCA OR CARDIAC CATH	4.0403	6.9	7.8
110 ...	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES W CC	4.1600	7.2	9.6
111 ...	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES W/O CC	2.2267	4.9	5.7
112 ...	05	SURG	PERCUTANEOUS CARDIOVASCULAR PROCEDURES	1.9222	2.7	3.8
113 ...	05	SURG	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE.	2.7283	9.5	12.6
114 ...	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS.	1.5555	6.0	8.2
115 ...	05	SURG	PRM CARD PACEM IMPL W AMI, HRT FAIL OR SHK, OR AICD LEAD OR GNRTR PR.	3.4727	6.2	8.4
116 ...	05	SURG	OTH PERM CARD PACEMAK IMPL OR PTCA W CORONARY ARTERY STENT IMPLNT.	2.4651	2.8	3.9
117 ...	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT.	1.2931	2.7	4.1
118 ...	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT	1.5480	2.0	2.9
119 ...	05	SURG	VEIN LIGATION & STRIPPING	1.2297	3.0	4.9
120 ...	05	SURG	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	2.0136	5.0	8.2
121 ...	05	MED	CIRCULATORY DISORDERS W AMI & MAJOR COMP, DISCHARGED ALIVE.	1.6295	5.6	6.8
122 ...	05	MED	CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE.	1.1063	3.4	4.2
123 ...	05	MED	CIRCULATORY DISORDERS W AMI, EXPIRED	1.5108	2.7	4.4
124 ...	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG.	1.4020	3.4	4.5
125 ...	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG.	1.0436	2.2	2.8
126 ...	05	MED	ACUTE & SUBACUTE ENDOCARDITIS	2.5170	9.3	12.1
127 ...	05	MED	HEART FAILURE & SHOCK	1.0144	4.2	5.4
128 ...	05	MED	DEEP VEIN THROMBOPHLEBITIS	.7645	5.1	5.9
129 ...	05	MED	CARDIAC ARREST, UNEXPLAINED	1.0770	1.8	2.8
130 ...	05	MED	PERIPHERAL VASCULAR DISORDERS W CC	.9469	4.7	5.9

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS
131 ...	05	MED	PERIPHERAL VASCULAR DISORDERS W/O CC	.6050	3.7	4.5
132 ...	05	MED	ATHEROSCLEROSIS W CC	.6713	2.5	3.1
133 ...	05	MED	ATHEROSCLEROSIS W/O CC	.5675	1.9	2.4
134 ...	05	MED	HYPERTENSION	.5846	2.6	3.3
135 ...	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE ≤17 W CC.	.8704	3.3	4.4
136 ...	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE ≤17 W/O CC.	.6004	2.3	2.9
137 ...	05	MED	*CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0–17	.8188	3.3	3.3
138 ...	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	.8154	3.1	4.0
139 ...	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	.5079	2.1	2.5
140 ...	05	MED	ANGINA PECTORIS	.5829	2.3	2.8
141 ...	05	MED	SYNCOPE & COLLAPSE W CC	.7091	2.9	3.7
142 ...	05	MED	SYNCOPE & COLLAPSE W/O CC	.5419	2.2	2.7
143 ...	05	MED	CHEST PAIN	.5342	1.8	2.2
144 ...	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	1.1526	3.8	5.4
145 ...	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	.6497	2.2	2.8
146 ...	06	SURG	RECTAL RESECTION W CC	2.7862	9.1	10.3
147 ...	06	SURG	RECTAL RESECTION W/O CC	1.6382	6.1	6.7
148 ...	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	3.4289	10.1	12.1
149 ...	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.5723	6.2	6.7
150 ...	06	SURG	PERITONEAL ADHESIOLYSIS W CC	2.8098	9.0	11.0
151 ...	06	SURG	PERITONEAL ADHESIOLYSIS W/O CC	1.3437	4.9	6.0
152 ...	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.9606	6.9	8.3
153 ...	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.2170	5.0	5.6
154 ...	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC.	4.1335	10.1	13.2
155 ...	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC.	1.3781	3.5	4.5
156 ...	06	SURG	*STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0–17.	.8432	6.0	6.0
157 ...	06	SURG	ANAL & STOMAL PROCEDURES W CC	1.2392	4.0	5.6
158 ...	06	SURG	ANAL & STOMAL PROCEDURES W/O CC	.6561	2.1	2.6
159 ...	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC.	1.3097	3.7	5.0
160 ...	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC.	.7801	2.2	2.7
161 ...	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	1.0976	2.9	4.2
162 ...	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	.6283	1.6	2.0
163 ...	06	SURG	*HERNIA PROCEDURES AGE 0–17	.8720	2.1	2.1
164 ...	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	2.3463	7.3	8.5
165 ...	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	1.2655	4.4	4.9
166 ...	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	1.4788	4.1	5.1
167 ...	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	.8995	2.4	2.8
168 ...	03	SURG	MOUTH PROCEDURES W CC	1.2039	3.3	4.6
169 ...	03	SURG	MOUTH PROCEDURES W/O CC	.7492	1.9	2.5
170 ...	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	2.8435	7.8	11.3
171 ...	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC	1.2556	3.6	4.8
172 ...	06	MED	DIGESTIVE MALIGNANCY W CC	1.3144	5.1	6.9
173 ...	06	MED	DIGESTIVE MALIGNANCY W/O CC	.7123	2.7	3.8
174 ...	06	MED	G.I. HEMORRHAGE W CC	.9981	3.9	4.9
175 ...	06	MED	G.I. HEMORRHAGE W/O CC	.5456	2.5	2.9
176 ...	06	MED	COMPLICATED PEPTIC ULCER	1.0968	4.1	5.3
177 ...	06	MED	UNCOMPLICATED PEPTIC ULCER W CC	.8802	3.7	4.5
178 ...	06	MED	UNCOMPLICATED PEPTIC ULCER W/O CC	.6502	2.6	3.2
179 ...	06	MED	INFLAMMATORY BOWEL DISEASE	1.0869	4.8	6.2
180 ...	06	MED	G.I. OBSTRUCTION W CC	.9206	4.2	5.4
181 ...	06	MED	G.I. OBSTRUCTION W/O CC	.5277	2.8	3.4
182 ...	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST. DISORDERS AGE >17 W CC.	.7821	3.4	4.3
183 ...	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST. DISORDERS AGE >17 W/O CC.	.5710	2.4	3.0
184 ...	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST. DISORDERS AGE 0–17.	.5286	2.3	3.0
185 ...	03	MED	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17.	.8593	3.3	4.5
186 ...	03	MED	*DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0–17.	.3214	2.9	2.9
187 ...	03	MED	DENTAL EXTRACTIONS & RESTORATIONS	.7790	2.9	3.9
188 ...	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	1.0942	4.1	5.6

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS
189 ...	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	.5831	2.4	3.2
190 ...	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0–17	1.0011	3.9	5.6
191 ...	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W CC	4.3837	10.6	14.2
192 ...	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	1.8454	5.7	7.0
193 ...	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC.	3.4161	10.3	12.6
194 ...	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC.	1.6401	5.4	6.6
195 ...	07	SURG	CHOLECYSTECTOMY W C.D.E. W CC	2.9359	8.4	10.0
196 ...	07	SURG	CHOLECYSTECTOMY W C.D.E. W/O CC	1.6554	4.9	5.7
197 ...	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC.	2.4183	7.1	8.6
198 ...	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC.	1.2324	3.9	4.5
199 ...	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	2.3317	7.1	9.6
200 ...	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON–MALIGNANCY.	3.0708	7.2	11.1
201 ...	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES	3.5838	10.3	14.1
202 ...	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS	1.3188	5.0	6.6
203 ...	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	1.3046	5.0	6.7
204 ...	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	1.2161	4.6	6.0
205 ...	07	MED	DISORDERS OF LIVER EXCEPT MALIG, CIRR, ALC HEPA W CC	1.1816	4.7	6.4
206 ...	07	MED	DISORDERS OF LIVER EXCEPT MALIG, CIRR, ALC HEPA W/O CC.	.7163	3.1	4.1
207 ...	07	MED	DISORDERS OF THE BILIARY TRACT W CC	1.1013	4.0	5.2
208 ...	07	MED	DISORDERS OF THE BILIARY TRACT W/O CC	.6455	2.3	2.9
209 ...	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF LOWER EXTREMITY.	2.1175	4.6	5.2
210 ...	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC.	1.8028	5.9	6.8
211 ...	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC.	1.2609	4.5	4.9
212 ...	08	SURG	*HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0–17	.8468	11.1	11.1
213 ...	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS.	1.7130	6.1	8.3
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.	2.1400	6.9	9.6
217 ...	08	SURG	WND DEBRID & SKN GRFT EXCEPT HAND, FOR MUSCSKELET & CONN TISS DIS.	2.8006	8.6	12.6
218 ...	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W CC.	1.4900	4.2	5.3
219 ...	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W/O CC.	1.0117	2.7	3.2
220 ...	08	SURG	*LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE 0–17.	.5841	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.	.9378	2.0	2.6
224 ...	08	SURG	SHOULDER, ELBOW OR FOREARM PROC, EXC MAJOR JOINT PROC, W/O CC.	.8042	1.7	2.0
225 ...	08	SURG	FOOT PROCEDURES	1.0518	3.2	4.5
226 ...	08	SURG	SOFT TISSUE PROCEDURES W CC	1.4383	4.1	6.0
227 ...	08	SURG	SOFT TISSUE PROCEDURES W/O CC	.8181	2.1	2.8
228 ...	08	SURG	MAJOR THUMB OR JOINT PROC, OR OTH HAND OR WRIST PROC W CC.	1.0516	2.4	3.6
229 ...	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	.7348	1.9	2.4
230 ...	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR.	1.1722	3.2	4.8
231 ...	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES EXCEPT HIP & FEMUR.	1.3623	3.1	4.6
232 ...	08	SURG	ARTHROSCOPY	1.1567	2.4	4.1
233 ...	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	2.0424	5.3	7.5
234 ...	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC.	1.2450	2.7	3.5
235 ...	08	MED	FRACTURES OF FEMUR	.7479	3.8	5.1
236 ...	08	MED	FRACTURES OF HIP & PELVIS	.7157	3.9	5.0
237 ...	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	.5451	2.9	3.6

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS
238 ...	08	MED	OSTEOMYELITIS	1.2831	6.4	8.4
239 ...	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY.	.9660	4.9	6.3
240 ...	08	MED	CONNECTIVE TISSUE DISORDERS W CC	1.2328	5.0	6.7
241 ...	08	MED	CONNECTIVE TISSUE DISORDERS W/O CC	.6089	3.2	4.0
242 ...	08	MED	SEPTIC ARTHRITIS	1.0168	5.1	6.7
243 ...	08	MED	MEDICAL BACK PROBLEMS	.7164	3.7	4.7
244 ...	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	.7024	3.8	4.8
245 ...	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	.4801	2.8	3.6
246 ...	08	MED	NON-SPECIFIC ARTHROPATHIES	.5545	3.0	3.7
247 ...	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE.	.5563	2.6	3.4
248 ...	08	MED	TENDONITIS, MYOSITIS & BURSITIS	.7554	3.6	4.6
249 ...	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE.	.6504	2.5	3.5
250 ...	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC.	.6700	3.2	4.1
251 ...	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC.	.4608	2.3	2.9
252 ...	08	MED	*FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0–17	.2537	1.8	1.8
253 ...	08	MED	FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE >17 W CC.	.7261	3.7	4.8
254 ...	08	MED	FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE >17 W/O CC.	.4339	2.6	3.2
255 ...	08	MED	*FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE 0–17.	.2954	2.9	2.9
256 ...	08	MED	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES.	.7687	3.8	5.1
257 ...	09	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W CC	.9134	2.3	2.9
258 ...	09	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	.7227	1.8	2.1
259 ...	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	.8673	1.9	2.8
260 ...	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	.6444	1.3	1.5
261 ...	09	SURG	BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION.	.9188	1.7	2.2
262 ...	09	SURG	BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY	.8392	2.7	3.9
263 ...	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC.	2.0609	8.7	11.8
264 ...	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC.	1.1216	5.3	7.1
265 ...	09	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC.	1.5650	4.4	7.0
266 ...	09	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC.	.8495	2.4	3.3
267 ...	09	SURG	PERIANAL & PILONIDAL PROCEDURES	.9815	2.9	4.1
268 ...	09	SURG	SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES.	1.1979	2.4	3.8
269 ...	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.6147	5.6	7.9
270 ...	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC	.7447	2.2	3.1
271 ...	09	MED	SKIN ULCERS	.9905	5.6	7.1
272 ...	09	MED	MAJOR SKIN DISORDERS W CC	1.0003	4.8	6.3
273 ...	09	MED	MAJOR SKIN DISORDERS W/O CC	.6275	3.3	4.4
274 ...	09	MED	MALIGNANT BREAST DISORDERS W CC	1.1335	4.7	6.6
275 ...	09	MED	MALIGNANT BREAST DISORDERS W/O CC	.6322	2.6	3.9
276 ...	09	MED	NON-MALIGANT BREAST DISORDERS	.6529	3.5	4.4
277 ...	09	MED	CELLULITIS AGE >17 W CC	.8312	4.7	5.8
278 ...	09	MED	CELLULITIS AGE >17 W/O CC	.5621	3.7	4.4
279 ...	09	MED	CELLULITIS AGE 0–17	.6641	4.1	5.1
280 ...	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC	.6736	3.3	4.2
281 ...	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC.	.4596	2.4	3.1
282 ...	09	MED	*TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0–17	.2569	2.2	2.2
283 ...	09	MED	MINOR SKIN DISORDERS W CC	.7129	3.6	4.7
284 ...	09	MED	MINOR SKIN DISORDERS W/O CC	.4373	2.5	3.2
285 ...	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE, NUTRIT, & METABOL DISORDERS.	2.0217	7.7	10.6
286 ...	10	SURG	ADRENAL & PITUITARY PROCEDURES	2.2287	5.2	6.6
287 ...	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS.	1.8045	7.4	10.4
288 ...	10	SURG	O.R. PROCEDURES FOR OBESITY	2.0665	4.6	5.7
289 ...	10	SURG	PARATHYROID PROCEDURES	.9756	2.1	3.0

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS
290 ...	10	SURG	THYROID PROCEDURES	.9174	1.9	2.4
291 ...	10	SURG	THYROGLOSSAL PROCEDURES	.6732	1.6	2.0
292 ...	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	2.4719	7.1	10.4
293 ...	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	1.1942	3.5	5.0
294 ...	10	MED	DIABETES AGE >35	.7518	3.7	4.7
295 ...	10	MED	DIABETES AGE 0–35	.7464	3.0	3.9
296 ...	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	.8556	4.0	5.3
297 ...	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC.	.5204	2.8	3.5
298 ...	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0–17	.4954	2.4	3.5
299 ...	10	MED	INBORN ERRORS OF METABOLISM	.9475	3.8	5.4
300 ...	10	MED	ENDOCRINE DISORDERS W CC	1.0779	4.8	6.2
301 ...	10	MED	ENDOCRINE DISORDERS W/O CC	.5889	2.8	3.6
302 ...	11	SURG	KIDNEY TRANSPLANT	3.5669	8.2	9.7
303 ...	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM.	2.5401	7.2	8.8
304 ...	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC.	2.3458	6.5	8.9
305 ...	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC.	1.1857	3.2	3.9
306 ...	11	SURG	PROSTATECTOMY W CC	1.2448	3.7	5.4
307 ...	11	SURG	PROSTATECTOMY W/O CC	.6588	2.0	2.4
308 ...	11	SURG	MINOR BLADDER PROCEDURES W CC	1.5907	4.1	6.1
309 ...	11	SURG	MINOR BLADDER PROCEDURES W/O CC	.9442	2.0	2.5
310 ...	11	SURG	TRANSURETHRAL PROCEDURES W CC	1.0869	3.0	4.3
311 ...	11	SURG	TRANSURETHRAL PROCEDURES W/O CC	.6126	1.6	1.9
312 ...	11	SURG	URETHRAL PROCEDURES, AGE >17 W CC	1.0270	3.1	4.6
313 ...	11	SURG	URETHRAL PROCEDURES, AGE >17 W/O CC	.6640	1.8	2.4
314 ...	11	SURG	*URETHRAL PROCEDURES, AGE 0–17	.4950	2.3	2.3
315 ...	11	SURG	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	2.0660	4.5	7.8
316 ...	11	MED	RENAL FAILURE	1.3380	4.9	6.7
317 ...	11	MED	ADMIT FOR RENAL DIALYSIS	.6965	2.1	3.2
318 ...	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W CC	1.1413	4.4	6.0
319 ...	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W/O CC	.6187	2.1	2.9
320 ...	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	.8647	4.4	5.4
321 ...	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	.5785	3.3	3.9
322 ...	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE 0–17	.5606	3.0	3.7
323 ...	11	MED	URINARY STONES W CC, &/OR ESW LITHOTRIPSY	.7816	2.4	3.2
324 ...	11	MED	URINARY STONES W/O CC	.4475	1.6	1.9
325 ...	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC.	.6287	3.0	3.9
326 ...	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC.	.4203	2.2	2.7
327 ...	11	MED	*KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0–17	.3541	3.1	3.1
328 ...	11	MED	URETHRAL STRICTURE AGE >17 W CC	.7024	2.7	3.7
329 ...	11	MED	URETHRAL STRICTURE AGE >17 W/O CC	.5172	1.7	2.4
330 ...	11	MED	*URETHRAL STRICTURE AGE 0–17	.3189	1.6	1.6
331 ...	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC	1.0157	4.1	5.5
332 ...	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC.	.6104	2.6	3.4
333 ...	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0–17	.7642	3.3	4.4
334 ...	12	SURG	MAJOR MALE PELVIC PROCEDURES W CC	1.5864	4.3	5.0
335 ...	12	SURG	MAJOR MALE PELVIC PROCEDURES W/O CC	1.1911	3.3	3.5
336 ...	12	SURG	TRANSURETHRAL PROSTATECTOMY W CC	.8965	2.8	3.6
337 ...	12	SURG	TRANSURETHRAL PROSTATECTOMY W/O CC	.6229	2.0	2.2
338 ...	12	SURG	TESTES PROCEDURES, FOR MALIGNANCY	1.1552	3.3	5.1
339 ...	12	SURG	TESTES PROCEDURES, NON-MALIGNANCY AGE >17	1.0600	2.9	4.5
340 ...	12	SURG	*TESTES PROCEDURES, NON-MALIGNANCY AGE 0–17	.2834	2.4	2.4
341 ...	12	SURG	PENIS PROCEDURES	1.1141	2.1	3.2
342 ...	12	SURG	CIRCUMCISION AGE >17	.8601	2.6	3.5
343 ...	12	SURG	*CIRCUMCISION AGE 0–17	.1540	1.7	1.7
344 ...	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY.	1.1025	1.6	2.4
345 ...	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY.	.8816	2.5	3.7
346 ...	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC	.9645	4.2	5.7
347 ...	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC	.5828	2.3	3.1
348 ...	12	MED	BENIGN PROSTATIC HYPERTROPHY W CC	.6983	3.2	4.2
349 ...	12	MED	BENIGN PROSTATIC HYPERTROPHY W/O CC	.4345	2.0	2.5
350 ...	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	.6957	3.6	4.4

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS
351 ...	12	MED	*STERILIZATION, MALE	.2363	1.3	1.3
352 ...	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	.6769	2.7	3.9
353 ...	13	SURG	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY.	1.9721	5.4	7.1
354 ...	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC.	1.5134	4.8	5.8
355 ...	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC.	.9477	3.2	3.4
356 ...	13	SURG	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES.	.7916	2.2	2.6
357 ...	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY.	2.3699	7.0	8.7
358 ...	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	1.2357	3.7	4.4
359 ...	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	.8699	2.7	2.9
360 ...	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES	.8823	2.5	3.0
361 ...	13	SURG	LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	1.1894	2.4	3.4
362 ...	13	SURG	*ENDOSCOPIC TUBAL INTERRUPTION	.3020	1.4	1.4
363 ...	13	SURG	D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	.7807	2.5	3.3
364 ...	13	SURG	D&C, CONIZATION EXCEPT FOR MALIGNANCY	.7601	2.6	3.5
365 ...	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	1.8299	4.9	7.1
366 ...	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	1.2474	4.7	6.8
367 ...	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	.5509	2.2	3.0
368 ...	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	1.0499	4.8	6.2
369 ...	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS.	.5526	2.4	3.2
370 ...	14	SURG	CESAREAN SECTION W CC	1.0974	4.4	5.9
371 ...	14	SURG	CESAREAN SECTION W/O CC	.7212	3.3	3.6
372 ...	14	MED	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	.5920	2.6	3.5
373 ...	14	MED	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	.4020	1.9	2.1
374 ...	14	SURG	VAGINAL DELIVERY W STERILIZATION &/OR D&C	.7081	2.5	3.2
375 ...	14	SURG	*VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	.6856	4.4	4.4
376 ...	14	MED	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE.	.5342	2.4	3.4
377 ...	14	SURG	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE.	1.3506	3.1	5.4
378 ...	14	MED	ECTOPIC PREGNANCY	.9394	2.2	2.8
379 ...	14	MED	THREATENED ABORTION	.4424	2.1	3.1
380 ...	14	MED	ABORTION W/O D&C	.3404	1.6	1.9
381 ...	14	SURG	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY.	.6002	1.7	2.3
382 ...	14	MED	FALSE LABOR	.2045	1.2	1.3
383 ...	14	MED	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS.	.5334	2.8	4.0
384 ...	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS.	.3437	1.8	2.4
385 ...	15		*NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY.	1.3760	1.8	1.8
386 ...	15		*EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE.	4.5376	17.9	17.9
387 ...	15		*PREMATURITY W MAJOR PROBLEMS	3.0991	13.3	13.3
388 ...	15		*PREMATURITY W/O MAJOR PROBLEMS	1.8699	8.6	8.6
389 ...	15		*FULL TERM NEONATE W MAJOR PROBLEMS	1.8398	4.7	4.7
390 ...	15		*NEONATE W OTHER SIGNIFICANT PROBLEMS	1.6011	3.4	3.4
391 ...	15		*NORMAL NEWBORN	.1526	3.1	3.1
392 ...	16	SURG	SPLENECTOMY AGE >17	3.1411	7.2	9.7
393 ...	16	SURG	*SPLENECTOMY AGE 0–17	1.3479	9.1	9.1
394 ...	16	SURG	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS.	1.6806	4.1	6.8
395 ...	16	MED	RED BLOOD CELL DISORDERS AGE >17	.8168	3.3	4.6
396 ...	16	MED	RED BLOOD CELL DISORDERS AGE 0–17	1.0917	2.1	3.2
397 ...	16	MED	COAGULATION DISORDERS	1.2154	3.9	5.4
398 ...	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	1.2507	4.7	6.0
399 ...	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC	.7085	3.0	3.7
400 ...	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE	2.6610	5.9	9.1
401 ...	17	SURG	LYMPHOMA & NON–ACUTE LEUKEMIA W OTHER O.R. PROC W CC.	2.6191	7.8	11.1
402 ...	17	SURG	LYMPHOMA & NON–ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC.	1.0641	2.8	4.2
403 ...	17	MED	LYMPHOMA & NON–ACUTE LEUKEMIA W CC	1.7181	5.7	8.1
404 ...	17	MED	LYMPHOMA & NON–ACUTE LEUKEMIA W/O CC	.8549	3.2	4.3

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS
405 ...	17		*ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0–17 ...	1.9110	4.9	4.9
406 ...	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC.	2.7833	7.5	10.1
407 ...	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC.	1.2463	3.4	4.2
408 ...	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC.	1.9990	4.7	7.7
409 ...	17	MED	RADIOTHERAPY	1.0631	4.5	6.1
410 ...	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS.	.9015	2.8	3.6
411 ...	17	MED	HISTORY OF MALIGNANCY W/O ENDOSCOPY	.4335	1.9	2.4
412 ...	17	MED	HISTORY OF MALIGNANCY W ENDOSCOPY	.4070	1.5	2.0
413 ...	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC.	1.3925	5.5	7.5
414 ...	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC.	.7824	3.1	4.2
415 ...	18	SURG	O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	3.5541	10.3	14.1
416 ...	18	MED	SEPTICEMIA AGE >17	1.4988	5.6	7.3
417 ...	18	MED	SEPTICEMIA AGE 0–17	.8695	3.5	4.8
418 ...	18	MED	POSTOPERATIVE & POST–TRAUMATIC INFECTIONS	.9931	4.8	6.1
419 ...	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W CC	.8885	3.9	4.9
420 ...	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	.6136	3.0	3.7
421 ...	18	MED	VIRAL ILLNESS AGE >17	.6663	3.1	3.9
422 ...	18	MED	VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0–17	.4792	2.4	3.0
423 ...	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	1.6019	5.7	7.7
424 ...	19	SURG	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS.	2.3706	8.7	14.1
425 ...	19	MED	ACUTE ADJUSTMENT REACTION & PSYCHOLOGICAL DYSFUNCTION.	.6805	3.0	4.1
426 ...	19	MED	DEPRESSIVE NEUROSES	.5363	3.4	4.7
427 ...	19	MED	NEUROSES EXCEPT DEPRESSIVE	.5714	3.4	4.9
428 ...	19	MED	DISORDERS OF PERSONALITY & IMPULSE CONTROL	.6982	4.4	6.9
429 ...	19	MED	ORGANIC DISTURBANCES & MENTAL RETARDATION	.8448	4.9	6.7
430 ...	19	MED	PSYCHOSES	.7881	6.0	8.4
431 ...	19	MED	CHILDHOOD MENTAL DISORDERS	.7532	4.7	7.1
432 ...	19	MED	OTHER MENTAL DISORDER DIAGNOSES	.7083	3.3	5.2
433 ...	20		ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	.2961	2.3	3.1
434 ...	20		ALC/DRUG ABUSE OR DEPEND, DETOX OR OTH SYMPT TREAT W CC.	.7296	3.9	5.2
435 ...	20		ALC/DRUG ABUSE OR DEPEND, DETOX OR OTH SYMPT TREAT W/O CC.	.4275	3.4	4.4
436 ...	20		ALC/DRUG DEPENDENCE W REHABILITATION THERAPY	.7850	10.7	13.6
437 ...	20		ALC/DRUG DEPENDENCE, COMBINED REHAB & DETOX THERAPY.	.6864	7.5	9.0
438 ...			NO LONGER VALID	.0000	.0	.0
439 ...	21	SURG	SKIN GRAFTS FOR INJURIES	1.6571	5.0	7.5
440 ...	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES	1.9354	5.7	9.0
441 ...	21	SURG	HAND PROCEDURES FOR INJURIES	.9179	2.2	3.1
442 ...	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W CC	2.2454	5.2	7.9
443 ...	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W/O CC	.9614	2.5	3.3
444 ...	21	MED	TRAUMATIC INJURY AGE >17 W CC	.7087	3.3	4.3
445 ...	21	MED	TRAUMATIC INJURY AGE >17 W/O CC	.4800	2.4	3.0
446 ...	21	MED	*TRAUMATIC INJURY AGE 0–17	.2962	2.4	2.4

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS
447 ...	21	MED	ALLERGIC REACTIONS AGE >17	.5220	1.9	2.5
448 ...	21	MED	*ALLERGIC REACTIONS AGE 0–17	.0974	2.9	2.9
449 ...	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC	.8149	2.6	3.7
450 ...	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC	.4352	1.6	2.0
451 ...	21	MED	*POISONING & TOXIC EFFECTS OF DRUGS AGE 0–17	.2631	2.1	2.1
452 ...	21	MED	COMPLICATIONS OF TREATMENT W CC	.9920	3.5	4.9
453 ...	21	MED	COMPLICATIONS OF TREATMENT W/O CC	.5060	2.2	2.9
454 ...	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC	.8152	3.2	4.5
455 ...	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC	.4663	1.9	2.6
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.	1.1309	2.4	4.5
462 ...	23	MED	REHABILITATION	1.3599	9.9	12.4
463 ...	23	MED	SIGNS & SYMPTOMS W CC	.6811	3.3	4.3
464 ...	23	MED	SIGNS & SYMPTOMS W/O CC	.4942	2.5	3.2
465 ...	23	MED	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS.	.6720	2.0	3.6
466 ...	23	MED	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS.	.7129	2.3	4.0
467 ...	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	.4986	2.1	3.3
468 ...			EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	3.6400	9.3	13.2
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.	3.2205	4.9	5.6
472 ...			NO LONGER VALID	.0000	.0	.0
473 ...	17		ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	3.7200	7.8	13.4
474 ...			NO LONGER VALID	.0000	.0	.0
475 ...	04	MED	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT.	3.7065	8.0	11.2
476 ...	.....	SURG	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	2.2633	8.6	11.7
477 ...		SURG	NON–EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	1.7696	5.3	8.1
478 ...	05	SURG	OTHER VASCULAR PROCEDURES W CC	2.3515	5.0	7.3
479 ...	05	SURG	OTHER VASCULAR PROCEDURES W/O CC	1.4618	2.9	3.8
480 ...		SURG LIVER TRANS PLANT	10.7834	17.5	23.1	
481 ...		SURG	BONE MARROW TRANSPLANT	8.7285	21.9	24.9
482 ...		SURG	TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES	3.6454	9.9	12.9
483 ...		SURG	TRACHEOSTOMY EXCEPT FOR FACE, MOUTH & NECK DIAGNOSES.	16.1211	33.0	40.9
484 ...	24	SURG	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	5.5421	8.9	13.3
485 ...	24	SURG	LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TRA.	3.0757	7.4	9.2

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS
486 ...	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA.	4.8962	8.4	12.3
487 ...	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA	1.9536	5.3	7.4
488 ...	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE	4.7891	12.0	18.1
489 ...	25	MED	HIV W MAJOR RELATED CONDITION	1.7913	6.1	8.8
490 ...	25	MED	HIV W OR W/O OTHER RELATED CONDITION	.9651	3.8	5.3
491 ...	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY.	1.6673	3.0	3.5
492 ...	17	MED	CHEMOTHERAPY W ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS.	4.4470	11.4	16.8
493 ...	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.8290	4.3	5.7
494 ...	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	1.0246	2.0	2.5
495 ...		SURG	LUNG TRANSPLANT	8.8332	12.9	15.6
496 ...	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION	5.6871	8.4	10.8
497 ...	08	SURG	SPINAL FUSION W CC	2.8441	4.9	6.3
498 ...	08	SURG	SPINAL FUSION W/O CC	1.7952	2.8	3.4
499 ...	08	SURG	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC	1.4487	3.6	4.8
500 ...	08	SURG	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC	.9836	2.3	2.8
501 ...	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W CC	2.5305	8.0	10.0
502 ...	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W/O CC	1.5559	5.2	6.3
503 ...	08	SURG	KNEE PROCEDURES W/O PDX OF INFECTION	1.2029	3.1	4.0
504 ...	22	SURG	EXTENSIVE 3RD DEGREE BURNS W SKIN GRAFT	13.2930	24.0	31.6
505 ...	22		EXTENSIVE 3RD DEGREE BURNS W/O SKIN GRAFT	2.2593	2.6	5.2
506 ...	22		FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA.	4.2007	12.5	16.8
507 ...	22		FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA.	1.8942	6.8	9.5
508 ...	22		FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ W CC OR SIG TRAUMA.	1.5971	5.8	8.6
509 ...	22		FULL THICKNESS BURN W/O SKIN GRFT OR INH INJ W/O CC OR SIG TRAUMA.	.8554	3.9	5.4
510 ...	22		NON–EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA	1.3335	5.1	7.3
511 ...	22		NON–EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA	.8312	3.6	5.2

*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

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY

[FY98 MEDPAR Update 03/99 Grouper V16.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
1	36836	9.2593	2	4	7	12	19
2	7214	9.8343	3	5	7	12	19
3	7	10.5714	1	4	12	12	14
4	6080	7.4523	1	3	5	9	16
5	99334	3.4177	1	1	2	4	7
6	378	3.1138	1	1	2	4	7
7	11825	9.7856	2	4	7	12	19
8	3419	3.1120	1	1	2	4	7
9	1714	6.1190	1	3	5	8	12
10	19310	6.5665	2	3	5	8	13
11	3187	4.0446	1	2	3	5	8
12	44543	6.2764	2	3	4	7	12
13	6583	5.1621	2	3	4	6	9
14	356495	6.0058	2	3	5	7	11
15	144927	3.7348	1	2	3	5	7
16	12107	5.9202	2	3	5	7	11
17	3316	3.3685	1	2	3	4	6
18	27243	5.4721	2	3	4	7	10
19	7972	3.7881	1	2	3	5	7
20	6169	9.9651	2	5	8	13	19
21	1426	6.8079	2	3	5	9	13
22	2583	4.9001	2	2	4	6	9
23	7700	4.1762	1	2	3	5	8
24	54812	5.0310	1	2	4	6	10

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 03/99 Grouper V16.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
25	24401	3.3481	1	2	3	4	6
26	29	3.5862	1	1	3	4	6
27	3652	5.2916	1	1	3	7	12
28	11240	6.0932	1	3	5	8	12
29	3756	3.6140	1	2	3	5	7
30	1	13.0000	13	13	13	13	13
31	3208	4.3332	1	2	3	5	8
32	1420	2.6901	1	1	2	3	5
34	20085	5.3312	1	2	4	6	10
35	4903	3.4852	1	2	3	4	7
36	4666	1.4256	1	1	1	1	2
37	1560	3.8372	1	1	3	4	8
38	107	2.6355	1	1	2	3	5
39	1469	1.8693	1	1	1	2	4
40	1988	3.3441	1	1	2	4	7
42	3314	2.1177	1	1	1	2	4
43	85	4.0471	1	2	2	4	7
44	1360	4.9669	2	3	4	6	9
45	2503	3.4259	1	2	3	4	6
46	3061	4.5541	1	2	3	6	9
47	1208	3.1283	1	1	2	4	6
48	1	6.0000	6	6	6	6	6
49	2282	5.0206	1	2	4	6	10
50	2831	1.9947	1	1	1	2	3
51	278	2.8921	1	1	1	3	7
52	243	1.9506	1	1	1	2	3
53	2719	3.6348	1	1	2	4	8
54	1	1.0000	1	1	1	1	1
55	1561	2.8482	1	1	2	3	6
56	587	2.8399	1	1	2	3	6
57	501	4.7665	1	1	3	5	12
59	79	2.5316	1	1	2	3	6
60	4	1.2500	1	1	1	1	2
61	239	4.8075	1	1	3	6	10
62	2	2.5000	2	2	3	3	3
63	3306	4.4574	1	2	3	5	9
64	3302	6.6087	1	2	4	8	14
65	31897	2.9095	1	1	2	4	5
66	7003	3.2128	1	2	3	4	6
67	512	3.7051	1	2	3	4	7
68	13164	4.1907	2	2	3	5	7
69	4092	3.3140	1	2	3	4	6
70	38	2.7368	1	2	2	3	5
71	109	3.4037	1	2	3	4	6
72	804	3.5162	1	2	3	4	7
73	6475	4.3396	1	2	3	5	8
74	1	2.0000	2	2	2	2	2
75	40541	9.9139	3	5	7	12	19
76	40510	11.0970	3	5	9	14	21
77	2204	5.1134	1	2	4	7	10
78	30089	7.0769	3	5	6	9	12
79	204223	8.4303	3	4	7	10	16
80	8430	5.5426	2	3	5	7	10
81	9	6.1111	1	4	6	7	9
82	67992	6.9678	2	3	5	9	14
83	6986	5.4814	2	3	4	7	10
84	1530	3.2170	1	2	3	4	6
85	21593	6.5211	2	3	5	8	13
86	1741	3.7731	1	2	3	5	7
87	67713	6.2694	1	3	5	8	12
88	398220	5.2575	2	3	4	7	9
89	510879	6.1132	2	3	5	8	11
90	46381	4.3406	2	3	4	5	7
91	64	3.9531	1	2	3	5	7
92	14187	6.2415	2	3	5	8	12
93	1438	4.2976	1	2	4	6	8
94	13076	6.3852	2	3	5	8	12
95	1514	3.6242	1	2	3	4	7
96	63671	4.7632	2	3	4	6	8
97	28420	3.7362	1	2	3	5	7

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 03/99 Grouper V16.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
98	18	4.5000	2	2	3	4	5
99	19449	3.1467	1	1	2	4	6
100	7748	2.1705	1	1	2	3	4
101	20140	4.4049	1	2	3	6	8
102	4778	2.6877	1	1	2	3	5
103	547	56.5466	9	15	39	81	126
104	32842	11.8946	3	6	10	15	22
105	28697	9.4228	4	5	7	11	17
106	3906	10.9158	5	7	9	13	18
107	97459	10.4755	5	7	9	12	17
108	5282	10.9737	3	6	9	14	21
109	66660	7.8095	4	5	7	9	13
110	59376	9.5303	2	5	8	11	18
111	6606	5.6197	2	4	6	7	8
112	80818	3.8201	1	1	3	5	8
113	46280	11.9185	3	5	9	15	23
114	8726	8.1877	2	4	7	10	16
115	14436	8.4070	2	4	7	11	16
116	272446	3.9260	1	1	3	5	8
117	3511	4.1398	1	1	3	5	9
118	6439	2.8987	1	1	2	4	6
119	1554	4.8932	1	1	3	6	11
120	36832	8.2211	1	2	5	11	18
121	169544	6.5073	2	4	5	8	12
122	83742	3.9783	1	2	4	5	7
123	42140	4.4070	1	1	2	6	10
124	145335	4.4326	1	2	3	6	8
125	69830	2.8428	1	1	2	4	6
126	5297	11.8577	3	6	9	15	23
127	725354	5.3846	2	3	4	7	10
128	13964	5.8876	3	4	5	7	9
129	4522	2.8074	1	1	1	3	7
130	93798	5.8395	2	3	5	7	10
131	26368	4.4800	1	3	4	6	7
132	167891	3.0914	1	2	2	4	6
133	7132	2.3751	1	1	2	3	4
134	32871	3.3420	1	2	3	4	6
135	7556	4.3634	1	2	3	5	8
136	1151	2.9427	1	1	2	4	6
138	204380	3.9935	1	2	3	5	8
139	74952	2.5369	1	1	2	3	5
140	90171	2.8048	1	1	2	3	5
141	85551	3.7306	1	2	3	5	7
142	40836	2.7078	1	1	2	3	5
143	174426	2.1903	1	1	2	3	4
144	77995	5.3213	1	2	4	7	11
145	6796	2.8261	1	1	2	4	5
146	12246	10.3034	5	7	9	12	17
147	2305	6.7080	3	5	7	8	10
148	143500	12.1060	5	7	10	14	21
149	16362	6.7222	4	5	6	8	10
150	22214	11.0307	4	6	9	14	19
151	4386	5.9758	2	3	6	8	11
152	4778	8.3024	3	5	7	10	14
153	1793	5.6168	3	4	5	7	8
154	32409	13.1933	4	7	10	16	25
155	5603	4.5138	1	2	4	6	8
156	5	10.6000	2	2	11	13	22
157	8595	5.5779	1	2	4	7	11
158	4411	2.6384	1	1	2	3	5
159	17429	4.9651	1	2	4	6	10
160	10531	2.7382	1	1	2	4	5
161	12611	4.1561	1	2	3	5	9
162	6778	2.0031	1	1	1	2	4
163	6	3.3333	1	3	3	5	5
164	5103	8.5348	4	5	7	10	14
165	1821	4.9368	2	3	5	6	8
166	3423	5.1440	2	3	4	6	10
167	2688	2.7742	1	2	2	3	5
168	1682	4.6843	1	2	3	6	10

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 03/99 Grouper V16.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
169	866	2.5208	1	1	2	3	5
170	12216	11.2317	2	5	8	14	22
171	1060	4.7679	1	2	4	6	9
172	32209	6.9183	2	3	5	9	14
173	2318	3.8007	1	1	3	5	8
174	250706	4.8426	2	3	4	6	9
175	25360	2.9403	1	2	3	4	5
176	17698	5.2788	2	3	4	6	10
177	10596	4.4886	2	2	4	6	8
178	3611	3.1742	1	2	3	4	6
179	12438	6.1530	2	3	5	8	12
180	90784	5.3432	2	3	4	7	10
181	24531	3.4095	1	2	3	4	6
182	236683	4.3360	1	2	3	5	8
183	77376	2.9902	1	1	2	4	6
184	89	3.0225	1	1	2	3	7
185	4281	4.5359	1	2	3	6	9
186	7	3.2857	1	2	3	4	4
187	865	3.9052	1	2	3	5	8
188	76094	5.5497	1	2	4	7	11
189	9709	3.2163	1	1	2	4	6
190	69	5.6087	1	2	4	7	9
191	9760	14.1831	4	7	10	17	28
192	838	7.0251	2	4	6	9	11
193	6564	12.6140	5	7	10	15	23
194	743	6.5639	2	4	6	8	11
195	5935	9.9928	4	6	8	12	17
196	1267	5.6780	2	4	5	7	9
197	23028	8.6261	3	5	7	10	15
198	6393	4.5098	2	3	4	6	8
199	1894	9.6172	2	4	7	13	19
200	1196	10.9983	2	4	8	14	22
201	1515	14.0614	4	6	11	18	28
202	27560	6.5773	2	3	5	8	13
203	30112	6.7066	2	3	5	9	13
204	55486	5.9715	2	3	5	7	11
205	23295	6.3206	2	3	5	8	12
206	1730	4.0694	1	2	3	5	8
207	32811	5.1164	1	2	4	6	10
208	9895	2.9051	1	1	2	4	6
209	355057	5.1351	3	3	4	6	8
210	134595	6.7578	3	4	6	8	11
211	29234	4.9046	3	3	4	6	7
212	8	3.6250	1	2	4	5	5
213	7936	8.3266	2	4	6	10	17
216	6080	9.5355	2	4	7	12	19
217	19791	12.6226	3	5	9	15	27
218	22787	5.2827	2	3	4	6	10
219	19533	3.1973	1	2	3	4	5
220	4	9.2500	1	1	6	12	18
223	17962	2.5659	1	1	2	3	5
224	8009	2.0411	1	1	2	3	4
225	5837	4.4655	1	2	3	6	9
226	5298	5.9932	1	2	4	8	12
227	4340	2.7548	1	1	2	3	5
228	2585	3.5791	1	1	2	4	8
229	1157	2.4408	1	1	2	3	4
230	2300	4.7948	1	2	3	6	10
231	11018	4.6331	1	2	3	6	10
232	535	4.0748	1	1	2	5	9
233	4876	7.5070	2	3	5	9	16
234	2587	3.4519	1	2	3	4	7
235	5406	5.0218	1	2	4	6	9
236	39509	4.9105	1	3	4	6	9
237	1711	3.5634	1	2	3	4	6
238	7793	8.3853	3	4	6	10	16
239	55949	6.2607	2	3	5	8	12
240	12987	6.6413	2	3	5	8	13
241	3039	4.0234	1	2	3	5	7
242	2683	6.6347	2	3	5	8	13

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 03/99 Grouper V16.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
243	84670	4.7255	1	3	4	6	9
244	12703	4.8316	1	3	4	6	9
245	4970	3.5777	1	2	3	4	7
246	1351	3.7187	1	2	3	5	7
247	14132	3.4177	1	2	3	4	7
248	9001	4.6185	1	2	4	6	9
249	10992	3.5375	1	1	2	4	7
250	3653	4.1237	1	2	3	5	8
251	2300	2.8961	1	1	2	4	5
253	19185	4.7469	1	3	4	6	9
254	10028	3.2017	1	2	3	4	6
256	5967	5.1324	1	2	4	6	10
257	19522	2.9195	1	2	2	3	5
258	16906	2.0608	1	1	2	2	3
259	3748	2.7620	1	1	2	3	6
260	4729	1.4743	1	1	1	2	2
261	1803	2.1780	1	1	1	3	4
262	653	3.9326	1	1	3	5	8
263	26034	11.3386	3	5	8	14	22
264	3840	6.9898	2	3	5	8	13
265	4133	6.9557	1	2	4	8	14
266	2546	3.3496	1	1	2	4	7
267	241	4.0788	1	1	3	5	9
268	897	3.8060	1	1	2	4	8
269	8851	7.8528	2	3	6	10	16
270	2749	3.1364	1	1	2	4	7
271	22655	7.0989	3	4	6	8	13
272	5664	6.2920	2	3	5	7	12
273	1357	4.3839	1	2	3	5	8
274	2464	6.5345	1	3	5	8	13
275	208	3.8894	1	1	2	5	8
276	1001	4.3906	1	2	4	5	8
277	84629	5.7563	2	3	5	7	10
278	27776	4.4282	2	3	4	5	8
279	11	5.0909	1	3	4	5	8
280	15056	4.2132	1	2	3	5	8
281	6510	3.0602	1	1	3	4	6
282	1	3.0000	3	3	3	3	3
283	5366	4.7128	1	2	4	6	9
284	1799	3.1957	1	1	3	4	6
285	6035	10.5781	3	5	8	13	21
286	2166	6.6307	2	3	5	8	13
287	6069	10.3935	3	5	7	12	20
288	2020	5.7025	3	3	4	6	9
289	4812	3.0247	1	1	2	3	6
290	8605	2.4284	1	1	2	3	4
291	76	2.0132	1	1	1	2	3
292	4847	10.4246	2	4	8	13	21
293	323	4.9567	1	2	4	6	11
294	84534	4.7447	1	2	4	6	9
295	3469	3.8665	1	2	3	5	7
296	234511	5.2830	2	3	4	6	10
297	36737	3.5367	1	2	3	4	6
298	90	3.4889	1	1	2	4	7
299	1124	5.3932	1	2	4	7	11
300	16177	6.2295	2	3	5	8	12
301	2822	3.5666	1	2	3	4	7
302	8038	9.6920	5	6	7	11	17
303	20077	8.7449	4	5	7	10	15
304	12388	8.8926	2	4	7	11	18
305	2795	3.9030	1	2	3	5	7
306	9132	5.4262	1	2	3	7	12
307	2186	2.3605	1	1	2	3	4
308	8285	6.1389	1	2	4	8	13
309	4064	2.5226	1	1	2	3	5
310	25390	4.3348	1	2	3	5	9
311	7973	1.9387	1	1	1	2	4
312	1665	4.5808	1	1	3	6	10
313	643	2.3919	1	1	2	3	5
314	1	2.0000	2	2	2	2	2

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 03/99 Grouper V16.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
315	28422	7.8309	1	2	5	10	17
316	94820	6.6602	2	3	5	8	13
317	801	3.1898	1	1	2	3	6
318	6098	5.9802	1	3	4	8	12
319	457	2.8665	1	1	2	4	6
320	183745	5.4047	2	3	4	7	10
321	26994	3.8755	2	2	3	5	7
322	68	3.6618	1	2	3	4	6
323	16793	3.2042	1	1	2	4	6
324	7668	1.9287	1	1	1	2	4
325	7806	3.8663	1	2	3	5	7
326	2390	2.7046	1	1	2	3	5
327	9	3.4444	1	2	3	6	6
328	691	3.7019	1	2	3	5	7
329	108	2.4259	1	1	1	3	5
331	45316	5.5090	1	3	4	7	11
332	4707	3.4391	1	1	3	4	7
333	267	4.4082	1	2	3	5	10
334	14231	4.9975	3	3	4	6	8
335	10417	3.5491	2	3	3	4	5
336	46652	3.6099	1	2	3	4	7
337	31028	2.2136	1	1	2	3	3
338	2147	5.1202	1	2	3	7	12
339	1813	4.4865	1	1	3	6	10
340	2	1.0000	1	1	1	1	1
341	4093	3.2057	1	1	2	3	6
342	880	3.4966	1	2	2	4	7
344	4123	2.3546	1	1	1	2	5
345	1236	3.7055	1	1	2	4	8
346	4984	5.7153	1	3	4	7	11
347	376	3.1303	1	1	2	4	7
348	3100	4.1839	1	2	3	5	8
349	600	2.5250	1	1	2	3	5
350	6572	4.3821	2	2	4	5	8
352	698	3.9169	1	1	3	5	7
353	2712	7.0749	3	4	5	8	13
354	9042	5.7710	3	3	4	6	10
355	5962	3.4074	2	3	3	4	5
356	28380	2.5532	1	2	2	3	4
357	6098	8.6471	3	5	7	10	16
358	25005	4.4148	2	3	3	5	7
359	29669	2.8899	2	2	3	3	4
360	17416	3.0307	1	2	3	3	5
361	478	3.3703	1	1	2	4	7
362	1	1.0000	1	1	1	1	1
363	3606	3.2887	1	2	2	3	7
364	1831	3.5281	1	1	2	4	7
365	2018	7.0927	2	3	5	9	15
366	4378	6.7106	1	3	5	8	14
367	476	2.9853	1	1	2	3	6
368	2781	6.2312	2	3	5	8	12
369	2776	3.2248	1	1	2	4	6
370	1166	5.9185	3	3	4	5	9
371	1248	3.6330	2	3	3	4	5
372	888	3.4651	1	2	2	3	5
373	3969	2.1464	1	2	2	2	3
374	140	3.1714	1	2	2	3	4
375	6	3.8333	1	1	2	5	5
376	205	3.4439	1	1	2	3	7
377	35	5.4000	1	1	3	5	13
378	177	2.7514	1	2	2	3	4
379	359	3.0836	1	1	2	3	6
380	91	1.8571	1	1	1	2	3
381	185	2.3297	1	1	1	3	5
382	56	1.2857	1	1	1	1	2
383	1526	4.0216	1	2	3	5	8
384	123	2.4065	1	1	2	2	5
385	1	2.0000	2	2	2	2	2
389	8	6.7500	1	5	5	7	12
390	9	3.3333	1	1	4	4	5

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 03/99 Grouper V16.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
392	2665	9.6432	3	4	7	12	20
394	1796	6.8135	1	2	4	8	15
395	77862	4.5487	1	2	3	6	9
396	17	3.1765	1	1	2	4	6
397	19299	5.3534	1	2	4	7	11
398	18648	5.9575	2	3	5	7	11
399	1513	3.7198	1	2	3	5	7
400	7367	9.1258	2	3	6	11	20
401	6271	11.0518	2	5	8	14	22
402	1464	4.1735	1	1	3	5	9
403	36559	8.0187	2	3	6	10	16
404	4130	4.3341	1	2	3	6	9
406	2851	10.1371	3	5	8	13	21
407	677	4.1773	1	2	3	5	7
408	2412	7.7363	1	2	5	10	18
409	3775	6.1094	2	3	4	6	12
410	50278	3.5715	1	2	3	4	6
411	20	2.3500	1	1	2	3	4
412	28	2.0000	1	1	1	2	4
413	7463	7.4528	2	3	6	10	15
414	693	4.1616	1	2	3	5	9
415	42974	14.0677	4	6	11	17	28
416	215135	7.3072	2	4	6	9	14
417	42	4.6905	1	2	3	6	10
418	22536	6.0572	2	3	5	7	11
419	15983	4.9037	2	2	4	6	9
420	3053	3.6495	1	2	3	5	7
421	13182	3.9219	1	2	3	5	7
422	93	2.9785	1	1	2	4	6
423	9177	7.6953	2	3	6	9	16
424	1398	14.0250	2	5	10	17	27
425	15652	4.0606	1	2	3	5	8
426	4620	4.6361	1	2	3	6	9
427	1678	4.9362	1	2	3	6	11
428	871	6.8726	1	2	4	8	15
429	29605	6.5253	2	3	5	8	13
430	59517	8.3640	2	3	6	11	17
431	313	7.1374	1	3	5	8	13
432	442	5.1833	1	2	3	5	10
433	6368	3.0974	1	1	2	4	6
434	21885	5.1509	1	2	4	6	10
435	14675	4.3381	1	2	4	5	8
436	3324	13.5096	4	7	12	21	27
437	11674	8.9895	3	5	8	11	15
439	1202	7.5166	1	3	5	9	15
440	5340	8.9891	2	3	6	11	19
441	571	3.0490	1	1	2	4	7
442	15865	7.8969	1	3	6	10	16
443	3389	3.2762	1	1	2	4	7
444	5071	4.2901	1	2	3	5	8
445	2242	2.9942	1	1	2	4	6
447	4724	2.5356	1	1	2	3	5
448	2	1.5000	1	1	2	2	2
449	26249	3.7076	1	1	3	4	7
450	6361	2.0483	1	1	1	2	4
451	4	3.7500	1	1	2	4	8
452	22505	4.9207	1	2	3	6	10
453	4265	2.8802	1	1	2	4	5
454	6007	4.4748	1	2	3	5	9
455	994	2.5905	1	1	2	3	5
461	3500	4.5026	1	1	2	5	11
462	11041	12.2571	4	6	10	16	23
463	16720	4.2907	1	2	3	5	8
464	4504	3.1854	1	2	3	4	6
465	204	3.6029	1	1	1	4	7
466	1771	4.0011	1	1	2	4	8
467	1238	3.2504	1	1	2	4	6
468	60480	13.2738	3	6	10	17	26
471	11960	5.6279	3	3	5	6	9
473	8085	13.1116	2	3	7	19	33

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 03/99 Grouper V16.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
475	110336	11.1055	2	5	9	15	22
476	5200	11.6544	2	6	10	15	21
477	27191	8.0489	1	3	6	10	17
478	119489	7.2839	1	3	5	9	15
479	21407	3.7730	1	2	3	5	7
480	459	23.1046	7	11	16	28	48
481	274	24.8759	10	19	23	30	40
482	6476	12.8700	4	7	10	15	23
483	43362	38.9597	14	21	32	48	71
484	416	13.1466	1	5	10	18	27
485	3232	9.1894	4	5	7	11	17
486	2171	12.1935	1	5	10	16	24
487	3766	7.3221	1	3	6	9	15
488	794	18.0416	3	7	13	23	37
489	14199	8.7326	2	3	6	11	18
490	4835	5.2709	1	2	4	7	10
491	11661	3.5467	2	2	3	4	6
492	2597	16.8063	4	5	11	27	35
493	55406	5.7168	1	3	5	7	11
494	26219	2.5095	1	1	2	3	5
495	143	15.6434	6	8	12	22	29
496	1111	10.7885	4	5	8	13	21
497	23280	6.2649	2	3	5	7	11
498	16782	3.4122	1	2	3	4	6
499	33561	4.8046	1	2	4	6	9
500	40918	2.7633	1	1	2	3	5
501	1994	10.0035	4	5	8	12	19
502	554	6.2708	3	4	5	7	11
503	5907	3.9661	1	2	3	5	7
504	123	31.6260	9	15	26	40	63
505	158	5.2405	1	1	2	6	13
506	1117	16.4270	4	7	13	22	33
507	415	9.5133	2	4	8	13	20
508	1111	7.3987	2	3	5	9	14
509	504	4.9187	1	2	3	6	11
510	1026	6.9688	2	3	5	8	15
511	307	4.8143	1	2	3	6	9
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TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY

[FY98 MEDPAR Update 03/99 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
1	36836	9.2593	2	4	7	12	19
2	7214	9.8343	3	5	7	12	19
3	7	10.5714	1	4	12	12	14
4	6080	7.4523	1	3	5	9	16
5	99334	3.4177	1	1	2	4	7
6	378	3.1138	1	1	2	4	7
7	12698	10.3438	2	4	7	13	21
8	3450	3.1467	1	1	2	4	7
9	1714	6.1190	1	3	5	8	12
10	19309	6.5667	2	3	5	8	13
11	3187	4.0446	1	2	3	5	8
12	44543	6.2764	2	3	4	7	12
13	6583	5.1621	2	3	4	6	9
14	356487	6.0057	2	3	5	7	11
15	144920	3.7348	1	2	3	5	7
16	12105	5.9197	2	3	5	7	11
17	3316	3.3685	1	2	3	4	6
18	27243	5.4721	2	3	4	7	10
19	7971	3.7885	1	2	3	5	7
20	6169	9.9651	2	5	8	13	19
21	1426	6.8079	2	3	5	9	13
22	2583	4.9001	2	2	4	6	9
23	7698	4.1758	1	2	3	5	8

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 03/99 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
24	54812	5.0310	1	2	4	6	10
25	24400	3.3482	1	2	3	4	6
26	29	3.5862	1	1	3	4	6
27	3652	5.2916	1	1	3	7	12
28	11239	6.0937	1	3	5	8	12
29	3756	3.6140	1	2	3	5	7
30	1	13.0000	13	13	13	13	13
31	3208	4.3332	1	2	3	5	8
32	1420	2.6901	1	1	2	3	5
34	20085	5.3312	1	2	4	6	10
35	4903	3.4852	1	2	3	4	7
36	4666	1.4256	1	1	1	1	2
37	1560	3.8372	1	1	3	4	8
38	107	2.6355	1	1	2	3	5
39	1469	1.8693	1	1	1	2	4
40	1988	3.3441	1	1	2	4	7
42	3314	2.1177	1	1	1	2	4
43	85	4.0471	1	2	2	4	7
44	1360	4.9669	2	3	4	6	9
45	2503	3.4259	1	2	3	4	6
46	3061	4.5541	1	2	3	6	9
47	1208	3.1283	1	1	2	4	6
48	1	6.0000	6	6	6	6	6
49	2282	5.0206	1	2	4	6	10
50	2831	1.9947	1	1	1	2	3
51	278	2.8921	1	1	1	3	7
52	159	1.8868	1	1	1	2	3
53	2719	3.6348	1	1	2	4	8
54	1	1.0000	1	1	1	1	1
55	1561	2.8482	1	1	2	3	6
56	587	2.8399	1	1	2	3	6
57	680	4.4588	1	1	2	5	11
59	79	2.5316	1	1	2	3	6
60	4	1.2500	1	1	1	1	2
61	239	4.8075	1	1	3	6	10
62	2	2.5000	2	2	3	3	3
63	3306	4.4574	1	2	3	5	9
64	3302	6.6087	1	2	4	8	14
65	31895	2.9094	1	1	2	4	5
66	7002	3.2129	1	2	3	4	6
67	512	3.7051	1	2	3	4	7
68	13163	4.1908	2	2	3	5	7
69	4092	3.3140	1	2	3	4	6
70	38	2.7368	1	2	2	3	5
71	109	3.4037	1	2	3	4	6
72	804	3.5162	1	2	3	4	7
73	6475	4.3396	1	2	3	5	8
74	1	2.0000	2	2	2	2	2
75	40541	9.9139	3	5	7	12	19
76	41055	11.1287	3	5	9	14	21
77	2213	5.1148	1	2	4	7	10
78	30088	7.0769	3	5	6	9	12
79	204216	8.4304	3	4	7	10	16
80	8429	5.5429	2	3	5	7	10
81	9	6.1111	1	4	6	7	9
82	67991	6.9678	2	3	5	9	14
83	6985	5.4805	2	3	4	7	10
84	1530	3.2170	1	2	3	4	6
85	21592	6.5212	2	3	5	8	13
86	1741	3.7731	1	2	3	5	7
87	67711	6.2696	1	3	5	8	12
88	398204	5.2576	2	3	4	7	9
89	510853	6.1132	2	3	5	8	11
90	46380	4.3406	2	3	4	5	7
91	64	3.9531	1	2	3	5	7
92	14187	6.2415	2	3	5	8	12
93	1438	4.2976	1	2	4	6	8
94	13076	6.3852	2	3	5	8	12
95	1514	3.6242	1	2	3	4	7
96	63669	4.7632	2	3	4	6	8

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 03/99 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
97	28418	3.7363	1	2	3	5	7
98	18	4.5000	2	2	3	4	5
99	19447	3.1469	1	1	2	4	6
100	7748	2.1705	1	1	2	3	4
101	20139	4.4047	1	2	3	6	8
102	4778	2.6877	1	1	2	3	5
103	547	56.5466	9	15	39	81	126
104	32842	11.8946	3	6	10	15	22
105	28697	9.4228	4	5	7	11	17
106	3906	10.9158	5	7	9	13	18
107	97459	10.4755	5	7	9	12	17
108	5282	10.9737	3	6	9	14	21
109	66660	7.8095	4	5	7	9	13
110	59376	9.5303	2	5	8	11	18
111	6606	5.6197	2	4	6	7	8
112	80818	3.8201	1	1	3	5	8
113	46280	11.9185	3	5	9	15	23
114	8726	8.1877	2	4	7	10	16
115	14436	8.4070	2	4	7	11	16
116	272446	3.9260	1	1	3	5	8
117	3511	4.1398	1	1	3	5	9
118	6439	2.8987	1	1	2	4	6
119	1554	4.8932	1	1	3	6	11
120	36921	8.2184	1	2	5	11	18
121	169542	6.5073	2	4	5	8	12
122	83737	3.9785	1	2	4	5	7
123	42138	4.4072	1	1	2	6	10
124	145335	4.4326	1	2	3	6	8
125	69830	2.8428	1	1	2	4	6
126	5297	11.8577	3	6	9	15	23
127	725343	5.3846	2	3	4	7	10
128	13957	5.8882	3	4	5	7	9
129	4522	2.8074	1	1	1	3	7
130	93795	5.8394	2	3	5	7	10
131	26365	4.4803	1	3	4	6	7
132	167887	3.0915	1	2	2	4	6
133	7131	2.3751	1	1	2	3	4
134	32871	3.3420	1	2	3	4	6
135	7556	4.3634	1	2	3	5	8
136	1151	2.9427	1	1	2	4	6
138	204377	3.9935	1	2	3	5	8
139	74949	2.5370	1	1	2	3	5
140	90166	2.8049	1	1	2	3	5
141	85549	3.7307	1	2	3	5	7
142	40835	2.7078	1	1	2	3	5
143	174420	2.1903	1	1	2	3	4
144	77994	5.3212	1	2	4	7	11
145	6796	2.8261	1	1	2	4	5
146	12246	10.3034	5	7	9	12	17
147	2305	6.7080	3	5	7	8	10
148	143500	12.1060	5	7	10	14	21
149	16362	6.7222	4	5	6	8	10
150	22213	11.0306	4	6	9	14	19
151	4386	5.9758	2	3	6	8	11
152	4778	8.3024	3	5	7	10	14
153	1793	5.6168	3	4	5	7	8
154	32408	13.1935	4	7	10	16	25
155	5602	4.5059	1	2	4	6	8
156	5	10.6000	2	2	11	13	22
157	8593	5.5783	1	2	4	7	11
158	4411	2.6384	1	1	2	3	5
159	17429	4.9651	1	2	4	6	10
160	10531	2.7382	1	1	2	4	5
161	12610	4.1558	1	2	3	5	9
162	6778	2.0031	1	1	1	2	4
163	6	3.3333	1	3	3	5	5
164	5103	8.5348	4	5	7	10	14
165	1821	4.9368	2	3	5	6	8
166	3422	5.1441	2	3	4	6	10
167	2688	2.7742	1	2	2	3	5

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 03/99 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
168	1624	4.6188	1	2	3	6	9
169	829	2.5223	1	1	2	3	5
170	12216	11.2317	2	5	8	14	22
171	1060	4.7679	1	2	4	6	9
172	32207	6.9186	2	3	5	9	14
173	2318	3.8007	1	1	3	5	8
174	250699	4.8426	2	3	4	6	9
175	25358	2.9404	1	2	3	4	5
176	17698	5.2788	2	3	4	6	10
177	10595	4.4886	2	2	4	6	8
178	3611	3.1742	1	2	3	4	6
179	12437	6.1533	2	3	5	8	12
180	90780	5.3431	2	3	4	7	10
181	24531	3.4095	1	2	3	4	6
182	236680	4.3360	1	2	3	5	8
183	77375	2.9902	1	1	2	4	6
184	89	3.0225	1	1	2	3	7
185	4281	4.5359	1	2	3	6	9
186	7	3.2857	1	2	3	4	4
187	865	3.9052	1	2	3	5	8
188	76090	5.5497	1	2	4	7	11
189	9709	3.2163	1	1	2	4	6
190	69	5.6087	1	2	4	7	9
191	9760	14.1831	4	7	10	17	28
192	838	7.0251	2	4	6	9	11
193	6564	12.6140	5	7	10	15	23
194	743	6.5639	2	4	6	8	11
195	5935	9.9928	4	6	8	12	17
196	1267	5.6780	2	4	5	7	9
197	23028	8.6261	3	5	7	10	15
198	6393	4.5098	2	3	4	6	8
199	1894	9.6172	2	4	7	13	19
200	1196	10.9983	2	4	8	14	22
201	1515	14.0614	4	6	11	18	28
202	27560	6.5773	2	3	5	8	13
203	30111	6.7062	2	3	5	9	13
204	55485	5.9715	2	3	5	7	11
205	23295	6.3206	2	3	5	8	12
206	1730	4.0694	1	2	3	5	8
207	32809	5.1165	1	2	4	6	10
208	9894	2.9049	1	1	2	4	6
209	355054	5.1351	3	3	4	6	8
210	134594	6.7578	3	4	6	8	11
211	29233	4.9046	3	3	4	6	7
212	8	3.6250	1	2	4	5	5
213	7936	8.3266	2	4	6	10	17
216	6080	9.5355	2	4	7	12	19
217	19791	12.6226	3	5	9	15	27
218	22787	5.2827	2	3	4	6	10
219	19533	3.1973	1	2	3	4	5
220	4	9.2500	1	1	6	12	18
223	17960	2.5661	1	1	2	3	5
224	8009	2.0411	1	1	2	3	4
225	5837	4.4655	1	2	3	6	9
226	5297	5.9941	1	2	4	8	12
227	4340	2.7548	1	1	2	3	5
228	2585	3.5791	1	1	2	4	8
229	1157	2.4408	1	1	2	3	4
230	2300	4.7948	1	2	3	6	10
231	11018	4.6331	1	2	3	6	10
232	535	4.0748	1	1	2	5	9
233	4876	7.5070	2	3	5	9	16
234	2587	3.4519	1	2	3	4	7
235	5406	5.0218	1	2	4	6	9
236	39504	4.9102	1	3	4	6	9
237	1711	3.5634	1	2	3	4	6
238	7793	8.3853	3	4	6	10	16
239	55949	6.2607	2	3	5	8	12
240	12987	6.6413	2	3	5	8	13
241	3039	4.0234	1	2	3	5	7

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 03/99 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
242	2683	6.6347	2	3	5	8	13
243	84667	4.7255	1	3	4	6	9
244	12703	4.8316	1	3	4	6	9
245	4969	3.5768	1	2	3	4	7
246	1351	3.7187	1	2	3	5	7
247	14131	3.4179	1	2	3	4	7
248	9001	4.6185	1	2	4	6	9
249	10990	3.5379	1	1	2	4	7
250	3653	4.1237	1	2	3	5	8
251	2300	2.8961	1	1	2	4	5
253	19183	4.7470	1	3	4	6	9
254	10028	3.2017	1	2	3	4	6
256	5967	5.1324	1	2	4	6	10
257	19521	2.9195	1	2	2	3	5
258	16906	2.0608	1	1	2	2	3
259	3748	2.7620	1	1	2	3	6
260	4729	1.4743	1	1	1	2	2
261	1803	2.1780	1	1	1	3	4
262	653	3.9326	1	1	3	5	8
263	26033	11.3385	3	5	8	14	22
264	3840	6.9898	2	3	5	8	13
265	4133	6.9557	1	2	4	8	14
266	2546	3.3496	1	1	2	4	7
267	241	4.0788	1	1	3	5	9
268	897	3.8060	1	1	2	4	8
269	8851	7.8528	2	3	6	10	16
270	2749	3.1364	1	1	2	4	7
271	22654	7.0990	3	4	6	8	13
272	5663	6.2930	2	3	5	7	12
273	1357	4.3839	1	2	3	5	8
274	2464	6.5345	1	3	5	8	13
275	208	3.8894	1	1	2	5	8
276	1001	4.3906	1	2	4	5	8
277	84624	5.7564	2	3	5	7	10
278	27774	4.4283	2	3	4	5	8
279	11	5.0909	1	3	4	5	8
280	15054	4.2136	1	2	3	5	8
281	6510	3.0602	1	1	3	4	6
282	1	3.0000	3	3	3	3	3
283	5366	4.7128	1	2	4	6	9
284	1799	3.1957	1	1	3	4	6
285	6035	10.5781	3	5	8	13	21
286	2166	6.6307	2	3	5	8	13
287	6069	10.3935	3	5	7	12	20
288	2020	5.7025	3	3	4	6	9
289	4812	3.0247	1	1	2	3	6
290	8605	2.4284	1	1	2	3	4
291	76	2.0132	1	1	1	2	3
292	4847	10.4246	2	4	8	13	21
293	323	4.9567	1	2	4	6	11
294	84531	4.7447	1	2	4	6	9
295	3469	3.8665	1	2	3	5	7
296	234504	5.2830	2	3	4	6	10
297	36736	3.5367	1	2	3	4	6
298	90	3.4889	1	1	2	4	7
299	1124	5.3932	1	2	4	7	11
300	16177	6.2295	2	3	5	8	12
301	2822	3.5666	1	2	3	4	7
302	8038	9.6920	5	6	7	11	17
303	20077	8.7449	4	5	7	10	15
304	12388	8.8926	2	4	7	11	18
305	2795	3.9030	1	2	3	5	7
306	9132	5.4262	1	2	3	7	12
307	2186	2.3605	1	1	2	3	4
308	8285	6.1389	1	2	4	8	13
309	4064	2.5226	1	1	2	3	5
310	25390	4.3348	1	2	3	5	9
311	7973	1.9387	1	1	1	2	4
312	1665	4.5808	1	1	3	6	10
313	643	2.3919	1	1	2	3	5

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 03/99 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
314	1	2.0000	2	2	2	2	2
315	28422	7.8309	1	2	5	10	17
316	94819	6.6602	2	3	5	8	13
317	801	3.1898	1	1	2	3	6
318	6096	5.9810	1	3	4	8	12
319	457	2.8665	1	1	2	4	6
320	183743	5.4047	2	3	4	7	10
321	26994	3.8755	2	2	3	5	7
322	68	3.6618	1	2	3	4	6
323	16792	3.2039	1	1	2	4	6
324	7668	1.9287	1	1	1	2	4
325	7806	3.8663	1	2	3	5	7
326	2390	2.7046	1	1	2	3	5
327	9	3.4444	1	2	3	6	6
328	691	3.7019	1	2	3	5	7
329	108	2.4259	1	1	1	3	5
331	45315	5.5089	1	3	4	7	11
332	4707	3.4391	1	1	3	4	7
333	267	4.4082	1	2	3	5	10
334	14231	4.9975	3	3	4	6	8
335	10417	3.5491	2	3	3	4	5
336	46652	3.6099	1	2	3	4	7
337	31028	2.2136	1	1	2	3	3
338	2147	5.1202	1	2	3	7	12
339	1813	4.4865	1	1	3	6	10
340	2	1.0000	1	1	1	1	1
341	4093	3.2057	1	1	2	3	6
342	880	3.4966	1	2	2	4	7
344	4123	2.3546	1	1	1	2	5
345	1236	3.7055	1	1	2	4	8
346	4983	5.7154	1	3	4	7	11
347	376	3.1303	1	1	2	4	7
348	3100	4.1839	1	2	3	5	8
349	600	2.5250	1	1	2	3	5
350	6571	4.3821	2	2	4	5	8
352	698	3.9169	1	1	3	5	7
353	2712	7.0749	3	4	5	8	13
354	9042	5.7710	3	3	4	6	10
355	5962	3.4074	2	3	3	4	5
356	28378	2.5532	1	2	2	3	4
357	6098	8.6471	3	5	7	10	16
358	25005	4.4148	2	3	3	5	7
359	29668	2.8899	2	2	3	3	4
360	17416	3.0307	1	2	3	3	5
361	478	3.3703	1	1	2	4	7
362	1	1.0000	1	1	1	1	1
363	3606	3.2887	1	2	2	3	7
364	1831	3.5281	1	1	2	4	7
365	2018	7.0927	2	3	5	9	15
366	4378	6.7106	1	3	5	8	14
367	476	2.9853	1	1	2	3	6
368	2781	6.2312	2	3	5	8	12
369	2776	3.2248	1	1	2	4	6
370	1166	5.9185	3	3	4	5	9
371	1248	3.6330	2	3	3	4	5
372	888	3.4651	1	2	2	3	5
373	3968	2.1467	1	2	2	2	3
374	140	3.1714	1	2	2	3	4
375	6	3.8333	1	1	2	5	5
376	205	3.4439	1	1	2	3	7
377	35	5.4000	1	1	3	5	13
378	177	2.7514	1	2	2	3	4
379	359	3.0836	1	1	2	3	6
380	91	1.8571	1	1	1	2	3
381	185	2.3297	1	1	1	3	5
382	56	1.2857	1	1	1	1	2
383	1526	4.0216	1	2	3	5	8
384	123	2.4065	1	1	2	2	5
385	1	2.0000	2	2	2	2	2
389	8	6.7500	1	5	5	7	12

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 03/99 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
390	9	3.3333	1	1	4	4	5
392	2665	9.6432	3	4	7	12	20
394	1796	6.8135	1	2	4	8	15
395	77861	4.5487	1	2	3	6	9
396	17	3.1765	1	1	2	4	6
397	19299	5.3534	1	2	4	7	11
398	18648	5.9575	2	3	5	7	11
399	1513	3.7198	1	2	3	5	7
400	7367	9.1258	2	3	6	11	20
401	6271	11.0518	2	5	8	14	22
402	1464	4.1735	1	1	3	5	9
403	36557	8.0188	2	3	6	10	16
404	4130	4.3341	1	2	3	6	9
406	2851	10.1371	3	5	8	13	21
407	677	4.1773	1	2	3	5	7
408	2412	7.7363	1	2	5	10	18
409	3775	6.1094	2	3	4	6	12
410	50278	3.5715	1	2	3	4	6
411	20	2.3500	1	1	2	3	4
412	28	2.0000	1	1	1	2	4
413	7463	7.4528	2	3	6	10	15
414	693	4.1616	1	2	3	5	9
415	42974	14.0677	4	6	11	17	28
416	215132	7.3072	2	4	6	9	14
417	42	4.6905	1	2	3	6	10
418	22536	6.0572	2	3	5	7	11
419	15983	4.9037	2	2	4	6	9
420	3053	3.6495	1	2	3	5	7
421	13182	3.9219	1	2	3	5	7
422	93	2.9785	1	1	2	4	6
423	9177	7.6953	2	3	6	9	16
424	1398	14.0250	2	5	10	17	27
425	15651	4.0608	1	2	3	5	8
426	4620	4.6361	1	2	3	6	9
427	1678	4.9362	1	2	3	6	11
428	871	6.8726	1	2	4	8	15
429	29599	6.5256	2	3	5	8	13
430	59517	8.3640	2	3	6	11	17
431	313	7.1374	1	3	5	8	13
432	442	5.1833	1	2	3	5	10
433	6368	3.0974	1	1	2	4	6
434	21885	5.1509	1	2	4	6	10
435	14675	4.3381	1	2	4	5	8
436	3324	13.5096	4	7	12	21	27
437	11674	8.9895	3	5	8	11	15
439	1202	7.5166	1	3	5	9	15
440	5340	8.9891	2	3	6	11	19
441	571	3.0490	1	1	2	4	7
442	15864	7.8964	1	3	6	10	16
443	3388	3.2760	1	1	2	4	7
444	5071	4.2901	1	2	3	5	8
445	2242	2.9942	1	1	2	4	6
447	4724	2.5356	1	1	2	3	5
448	2	1.5000	1	1	2	2	2
449	26247	3.7078	1	1	3	4	7
450	6361	2.0483	1	1	1	2	4
451	4	3.7500	1	1	2	4	8
452	22505	4.9207	1	2	3	6	10
453	4265	2.8802	1	1	2	4	5
454	6006	4.4745	1	2	3	5	9
455	994	2.5905	1	1	2	3	5
461	3500	4.5026	1	1	2	5	11
462	11041	12.2571	4	6	10	16	23
463	16720	4.2907	1	2	3	5	8
464	4503	3.1857	1	2	3	4	6
465	204	3.6029	1	1	1	4	7
466	1771	4.0011	1	1	2	4	8
467	1238	3.2504	1	1	2	4	6
468	58933	13.2171	3	6	10	17	26
471	11960	5.6279	3	3	5	6	9

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 03/99 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
473	8085	13.1116	2	3	7	19	33
475	110336	11.1055	2	5	9	15	22
476	5200	11.6544	2	6	10	15	21
477	27190	8.0489	1	3	6	10	17
478	119489	7.2839	1	3	5	9	15
479	21407	3.7730	1	2	3	5	7
480	459	23.1046	7	11	16	28	48
481	274	24.8759	10	19	23	30	40
482	6476	12.8700	4	7	10	15	23
483	43362	38.9597	14	21	32	48	71
484	416	13.1466	1	5	10	18	27
485	3232	9.1894	4	5	7	11	17
486	2171	12.1935	1	5	10	16	24
487	3766	7.3221	1	3	6	9	15
488	794	18.0416	3	7	13	23	37
489	14199	8.7326	2	3	6	11	18
490	4835	5.2709	1	2	4	7	10
491	11661	3.5467	2	2	3	4	6
492	2597	16.8063	4	5	11	27	35
493	55404	5.7170	1	3	5	7	11
494	26218	2.5095	1	1	2	3	5
495	143	15.6434	6	8	12	22	29
496	1111	10.7885	4	5	8	13	21
497	23280	6.2649	2	3	5	7	11
498	16782	3.4122	1	2	3	4	6
499	33561	4.8046	1	2	4	6	9
500	40918	2.7633	1	1	2	3	5
501	1994	10.0035	4	5	8	12	19
502	554	6.2708	3	4	5	7	11
503	5907	3.9661	1	2	3	5	7
504	123	31.6260	9	15	26	40	63
505	158	5.2405	1	1	2	6	13
506	974	16.7454	4	8	13	22	33
507	354	9.4831	2	4	8	13	19
508	602	8.5166	2	3	6	10	17
509	214	5.2991	1	2	4	7	10
510	1678	7.3194	2	3	5	9	16
511	658	5.1884	1	2	3	6	11
	11262262						

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) JULY 1999

State	Urban	Rural
ALABAMA	0.379	0.377
ALASKA	0.507	0.732
ARIZONA	0.368	0.532
ARKANSAS	0.478	0.454
CALIFORNIA	0.361	0.457
COLORADO	0.440	0.571
CONNECTICUT	0.500	0.506
DELAWARE	0.495	0.453
DISTRICT OF COLUMBIA	0.519	.....
FLORIDA	0.372	0.386
GEORGIA	0.486	0.487
HAWAII	0.492	0.556
IDAHO	0.549	0.576
ILLINOIS	0.441	0.531
INDIANA	0.559	0.596
IOWA	0.498	0.626
KANSAS	0.425	0.631
KENTUCKY	0.483	0.513
LOUISIANA	0.417	0.489

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) JULY 1999—Continued

State	Urban	Rural
MAINE	0.615	0.566
MARYLAND	0.764	0.821
MASSACHUSETTS	0.528	0.559
MICHIGAN	0.474	0.580
MINNESOTA	0.524	0.594
MISSISSIPPI	0.469	0.471
MISSOURI	0.423	0.512
MONTANA	0.501	0.568
NEBRASKA	0.488	0.625
NEVADA	0.288	0.492
NEW HAMPSHIRE	0.569	0.592
NEW JERSEY	0.412	.....
NEW MEXICO	0.476	0.511
NEW YORK	0.542	0.620
NORTH CAROLINA	0.537	0.506
NORTH DAKOTA	0.616	0.662
OHIO	0.520	0.564
OKLAHOMA	0.436	0.539
OREGON	0.547	0.594

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) JULY 1999—Continued

State	Urban	Rural
PENNSYLVANIA	0.403	0.531
PUERTO RICO	0.488	0.591
RHODE ISLAND	0.590	.....
SOUTH CAROLINA	0.453	0.455
SOUTH DAKOTA	0.522	0.617
TENNESSEE	0.465	0.490
TEXAS	0.416	0.519
UTAH	0.514	0.663
VERMONT	0.645	0.608
VIRGINIA	0.472	0.494
WASHINGTON	0.590	0.661
WEST VIRGINIA	0.592	0.571
WISCONSIN	0.562	0.634
WYOMING	0.475	0.681

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED) JULY 1999

State	Ratio
ALABAMA	0.047
ALASKA	0.066
ARIZONA	0.042
ARKANSAS	0.050
CALIFORNIA	0.039
COLORADO	0.049
CONNECTICUT	0.037
DELAWARE	0.055
DISTRICT OF COLUMBIA	0.039
FLORIDA	0.046
GEORGIA	0.056
HAWAII	0.046
IDAHO	0.060
ILLINOIS	0.042
INDIANA	0.059
IOWA	0.054
KANSAS	0.049
KENTUCKY	0.050
LOUISIANA	0.050

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED) JULY 1999—Continued

State	Ratio
MAINE	0.040
MARYLAND	0.013
MASSACHUSETTS	0.056
MICHIGAN	0.045
MINNESOTA	0.050
MISSISSIPPI	0.047
MISSOURI	0.049
MONTANA	0.051
NEBRASKA	0.057
NEVADA	0.029
NEW HAMPSHIRE	0.067
NEW JERSEY	0.037
NEW MEXICO	0.044
NEW YORK	0.052
NORTH CAROLINA	0.050
NORTH DAKOTA	0.075
OHIO	0.052

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED) JULY 1999—Continued

State	Ratio
OKLAHOMA	0.051
OREGON	0.049
PENNSYLVANIA	0.042
PUERTO RICO	0.049
RHODE ISLAND	0.035
SOUTH CAROLINA	0.047
SOUTH DAKOTA	0.069
TENNESSEE	0.055
TEXAS	0.051
UTAH	0.050
VERMONT	0.051
VIRGINIA	0.060
WASHINGTON	0.066
WEST VIRGINIA	0.056
WISCONSIN	0.056
WYOMING	0.053

TABLE 10.—PERCENTAGE DIFFERENCE IN WAGE INDEXES FOR AREAS THAT QUALIFY FOR A WAGE INDEX EXCEPTION FOR EXCLUDED HOSPITALS AND UNITS

Area	1982–1996 difference	1984–1996 difference	1988–1996 difference	1990–1996 difference	1991–1996 difference	1992–1996 difference	1993–1996 difference	1994–1996 difference
Colorado					10.4524		8.1881	
Connecticut	19.6203	21.9951						
Delaware		10.0096						
Florida		10.2983						
Georgia		8.7027						
Hawaii		21.3348	11.4158		12.6562	8.9266		
Illinois				9.5874	8.7873			
Indiana				9.2802				
Iowa				8.2639	9.0834			
Maryland		8.3480						
Massachusetts	8.6383	12.1756						
Mississippi				9.6174	9.9473	8.1089		
Nebraska			14.3694	11.6425	9.9561	10.9156	10.9771	
New Hampshire		11.6434						
New Mexico				11.9006				
North Carolina		8.5221						
South Carolina		14.2383						
South Dakota				8.9288	9.0543	8.3679		
Tennessee		8.6185						
Vermont		11.9881						
Washington			8.3161	12.0455	8.3048			
Wyoming				12.9830	11.6587	10.5578	8.3272	
Akron, OH				9.7516				
Albany, GA	27.7655	33.1280	28.7328	21.9948	17.5830	20.4926	20.6327	
Anniston, Al		10.2828						
Arecibo, PR		10.1831	21.6831	29.8544	26.7773		9.4816	
Athens, GA	19.5810	25.7158	18.1110	18.0248	9.5754			
Atlanta, GA		8.1459		6.4055				
Atlantic-Cape May, NJ		14.8340						
Bellingham, WA			8.4523					
Bergen-Passaic, NJ	12.8013	14.7272	16.7200					
Billings, MT	16.1065	19.1965	26.2081	30.8632	35.1113	35.3130	29.6247	
Bremerton, WA	13.0957	15.0214	15.3709	15.4435	13.8559			
Brownsville-Harlingen-San Benito, TX				8.5425	12.0954			
Bryan-College, Station, TX								
Burlington, VT		12.4268	12.7269	10.3355		13.9804		
Caquas, PR		14.7999						
Casper, WY				9.2907	9.6686	9.1351		
Cedar Rapids, IA				10.3119				
Charlotte-Gastonia-Rock Hill, NC–SC		12.6597						
Charlottesville, VA	14.0438	19.5365	9.8608	11.4472	12.9594	15.1868	15.4762	
Chattanooga, TN–GA		13.4017			8.8235		9.9797	
Cheyenne, WY						8.3488	9.3340	
Clarksville-Hopkinsville, TN–KY		11.2945	10.4286	18.4133				
Columbia, SC		10.8124						
Columbus, GA–AL	8.1734	15.8296	13.6333	12.7302	9.6367	9.7215	9.3830	
Cumberland, MD–MVA				8.5070	9.0177			
Danville, VA	12.9378	18.7705	20.6043	14.8561	11.9610			
Decatur, AL			17.3472	15.8281	8.4468			
Dubuque, IA					9.1888			

TABLE 10.—PERCENTAGE DIFFERENCE IN WAGE INDEXES FOR AREAS THAT QUALIFY FOR A WAGE INDEX EXCEPTION FOR EXCLUDED HOSPITALS AND UNITS—Continued

Area	1982–1996 difference	1984–1996 difference	1988–1996 difference	1990–1996 difference	1991–1996 difference	1992–1996 difference	1993–1996 difference	1994–1996 difference
Duluth-Superior, MN–WI				10.7902	10.0227			
Dutchess County, NY		8,4704						
Elkhart-Goshen, IN				9.4527				
Eugene-Springfield, OR				11.7281				
Flagstaff, AZ–UT								
Florence, AL		11.8054						
Florence, SC	13.0320	11.8640						
Gadsen, AL				12.1611				
Gainsville, FL		15.7424	14.7172	13.7100	14.4832	12.2944		
Grand Junction, CO								
Great Falls, MT				18.0341	21.0392	17.3455	20.4676	
Greeley, CO				11.4525				
Hickory-Morganton-Lenoir, NC		10.9461						
Houma, LA			9.0896					
Huntington-Ashland, WV–KY–OH				8.6526	8.6163	8.4473		
Jackson, MS			8.3592	12.0957	12.2607	11.1892		
Jackson, TN	9.5132	13.7566	8.6270					
Jacksonville, NC		8.7685	8.6495	8.9799	9.1010	13.3699	11.2812	
Janesville-Beliot, WI			13.9620	14.6249	13.0547	9.9021	11.6946	
Jersey City, NJ		8.7268	10.8011					
Killeen-Temple, TX	13.1336							
Knoxville, TN		12.1556				8.5300	8.5044	
Laredo, TX		13.0842	14.2641	26.7784	19.4632	23.3037	17.6562	
Las Cruse, NM			8.5144					
Lawton, OK		11.8386	13.5303	12.6581	12.2204	10.9146	13.9374	
Lima, OH			10.3470					
Lynchburg, VA							8.5602	
Macon, GA			9.3169					
Mayaguez, PR							10.8634	
Medford-Ashland, OR		8.6916		12.5510	8.3660			
Middlesex-Somerset-Hunterdon, NJ	8.3277	12.0153						
Monmouth-Ocean, NJ	14.3408	19.9318	13.6139	9.5243				
Muncie, IN	8.4919	12.2462	34.1672	26.6394	14.0301	18.7288	11.5183	
Nassau-Suffolk, NY		16.2468	8.6879					
New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	10.4496	14.7474						
New London-Norwich, CT	12.8280	16.4870						
New York, NY		10.1191						
Newburgh, NY–PA	18.2439	22.5618	12.9076					
Ocala, FL	10.9508	18.0769	11.5170	13.1443	9.4978			
Omaha, NEIA			16.2054				10.2732	
Owensboro, KY						8.0822		
Panama City, FL	10.6298	16.0633		9.5853	21.6370	12.0631	13.7311	
Parkersburg-Marietta, WV–OH				8.4838		8.5537		
Ponce, PR					9.0132			
Providence-Warwick-Pawtucket, RI		9.8100						
Pueblo, CO					10.4692			
Redding, CA		13.7562						
Richland-Kennewick-Pasco, WA	10.3096	15.4733	19.2774	21.6958	16.3350	12.1167	12.5664	
Richmond-Pertersburg, VA				8.3428				
Riverside-San Bernardino, CA								
Rochester, MN	12.0161			13.2930	8.6820		9.5886	
Salinas, CA	17.9442	16.9131	12.7030	11.4394				
San Angelo, TX					9.9972			
Santa Cruz-Watsonville, CA	12.9155	12.9980	8.8387	9.1800				
Santa Fe, NM		10.0021	14.1030					
Savannah, GA	12.5014	18.2769	19.4121	14.6131		10.9835		
Sherman-Denison, TX							8.3004	
Tacoma, WA		12.0133	11.1455	12.9502	10.2700			
Vallejo-Fairfield-Napa, CA		8.7346						
Wilmington-Newark, DE–MD		9.6799						
Wilmington, NC		18.6820	11.3188					
Yakima, WA				9.5536	8.2905			
Yuma, AZ			11.5934		14.3977			

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 reduce payments to hospitals by approximately $125 million in FY 2000. Therefore, this rule is a major rule as defined in Title 5, United States Code, section 804(2).

We generally prepare a regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C.

601 through 612), unless we certify that a final rule will not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, we consider all hospitals to be small entities.

Also, section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any 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 604 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 hospital inpatient prospective payment system, we classify these hospitals as urban hospitals.

It is clear that the changes being made in this document would 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 risen by 0.2 and 0.3 percentage points, respectively. As a result, the updates are 0.2 percent higher than the updates reflected in the impact analysis for the proposed rule.

Since the May 7, 1999 proposed rule, we have discovered that incorrect data were used in the capital (and operating) update framework in estimating the proposed adjustment for the effect of FY 1998 Reclassification and Recalibration. The revised adjustment resulted in a 0.91 percent increase in the capital rate update factor in this final rule.

With the exception of these changes, we are generally implementing the policy and statutory provisions discussed in the proposed rule.

III. Limitations of Our Analysis

As has been the case in our 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 2000, 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. 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 44 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 1999, we have included 4,922 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.

V. Impact on Excluded Hospitals and Units

As of July 1999, there were 1,112 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. Broken down by specialty, there were 586 psychiatric, 200 rehabilitation, 225 long-term care, 71 children's, 20 Christian Science Sanatoria, and 10 cancer hospitals. In addition, there were 1,497 psychiatric and 942 rehabilitation units in hospitals otherwise subject to the prospective payment system. These excluded units are also paid in accordance with § 413.40. Under § 413.40(a)(2)(i)(A), the target rate-of-increase ceiling is not applicable to the 20 specialty hospitals and units in Maryland that are paid in accordance with the waiver at section 1814(b)(3) of the Act.

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 2000 will be between 0 and 2.9 percent, depending on the hospital's or unit's costs in relation to its limit for the most recent cost reporting period for which information is available.

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* the lesser of 50 percent of the difference between its reasonable costs and 110 percent of the limit, or 10 percent of the limit. In no case would the payment exceed 110 percent of the 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.

VI. Quantitative Impact Analysis of the 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 1998 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 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 1998 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 2000 changes to the capital prospective payment system are discussed below in section VII of this Appendix.

The final changes discussed separately below are the following:

- 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 the floor on the wage index established by section 4410(a) of the BBA of 1997, which provided that the wage index for urban hospitals may not be less than the area wage index applicable to hospitals in rural areas of the State in which the hospital is located.
- The effects of changes in hospitals' wage index values reflecting the wage index update (FY 1996 data).
- The effects of fully removing from the wage index the costs and hours associated with teaching physicians Part A, residents, and CRNAs; and the effects of our policy to implement the first year of a 5-year phase-out of these costs, by calculating a wage index based on 20 percent of hospitals' average hourly wages after removing the costs and hours associated with teaching physicians, residents, and CRNAs, and 80 percent of hospitals' average hourly wages with these costs included.
- The effects of geographic reclassifications by the MGCRB that will be effective in FY 2000.
- The total change in payments based on FY 2000 policies relative to payments based on FY 1999 policies.

To illustrate the impacts of the FY 2000 final changes, our analysis begins with a FY 2000 baseline simulation model using: the FY 1999 GROUPER (version 16.0); the FY 1999 wage index without applying the rural floor; and no MGCRB reclassifications. Outlier payments are set at 5.1 percent of total DRG plus outlier payments.

Each final and statutory policy change is then added incrementally to this baseline model, finally arriving at an FY 2000 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 1999 to FY 2000. Four factors have significant impacts here. The 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 2000 using the most recently forecasted hospital market basket increase for FY 2000 of 2.9 percent minus 1.8 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), essential access community hospitals (EACHs) (which are treated as SCHs for payment purposes), and Medicare-dependent, small rural hospitals (MDHs) is equal to the market basket increase of 2.9 percent minus 1.8 percentage points (for an update of 1.1 percent).

A second significant factor that impacts changes in hospitals' payments per case from FY 1999 to FY 2000 is a change in MGCRB reclassification status from one year to the next. That is, hospitals reclassified in FY 1999 that are no longer reclassified in FY 2000 may have a negative payment impact going from FY 1999 to FY 2000; conversely, hospitals not reclassified in FY 1999 that are reclassified in FY 2000 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 1999 will be 6.3 percent of actual total DRG payments. When the FY 1999 final rule was published, we projected FY 1999 outlier payments would be 5.1 percent of total DRG plus outlier payments, and the standardized amounts were reduced correspondingly. The effects of the higher than expected outlier payments during FY 1999 (as discussed in the Addendum to this final rule) are reflected in the analyses below comparing our current estimates of FY 1999 payments per case to estimated FY 2000 payments per case.

Fourth, payment adjustments for indirect medical education (IME) and disproportionate share (DSH) are lower in FY 2000 relative to FY 1999. Section 1886(d)(5)(B)(ii) of the Act provides that the IME adjustment is reduced from approximately a 6.5 percent increase for every 10 percent increase in a hospital's resident-to-bed ratio in FY 1999, to a 6.0 percent increase in FY 2000. Similarly, in accordance with section 1886(d)(5)(F)(ix) of the Act, the DSH adjustment for FY 2000 is reduced by 3 percent from what would otherwise have been paid, compared to a 2 percent reduction for FY 1999.

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 4,922 hospitals included in the analysis. This figure represents 53 fewer hospitals than were included in the impact analysis in the FY 1999 final rule (63 FR 41106).

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 2,782 hospitals located in urban areas (MSAs or NECMAs) included in our analysis. Among these, there are 1,584 hospitals located in large urban areas (populations over 1 million), and 1,198 hospitals in other urban areas (populations of 1 million or fewer). In addition, there are 2,140 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 2000 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 that the number of hospitals paid based on these categorizations (after consideration of geographic reclassifications) are 2,858, 1,662, 1,197, and 2,064, 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) or receive DSH payments, or some combination of these two adjustments. There are 3,809 nonteaching hospitals in our analysis, 871 teaching hospitals with fewer than 100 residents, and 242 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 five 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 (154), SCHs (647), MDHs (355), and SCH and RRCs (57) shown here were not reclassified for purposes of the standardized amount. There are 15 RRCs, 3 SCHs, and 2 SCH and RRCs that will be reclassified for the standardized amount in FY 2000 that, therefore, are not included in these rows.

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 1997 Medicare cost report files, if available (otherwise FY 1996 data are used). Data needed to determine ownership status or Medicare utilization percentages were unavailable for some hospitals (80 and 82, respectively). 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 1999 and FY 2000, or for either of those 2 years, by urban and rural status. The next rows illustrate the overall number of FY 2000 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 2000 Operating Prospective Payment System
[PERCENT CHANGES IN PAYMENTS PER CASE]

	Number of hospitals[1]	DRG recalib.[2]	Wage index floor[3]	New wage data[4]	Remove GME and CRNA costs[5]	Blended wage index costs[6]	DRG & WI changes[7]	MGCRB reclassification[8]	All FY 2000 changes[9]
	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
(BY GEOGRAPHIC LOCATION)									
ALL HOSPITALS	4,922	0.0	0.1	0.1	0.4	0.1	0.0	0.0	−0.5
URBAN HOSPITALS	2,782	0.0	0.1	0.0	0.3	0.1	−0.1	−0.4	−0.7
LARGE URBAN	1,584	0.0	0.0	0.0	0.1	0.0	−0.1	−0.4	−0.8
OTHER URBAN	1,198	0.0	0.2	0.0	0.6	0.1	0.1	−0.4	−0.5
RURAL HOSPITALS	2,140	0.2	0.0	0.4	0.6	0.5	0.5	2.6	1.0
BED SIZE (URBAN):									
0–99 BEDS	727	0.1	0.3	−0.2	0.4	−0.2	0.1	−0.5	−0.2
100–199 BEDS	938	0.1	0.2	0.1	0.4	0.1	0.2	−0.5	−0.1
200–299 BEDS	553	0.0	0.1	0.1	0.4	0.1	0.0	−0.4	−0.5
300–499 BEDS	422	0.0	0.1	0.0	0.4	0.1	−0.1	−0.3	−0.7
500 OR MORE BEDS	142	−0.1	0.0	0.0	0.0	0.0	−0.2	−0.4	−1.6
BED SIZE (RURAL):									
0–49 BEDS	1,194	0.3	0.0	0.4	0.5	0.5	0.6	0.2	1.4
50–99 BEDS	571	0.2	0.0	0.4	0.5	0.5	0.5	1.0	1.2
100–149 BEDS	223	0.2	0.0	0.4	0.7	0.5	0.5	3.8	1.2
150–199 BEDS	87	0.1	0.0	0.5	0.6	0.6	0.5	4.5	1.2
200 OR MORE BEDS	65	0.1	0.0	0.4	0.5	0.5	0.4	4.8	0.3
URBAN BY CENSUS DIVISION:									
NEW ENGLAND	149	0.0	0.2	0.6	0.8	0.7	0.6	−0.2	−0.2
MIDDLE ATLANTIC	421	0.0	0.1	−0.2	−0.5	−0.2	−0.3	−0.3	−1.4
SOUTH ATLANTIC	407	0.0	0.2	0.1	0.9	0.3	0.2	−0.4	−0.2
EAST NORTH CENTRAL	467	0.0	0.1	0.4	0.0	0.4	0.3	−0.4	−0.4
EAST SOUTH CENTRAL	165	0.0	0.1	0.5	0.3	0.6	0.4	−0.4	0.0
WEST NORTH CENTRAL	190	−0.1	0.0	−0.1	0.1	0.0	−0.3	−0.5	−0.8
WEST SOUTH CENTRAL	353	0.0	0.0	−0.6	0.4	−0.5	−0.7	−0.5	−1.1
MOUNTAIN	134	−0.1	0.0	−0.1	0.2	0.0	−0.3	−0.5	−0.5
PACIFIC	449	0.0	0.1	−0.3	0.9	−0.2	−0.3	−0.4	−0.8
PUERTO RICO	47	0.1	0.0	0.4	0.3	0.4	0.4	−0.5	0.2
RURAL BY CENSUS DIVISION:									
NEW ENGLAND	52	0.1	0.0	−0.2	0.1	−0.1	−0.3	2.5	0.5
MIDDLE ATLANTIC	79	0.1	0.0	−0.4	0.0	−0.4	−0.4	2.2	0.7
SOUTH ATLANTIC	280	0.2	0.0	1.0	0.7	1.1	1.1	3.0	0.9
EAST NORTH CENTRAL	283	0.1	0.0	0.3	0.6	0.4	0.3	2.3	1.0
EAST SOUTH CENTRAL	267	0.3	0.0	0.7	0.8	0.8	0.9	2.7	1.6
WEST NORTH CENTRAL	492	0.1	0.0	0.8	0.4	0.9	0.8	2.3	1.5
WEST SOUTH CENTRAL	341	0.3	0.0	−0.3	0.7	−0.2	−0.1	3.5	0.9
MOUNTAIN	201	0.2	0.0	0.5	0.4	0.5	0.5	1.8	1.3
PACIFIC	140	0.1	0.0	−0.4	0.7	−0.2	−0.3	1.9	0.0
PUERTO RICO	5	0.1	0.0	1.8	0.6	1.9	1.9	1.6	2.4
(BY PAYMENT CATEGORIES)									
URBAN HOSPITALS	2,858	0.0	0.1	0.0	0.3	0.1	0.0	−0.3	−0.7
LARGE URBAN	1,662	0.0	0.0	0.0	0.1	0.0	−0.1	−0.3	−0.9
OTHER URBAN	1,197	0.0	0.2	0.1	0.6	0.2	0.1	−0.3	−0.4
RURAL HOSPITALS	2,064	0.2	0.0	0.4	0.6	0.5	0.5	2.3	1.1
TEACHING STATUS:									
NON-TEACHING	3,809	0.1	0.1	0.1	0.5	0.2	0.2	0.3	0.2
LESS THAN 100 RESIDENTS	871	0.0	0.1	0.0	0.4	0.1	−0.1	−0.3	−0.6
100+ RESIDENTS	242	0.0	0.0	0.1	−0.1	0.1	−0.1	−0.2	−1.5
DISPROPORTIONATE SHARE HOSPITALS (DSH):									
NON-DSH	3,069	0.0	0.1	0.1	0.4	0.1	0.0	0.3	−0.2
URBAN DSH 100 BEDS OR MORE	1,387	0.0	0.1	0.0	0.3	0.1	0.0	−0.4	−0.8
FEWER THAN 100 BEDS	89	0.2	0.1	−0.2	0.6	0.0	0.1	−0.5	0.1
RURAL DSH SOLE COMMUNITY (SCH)	158	0.3	0.0	0.4	0.6	0.6	0.6	0.3	2.1
REFERRAL CENTERS (RRC)	60	0.2	0.0	0.7	0.7	0.8	0.8	5.0	1.2
OTHER RURAL DSH HOSPITALS 100 BEDS OR MORE	49	0.2	0.0	0.7	0.8	0.8	0.9	1.0	1.1
FEWER THAN 100 BEDS	110	0.4	0.0	0.7	0.8	0.9	1.0	0.2	2.0
URBAN TEACHING AND DSH:									
BOTH TEACHING AND DSH	716	0.0	0.0	0.0	0.2	0.1	−0.1	−0.4	−1.1
TEACHING AND NO DSH	331	−0.1	0.1	0.0	0.2	0.1	−0.2	−0.1	−0.8
NO TEACHING AND DSH	760	0.1	0.2	0.0	0.6	0.1	0.1	−0.2	0.0
NO TEACHING AND NO DSH	1,052	0.0	0.2	0.0	0.4	0.1	0.1	−0.4	−0.3
RURAL HOSPITAL TYPES:									
NONSPECIAL STATUS HOSPITALS	851	0.3	0.0	0.5	0.7	0.7	0.7	1.1	1.2
RRC	154	0.1	0.0	0.4	0.7	0.6	0.4	5.7	0.6
SCH	647	0.2	0.0	0.2	0.3	0.3	0.3	0.3	1.4
MDH	355	0.3	0.0	0.4	0.5	0.5	0.6	0.3	1.2
SCH AND RRC	57	0.1	0.0	0.2	0.3	0.2	0.1	2.2	1.4
TYPE OF OWNERSHIP:									
VOLUNTARY	2,831	0.0	0.1	0.1	0.3	0.1	0.0	−0.1	−0.5
PROPRIETARY	752	0.1	0.1	0.0	0.6	0.1	0.0	0.0	−0.2
GOVERNMENT	1,259	0.1	0.1	0.2	0.6	0.3	0.2	0.3	−0.3
UNKNOWN	80	0.0	0.0	0.3	−0.8	0.1	0.0	−0.5	−1.4

Table I—Impact Analysis of Changes For FY 2000 Operating Prospective Payment System—Continued

[PERCENT CHANGES IN PAYMENTS PER CASE]

	Number of hospitals[1] (0)	DRG recalib.[2] (1)	Wage index floor[3] (2)	New wage data[4] (3)	Remove GME and CRNA costs[5] (4)	Blended wage index costs[6] (5)	DRG & WI changes[7] (6)	MGCRB reclassification[8] (7)	All FY 2000 changes[9] (8)
MEDICARE UTILIZATION AS A PERCENT OF INPATIENT DAYS:									
0–25	386	0.1	0.0	−0.3	0.6	−0.1	−0.3	−0.1	−1.3
25–50	1,775	0.0	0.0	0.0	0.3	0.1	−0.1	−0.3	−0.8
50–65	1,893	0.0	0.1	0.1	0.4	0.2	0.1	0.2	−0.1
OVER 65	786	0.1	0.2	0.3	0.4	0.3	0.4	0.3	0.1
UNKNOWN	82	0.0	0.0	0.3	−0.8	0.1	0.0	−0.5	−1.4
HOSPITALS RECLASSIFIED BY THE MEDICARE GEOGRAPHIC REVIEW BOARD									
RECLASSIFICATION STATUS DURING FY 1999 AND FY 2000:									
RECLASSIFIED DURING BOTH FY 1999 AND FY 2000	370	0.1	0.0	0.3	0.7	0.4	0.3	5.9	0.0
URBAN	57	0.0	0.0	0.0	0.9	0.1	0.0	4.4	−1.4
RURAL	313	0.1	0.0	0.4	0.6	0.5	0.4	6.6	0.7
RECLASSIFIED DURING FY 2000 ONLY	127	0.1	0.0	0.2	0.5	0.3	0.2	4.4	4.7
URBAN	26	0.0	0.1	−0.1	0.4	0.0	−0.2	3.3	2.7
RURAL	101	0.2	0.0	0.6	0.6	0.7	0.7	5.7	7.0
RECLASSIFIED DURING FY 1999 ONLY	188	0.1	1.1	−0.2	0.6	−0.1	0.8	−0.5	−3.9
URBAN	100	0.0	1.7	−0.6	0.6	−0.4	1.0	−0.5	−3.7
RURAL	88	0.2	0.0	0.4	0.6	0.5	0.5	−0.5	−4.2
FY 2000 RECLASSIFICATIONS:									
ALL RECLASSIFIED HOSPITALS	498	0.1	0.0	0.3	0.6	0.4	0.3	5.6	0.9
STANDARDIZED AMOUNT ONLY	66	0.2	0.0	0.3	0.8	0.4	0.4	2.6	−1.4
WAGE INDEX ONLY	386	0.1	0.0	0.3	0.6	0.4	0.3	6.0	1.3
BOTH	46	0.1	0.0	−0.1	0.7	0.0	−0.1	4.8	−0.5
NONRECLASSIFIED	4,398	0.0	0.1	0.1	0.3	0.1	0.0	−0.6	−0.6
ALL URBAN RECLASSIFIED	83	0.0	0.0	−0.1	0.7	0.1	−0.1	4.1	−0.2
STANDARDIZED AMOUNT ONLY	13	0.1	0.1	−0.4	0.9	−0.2	−0.2	0.8	−4.4
WAGE INDEX ONLY	47	0.0	0.1	0.2	0.7	0.3	0.1	5.4	0.6
BOTH	23	0.2	0.0	−0.8	0.7	−0.6	−0.7	0.7	−1.1
NONRECLASSIFIED	2,673	0.0	0.1	0.0	0.3	0.1	−0.1	−0.6	−0.7
ALL RURAL RECLASSIFIED	416	0.1	0.0	0.5	0.6	0.6	0.5	6.5	1.5
STANDARDIZED AMOUNT ONLY	53	0.2	0.0	0.7	0.8	0.9	0.9	3.9	0.6
WAGE INDEX ONLY	339	0.1	0.0	0.4	0.6	0.5	0.4	6.3	1.7
BOTH	23	0.1	0.0	1.0	0.6	1.1	1.0	11.6	0.5
NONRECLASSIFIED	1,725	0.2	0.0	0.4	0.5	0.5	0.5	−0.4	0.6
OTHER RECLASSIFIED HOSPITALS (SECTION 1886(d)(8)(B))	26	0.1	8.7	−0.4	0.3	−0.3	8.3	1.5	3.2

[1] Because data necessary to classify some hospitals by category were missing, the total number of hospitals in each category may not equal the national total. Discharge data are from FY 1998, and hospital cost report data are from reporting periods beginning in FY 1996 and FY 1997.

[2] This column displays the payment impact of the recalibration of the DRG weights based on FY 1998 MedPAR data and the DRG reclassification changes, in accordance with section 1886(d)(4)(C) of the Act.

[3] This column shows the impacts of implementing the rural wage index floor for urban hospitals in an area that otherwise would have a wage index below the Statewide rural wage index. This was established by section 4410(a) of the BBA of 1997.

[4] This column shows the payment effects of updating the data used to calculate the wage index with data from the FY 1996 cost reports.

[5] This column displays the impact of completely removing the costs and hours associated with teaching physicians Part A, residents, and CRNAs from the wage index calculation.

[6] This column illustrates the payment impact of phasing out the costs and hours associated with teaching physicians Part A, residents, and CRNAs, by calculating the wage index based on a blend of 20 percent of an average hourly wage after removing these costs and 80 percent of an average hourly wage without removing these costs.

[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 1, 2, 3, 4, and 5, and the FY 2000 budget neutrality factor of 0.997808.

[8] Shown here are the effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB). The effects demonstrate the FY 2000 payment impact of going from no reclassifications to the reclassifications scheduled to be in effect for FY 2000. Reclassification for prior years has no bearing on the payment impacts shown here.

[9] This column shows changes in payments from FY 1999 to FY 2000. It incorporates all of the changes displayed in columns 6 and 7 (the changes displayed in columns 1, 2 and 5 are included in column 6). It also displays the impact of the FY 2000 update, changes in hospitals' reclassification status in FY 2000 compared to FY 1999, the difference in outlier payments from FY 1999 to FY 2000, and the reductions to payments through the IME and DSH adjustments taking effect during FY 2000. The sum of these columns may be different from the percentage changes shown here due to rounding and interactive effects.

B. Impact of the Changes to the DRG Reclassifications and Recalibration of Relative Weights (Column 1)

In column 1 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 1999 DRG relative weights (GROUPER version 16) to aggregate payments using the FY 2000 DRG relative weights (GROUPER version 17). Overall payments per case are unchanged due to the DRG reclassifications and recalibration. Consistent with the minor

changes we made in the FY 2000 GROUPER, the redistributional impacts of DRG reclassifications and recalibration across hospital groups are very small (no change for large and other urban hospitals; a 0.2 percent increase for rural hospitals). Within hospital categories, the net effects for urban hospitals are small positive changes for small hospitals (a 0.1 percent increase for hospitals with fewer than 200 beds), and small decreases for larger hospitals (a 0.1 percent decrease for hospitals with more than 500 beds). Among rural hospitals, small hospital categories experience the largest increases, a 0.3 percent increase for hospitals with fewer than 50 beds.

The breakdown by urban census division shows either no impact or a small decrease (0.1 percent), except that payments to urban hospitals in Puerto Rico increase by 0.1 percent. All rural hospital census divisions experience payment increases, which range from 0.1 percent to 0.3 percent for hospitals in the East South Central and West South Central census divisions.

This pattern of payment increases for small hospitals and decreases for larger hospitals persists among other categories. Declines in the relative weights of several specific DRGs likely contribute to this trend. Among these DRGs, the relative weight for DRG 108 (Other Cardiothoracic Procedures), declined from 5.9764 in FY 1999 to 5.7715 in this final rule for FY 2000. Also, the relative weight for DRG 112 (Percutaneous Cardiovascular Procedures) declined from 1.9893 in FY 1999 to 1.9217 in this final rule for FY 2000. Although these cardiovascular procedures are not necessarily limited to very large hospitals, we would expect they are more likely to occur in larger hospitals. As the relative weights of DRGs predominantly occurring in large hospitals decline, the relative weights of other DRGs rise, leading to the small payment increases in hospitals less likely to be affected by the declines in the DRGs noted above.

C. Impact of the Wage Index Floor for Urban Areas (Column 2)

Section 4410(a) of the BBA of 1997 required that the wage indexes for urban hospitals may not be below the Statewide rural wage index for the State in which the urban hospitals are located. The section went on to state that this floor must be implemented in a budget neutral manner, so that total payments after establishing the floor are equal to what they were prior to establishing the floor. We include this impact when we calculate the wage and recalibration budget neutrality factor, as noted in the Addendum to this final rule.

There are 36 MSAs (and 226 hospitals) affected by this provision for FY 2000. The MSAs affected are identified in Table 4A, as indicated in the footnote. The largest impacts among census divisions are increases of 0.2 percent for urban hospitals in New England and the South Atlantic. In New England, several Massachusetts MSAs (including the 63 hospitals in the Boston MSA) receive the rural Massachusetts wage index. Similarly, in the South Atlantic, seven Florida MSAs receive the rural Florida wage index.

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 2000 is based on data submitted for hospital cost reporting periods beginning on or after October 1, 1995 and before October 1, 1996. 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 1999 wage index (effective for discharges on or after March 1, 1999 (64 FR 9378)) based on FY 1995 wage data before geographic reclassifications including the application of the rural floor to a model using the FY 2000 prereclassification wage index based on FY 1996 wage data.

The wage data collected on the FY 1996 cost reports are similar to the data used in the calculation of the FY 1999 wage index. For example, the wage index values used here include all physician Part A costs (direct and contracted), resident costs, and CRNA costs. Also, as in the calculation for the FY 1999 wage index, contract labor costs and hours for top management positions are included, and the overhead costs allocated to patient care areas excluded from the calculation of the wage index are excluded as well.

The results indicate that the new wage data have an overall impact of a 0.1 percent increase in hospital payments (prior to applying the budget neutrality factor, see column 6). Rural hospitals especially appear to benefit from the update. Their payments increase by 0.4 percent. Rural Arizona experiences an increase of nearly 7 percent in the prereclassification wage index values due to new data.

Urban hospitals as a group are not significantly affected by the updated wage data. Urban West South Central hospitals experience a 0.6 percent decrease. Meanwhile, the urban New England census division experiences a 0.6 percent increase, and urban East South Central payments per case increase 0.5 percent due to the update to the wage data.

The largest increases are seen in the rural census divisions. Rural Puerto Rico experiences the greatest positive impact, 1.8 percent. Hospitals in three other rural census divisions receive relatively large positive impacts: South Atlantic at 1.0 percent, East South Central at 0.7 percent, and West North Central at 0.8 percent.

E. Impact of Removing Teaching Physicians' Part A, Residents', and CRNAs' Costs (Column 4)

As discussed in section III.C of the preamble, we are revising the calculation of the wage index by phasing out the costs and hours associated with teaching physicians Part A, residents, and CRNAs. Although the FY 2000 wage index is based upon a blend of 20 percent of hospitals' average hourly wages after removing these costs and 80 percent of average hourly wages calculated without removing these costs, this column displays the impacts on payments per case of completely removing these costs from the wage index calculation.

As described above in section III.C.1 of the preamble, we determined teaching physician costs by first subtracting the costs and hours attributable to teaching physicians based upon the special survey data we collected for this purpose. If these data were not available from the survey for a particular teaching hospital, 80 percent of the total physician Part A costs and hours for that hospital were removed, consistent with the recommendation of the hospital industry (see discussion in section III.C.1 of the preamble). If a teaching hospital did not separately report its physician Part A costs on the cost report, the amount reported on Line 23, Column 1, of the Worksheet A was removed from the total wage data (as was an associated amount for hours). Resident and CRNA costs and hours were removed in their entirety, based upon the data separately attributed to these employees on the Worksheet S–3.

Column 4 shows the payment impacts of completely removing these costs, relative to wage index values calculated based on the FY 1996 wage data without removing these costs. The overall payment impact of completely removing these costs and hours from the wage index calculation would be a 0.4 percent increase in total payments (prior to applying budget neutrality). The FY 2000 wage index is, however, based on a blended average hourly wage. The impacts of this blended approach are shown in column 5.

The impacts of removing these costs from the wage index calculation are generally positive across the majority of hospital categories, with negative impacts concentrated in particular groups. Examining the impacts across urban and rural census divisions indicate that urban Middle Atlantic hospitals experience a 0.5 percent decrease. This effect is attributable to the concentration of teaching hospitals in this census division. The largest positive impacts occur in the urban South Atlantic and the Pacific census divisions, with 0.9 percent payment increases.

F. Impact of 5-Year Phase-Out of Teaching Physicians', Residents', and CRNAs' Costs (Column 5)

As described above in section III.E of this final rule, the FY 2000 wage index is calculated by blending 80 percent of hospitals' average hourly wages calculated without removing teaching physician Part A, residents, or CRNA costs (and hours), and 20 percent of average hourly wages calculated after removing these costs (and hours). This constitutes the first year of a 5-year phase-out of these costs, where the proportion of the calculation based upon average hourly wages after removing these costs increases by 20 percentage points per year.

This column shows the impact of the blended wage index relative to a wage index using FY 1996 wage data without removing costs or hours of Part A teaching physicians, residents, or CRNAs. As expected, the hospital categories experiencing significant payment impacts in column 4 are mitigated

considerably by the blend. The impact is 0.1 percent for all hospitals and for urban hospitals as a category, while for rural hospitals it is 0.5 percent.

The impacts in this column illustrate that, for the FY 2000 wage index, replacing hospitals' FY 1995 wage data with FY 1996 wage data has a much greater impact on the final wage indexes than the removal of GME and CRNA costs. The urban West South Central census division loses 0.6 percent from the new wage data, and gains 0.4 percent from the removal of GME and CRNA costs, but the impact of the blended wage index is a 0.5 decrease relative to last year's wage index.

The following chart compares the shifts in wage index values for labor market areas for FY 2000 relative to FY 1999. This chart demonstrates the impact of the changes for the FY 2000 wage index relative to the FY 1999 wage index. The majority of labor market areas (318) experience less than a 5-percent change. A total of 30 labor market areas experience an increase of more than 5 percent, with 8 having an increase greater than 10 percent. A total of 22 areas experience decreases of more than 5 percent. Of those, 5 decline by 10 percent or more.

Percentage change in area wage index values	Number of labor market areas	
	FY 1999	FY 2000
Increase more than 10 percent	9	8
Increase more than 5 percent and less than 10 percent	29	22
Increase or decrease less than 5 percent	305	318
Decrease more than 5 percent and less than 10 percent	28	17
Decrease more than 10 percent	0	5

Among urban hospitals, 112 would experience an increase of between 5 and 10 percent and 21 more than 10 percent. A total of 13 rural hospitals have increases greater than 5 percent, but none greater than 10 percent. On the negative side, 121 urban hospitals but no rural hospitals have decreases in their wage index values of at least 5 percent but less than 10 percent. There also are no rural hospitals with decreases greater than 10 percent. However, there are 18 urban hospitals in this category. The following chart shows the projected impact for urban and rural hospitals.

Percentage change in area wage index values	Number of hospitals	
	Urban	Rural
Increase more than 10 percent	21	0
Increase more than 5 percent and less than 10 percent	112	13
Increase or decrease less than 5 percent	2587	2051
Decrease more than 5 percent and less than 10 percent	121	0
Decrease more than 10 percent	18	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 simulated aggregate payments using the FY 1999 DRG relative weights and wage index (prior to application of the rural floor) to simulated aggregate payments using the FY 2000 DRG relative weights and blended wage index, after applying the rural floor. Based on this comparison, we computed a wage and recalibration budget neutrality factor of 0.997808. 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 1, 2, and 5, minus approximately 0.2 percent attributable to the budget neutrality factor. There may 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 2000. As noted below, these decisions affect hospitals' standardized amount and wage index area assignments. In addition, rural hospitals reclassified for purposes of the standardized amount qualify to be treated as urban for purposes of the 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, or for FYs 1999 through 2001, for purposes of qualifying for a DSH adjustment or to receive a higher DSH payment.

The FY 2000 wage index values incorporate all of the MGCRB's reclassification decisions for FY 2000. The wage index values also reflect any decisions made by the HCFA Administrator through the appeals and review process. Additional changes that resulted from the Administrator's review of MGCRB decisions or a request by a hospital to withdraw its application are reflected in this final rule.

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 0.993799 to ensure that the effects of reclassification are budget neutral. (See section II.A.4.b. of the Addendum to this final rule.)

As a group, rural hospitals benefit from geographic reclassification. Their payments rise 2.6 percent, while payments to urban hospitals decline 0.4 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. The smallest increases among the rural census divisions is 1.6 percent for Puerto Rico and 1.8 percent for Mountain. The largest increase is in rural West South Central, with an increase of 3.5 percent.

Among rural hospitals designated as RRCs, 128 hospitals are reclassified for purposes of the wage index only, leading to the 5.7 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 4.8 percent increase in payments.

Rural hospitals reclassified for FY 1999 and FY 2000 experience a 6.6 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 2000 but not FY 1999 experience a 5.7 percent increase in payments, while rural hospitals reclassified for FY 1999 but not FY 2000 experience a 0.5 percent decrease in payments. Urban hospitals reclassified for FY 1999 but not FY 2000 experience a 0.5 percent decline in payments overall. Urban hospitals reclassified for FY 2000 but not for FY 1999 experience a 3.3 percent increase in payments.

The FY 2000 Reclassification rows of Table I show the changes in payments per case for all FY 2000 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 an 11.6 percent increase in payments. In addition, rural hospitals reclassified just for the wage index receive a 6.3 percent payment increase. The overall impact on reclassified hospitals is to increase their payments per case by an average of 5.6 percent for FY 2000.

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 0.6 percent. Rural nonreclassified hospitals decrease by 0.4 percent, and urban nonreclassified hospitals lose 0.6 percent (the amount of the budget neutrality offset).

I. All Changes (Column 8)

Column 8 compares our estimate of payments per case, incorporating all changes reflected in this final rule for FY 2000 (including statutory changes), to our estimate of payments per case in FY 1999. It includes the effects of the 1.1 percent update to the standardized amounts and the hospital-specific rates for SCHs and MDHs. It also reflects the 1.2 percentage point difference between the projected outlier payments in FY 2000 (5.1 percent of total DRG payments) and the current estimate of the percentage of actual outlier payments in FY 1999 (6.3 percent), as described in the introduction to this Appendix and the Addendum to this final rule.

Additional changes affecting the difference between FY 1999 and FY 2000 payments are the reductions to the IME and DSH adjustments enacted by the BBA of 1997. 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 2000, IME is reduced to approximately a 6.0 percent rate of increase, and DSH is reduced by 3 percent from what hospitals otherwise would have received. We estimate the overall effect of these statutory changes to be a 0.5 percent reduction in FY 2000 payments. For hospitals receiving both IME and DSH, the impact is estimated to be a 0.8 percent reduction in payments per case.

We also note that column 8 includes the impacts of FY 2000 MGCRB reclassifications compared to the payment impacts of FY 1999 reclassifications. Therefore, when comparing FY 2000 payments to FY 1999, the percent changes due to FY 2000 reclassifications shown in column 7 need to be offset by the effects of reclassification on hospitals' FY 1999 payments (column 7 of Table 1, July 31, 1998 final rule (63 FR 41106)). For example, the impact of MGCRB reclassifications on rural hospitals' FY 1999 payments was approximately a 2.7 percent increase, more than offsetting the 2.6 percent increase in column 7 for FY 2000. Therefore, the net change in FY 2000 payments due to reclassification for rural hospitals is actually a decrease of 0.1 percent relative to FY 1999. 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 6 and 7, plus the other impacts that we are able to identify.

The overall payment change from FY 1999 to FY 2000 for all hospitals is a 0.5 percent decrease. This reflects the 1.1 percent update for FY 2000, the 1.2 percent lower outlier payments in FY 2000 compared to FY 1999 (5.1 percent compared to 6.3 percent); and the 0.5 percent reduction due to lower IME and DSH payments.

Hospitals in urban areas experience a 0.7 percent drop in payments per case compared to FY 1999. The 0.4 percent negative impact due to reclassification is offset by an identical negative impact for FY 1999. The impact of reducing IME and DSH is a 0.6 percent reduction in FY 2000 payments per case. Payment to hospitals in large urban areas are expected to fall 0.8 percent per case compared to 0.5 percent per case for hospitals in other urban areas.

Hospitals in rural areas, meanwhile, experience a 1.0 percent payment increase. As discussed above, this is primarily due to the positive effect of the wage index and DRG changes (0.5 percent increase).

Among census divisions, urban Middle Atlantic displays the largest negative impact (−1.4 percent), followed by the West South Central (−1.1 percent decrease in payments). In the case of hospitals in the urban Middle Atlantic census division, these decreases are related to changes to the wage index, plus a greater impact of the IME and DSH payment reductions and the decline in estimated outlier payments. In the case of the urban West South Central census division, the decline is largely related to changes in the wage index. East South Central and Puerto Rico are the only urban categories grouped by census division not exhibiting decreases in payments per case for FY 2000.

No rural census division experiences a negative payment impact, although payments to rural hospitals in the Pacific census division are unchanged from FY 1999. The largest increases by rural hospitals are in Puerto Rico at 2.4 percent. Among rural census divisions, the largest increases are in the East South Central and West North Central, with 1.6 percent and 1.5 percent increases in their FY 2000 payments per case, respectively. As with the other impacts discussed above, this is generally due to updating the wage data. One rural census division that did not experience an increase in payments as large as suggested by the positive impact of updating the wage data was the South Atlantic. This census division experienced a 3.8 percent payment increase due to geographic reclassification in FY 1999, but the effect of geographic reclassification in FY 2000 was only 3.0 percent.

Among special categories of rural hospitals, those hospitals receiving payment under the hospital-specific methodology (SCHs, MDHs, and SCH/RRCs) experience payment increases of 1.4 percent, 1.2 percent, and 1.4 percent, respectively. This outcome is primarily related to the fact that, for hospitals receiving payments under the hospital-specific methodology, there are no outlier payments. Therefore, these hospitals do not experience negative payment impacts from the decline in outlier payments from FY 1999 to FY 2000 (from 6.3 of total DRG plus outlier payments to the projected 5.1 percent) as do hospitals paid based on the national standardized amounts.

The largest negative payment impacts from FY 1999 to FY 2000 are among hospitals that were reclassified for FY 1999 and are not reclassified for FY 2000. Overall, these hospitals lose 3.9 percent. The urban hospitals in this category lose 3.7 percent, while the rural hospitals lose 4.2 percent. On the other hand, hospitals reclassified for FY 2000 that were not reclassified for FY 1999 would experience the greatest payment increases: 4.7 percent overall; 7.0 percent for 101 rural hospitals in this category and 2.7 percent for 26 urban hospitals.

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 2000 OPERATING PROSPECTIVE PAYMENT SYSTEM

[Payments per case]

	Number of hospitals (1)	Average FY 1999 payment per case (2) [1]	Average FY 2000 payment per case (3) [1]	All changes (4)
(BY GEOGRAPHIC LOCATION)				
ALL HOSPITALS	4,922	6,779	6,747	−0.5
URBAN HOSPITALS	2,782	7,344	7,293	−0.7
LARGE URBAN AREAS	1,584	7,881	7,815	−0.8
OTHER URBAN AREAS	1,198	6,620	6,590	−0.5
RURAL HOSPITALS	2,140	4,493	4,540	1.0
BED SIZE (URBAN):				
0–99 BEDS	727	4,969	4,958	−0.2
100–199 BEDS	938	6,150	6,141	−0.1
200–299 BEDS	553	7,012	6,977	−0.5
300–499 BEDS	422	7,819	7,764	−0.7
500 OR MORE BEDS	142	9,882	9,726	−1.6
BED SIZE (RURAL):				
0–49 BEDS	1,194	3,720	3,771	1.4
50–99 BEDS	570	4,225	4,274	1.2
100–149 BEDS	223	4,584	4,638	1.2
150–199 BEDS	87	4,962	5,019	1.2
200 OR MORE BEDS	65	5,734	5,749	0.3
URBAN BY CENSUS DIVISION:				
NEW ENGLAND	149	7,757	7,739	−0.2
MIDDLE ATLANTIC	421	8,278	8,162	−1.4
SOUTH ATLANTIC	407	6,970	6,954	−0.2
EAST NORTH CENTRAL	467	6,991	6,960	−0.4
EAST SOUTH CENTRAL	165	6,574	6,572	0.0
WEST NORTH CENTRAL	190	7,099	7,043	−0.8
WEST SOUTH CENTRAL	353	6,785	6,709	−1.1
MOUNTAIN	134	7,014	6,983	−0.5
PACIFIC	449	8,451	8,382	−0.8
PUERTO RICO	47	3,115	3,120	0.2
RURAL BY CENSUS DIVISION:				
NEW ENGLAND	52	5,354	5,383	0.5
MIDDLE ATLANTIC	79	4,858	4,892	0.7
SOUTH ATLANTIC	280	4,660	4,702	0.9
EAST NORTH CENTRAL	283	4,562	4,608	1.0
EAST SOUTH CENTRAL	267	4,138	4,203	1.6
WEST NORTH CENTRAL	492	4,282	4,348	1.5
WEST SOUTH CENTRAL	341	3,997	4,031	0.9
MOUNTAIN	201	4,763	4,825	1.3
PACIFIC	140	5,566	5,567	0.0
PUERTO RICO	5	2,327	2,383	2.4
(BY PAYMENT CATEGORIES)				
URBAN HOSPITALS	2,858	7,309	7,259	−0.7
LARGE URBAN	1,662	7,807	7,740	−0.9
OTHER URBAN	1,197	6,609	6,582	−0.4
RURAL HOSPITALS	2,064	4,468	4,516	1.1
TEACHING STATUS:				
NON-TEACHING	3,809	5,462	5,471	0.2
FEWER THAN 100 RESIDENTS	871	7,173	7,130	−0.6
100 OR MORE RESIDENTS	242	10,898	10,737	−1.5
DISPROPORTIONATE SHARE HOSPITALS (DSH):				
NON-DSH	3,069	5,800	5,787	−0.2
URBAN DSH:				
100 BEDS OR MORE	1,387	7,959	7,899	−0.8
FEWER THAN 100 BEDS	89	5,099	5,105	0.1
RURAL DSH:				
SOLE COMMUNITY (SCH)	158	4,190	4,277	2.1
REFERRAL CENTERS (RRC)	60	5,310	5,371	1.2
OTHER RURAL DSH HOSPITALS:				
100 BEDS OR MORE	49	4,051	4,094	1.1
FEWER THAN 100 BEDS	110	3,589	3,660	2.0
URBAN TEACHING AND DSH:				
BOTH TEACHING AND DSH	716	8,922	8,827	−1.1
TEACHING AND NO DSH	331	7,318	7,256	−0.8
NO TEACHING AND DSH	760	6,331	6,329	0.0
NO TEACHING AND NO DSH	1,052	5,641	5,624	−0.3

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 2000 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Payments per case]

	Number of hospitals (1)	Average FY 1999 payment per case (2) [1]	Average FY 2000 payment per case (3) [1]	All changes (4)
RURAL HOSPITAL TYPES:				
NONSPECIAL STATUS HOSPITALS	851	3,911	3,956	1.2
RRC	154	5,198	5,230	0.6
SCH	647	4,462	4,523	1.4
MDH	355	3,758	3,803	1.2
SCH AND RRC	57	5,374	5,446	1.4
TYPE OF OWNERSHIP:				
VOLUNTARY	2,831	6,957	6,920	−0.5
PROPRIETARY	752	6,187	6,171	−0.2
GOVERNMENT	1,259	6,295	6,279	−0.3
UNKNOWN	80	9,713	9,575	−1.4
MEDICARE UTILIZATION AS A PERCENT OF INPATIENT DAYS:				
0–25	386	8,790	8,678	−1.3
25–50	1,775	7,908	7,845	−0.8
50–65	1,893	5,998	5,992	−0.1
OVER 65	786	5,273	5,276	0.1
UNKNOWN	82	9,711	9,573	−1.4
HOSPITALS RECLASSIFIED BY THE MEDICARE GEOGRAPHIC REVIEW BOARD				
RECLASSIFICATION STATUS DURING FY 1999 AND FY 2000:				
RECLASSIFIED DURING BOTH FY 1999 AND FY 2000	370	5,823	5,826	0.0
URBAN	57	7,961	7,853	−1.4
RURAL	313	5,185	5,220	0.7
RECLASSIFIED DURING FY 2000 ONLY	127	5,580	5,840	4.7
URBAN	26	7,182	7,377	2.7
RURAL	101	4,385	4,693	7.0
RECLASSIFIED DURING FY 1999 ONLY	188	5,597	5,378	−3.9
URBAN	100	6,389	6,151	−3.7
RURAL	88	4,574	4,382	−4.2
FY 2000 RECLASSIFICATIONS:				
ALL RECLASSIFIED HOSPITALS	498	5,776	5,828	0.9
STANDARDIZED AMOUNT ONLY	66	4,768	4,701	−1.4
WAGE INDEX ONLY	386	5,822	5,900	1.3
BOTH	46	6,255	6,223	−0.5
NONRECLASSIFIED	4,398	6,910	6,867	−0.6
ALL URBAN RECLASSIFIED	83	7,717	7,704	−0.2
STANDARDIZED AMOUNT ONLY	13	5,279	5,047	−4.4
WAGE INDEX ONLY	47	8,415	8,464	0.6
BOTH	23	6,992	6,912	−1.1
NONRECLASSIFIED	2,673	7,342	7,289	−0.7
ALL RURAL RECLASSIFIED	416	5,062	5,139	1.5
STANDARDIZED AMOUNT ONLY	53	4,473	4,501	0.6
WAGE INDEX ONLY	339	5,089	5,175	1.7
BOTH	23	5,384	5,409	0.5
NONRECLASSIFIED	1,725	4,113	4,140	0.6
OTHER RECLASSIFIED HOSPITALS (SECTION 1886(d)(8)(B))	26	4,663	4,813	3.2

[1] These payment amounts per case do not reflect any estimates of annual case-mix increase.

Table II presents the projected impact of the changes for FY 2000 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 2000 with the average estimated per case payments for FY 1999, 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.

VII. Impact of Changes in the Capital Prospective Payment System

A. General Considerations

We now have cost report data for the 6th year of the capital prospective payment system (cost reports beginning in FY 1997) available through the March 1999 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: 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.

• 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 fiscal 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 fiscal 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 fiscal intermediary determinations of projected aggregate obligated capital amounts. We still do not know, however, 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 2000 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 2000 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 2000. In addition, we have integrated sufficient hospital-specific information into our actuarial model to project the impact of the FY 2000 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 are unable to predict accurately FY 2000 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 FY 2000 Actuarial Model

1. Assumptions

In this impact analysis, we model dynamically the impact of the capital prospective payment system from FY 1999 to FY 2000 using a capital cost model. The FY 2000 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 1997 as reported on the March 1999 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, 1999 in the provider-specific file. We used these data to determine the FY 2000 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 1997, 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 1997. All Federal rate payment parameters are assigned to the applicable hospital.

For purposes of this impact analysis, the FY 2000 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
1998	0.37
1999	1.00
2000	1.00

• The Medicare case-mix index will decrease by 0.5 percent in FY 1999 and increase by 0.5 percent in FY 2000.

• 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 FY 2000 update is 0.3 percent (see section IV of the Addendum to this final rule).

2. Results

We have used the actuarial model to estimate the change in payment for capital-related costs from FY 1999 to FY 2000. 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 2000

Type of hospital	Percent of hospitals	Percent of discharges	Percent of capital costs	Percent of capital payments
Low Cost Hospital	66	61	53	59
High Cost Hospital	34	39	47	41

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 into 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 1999 to FY 2000 using the above described actuarial model. With the Federal rate, we estimate aggregate Medicare capital payments will increase by 3.64 percent in FY 2000.

TABLE III.—IMPACT OF FINAL CHANGES FOR FY 2000 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 1999
FY 1999 Payments per Discharge:									
Low Cost Hospitals	3,203	6,746,008	$518.19	81.46	$59.00	$3.39	$8.65	$589.23	.....
Fully Prospective	2,983	16,158,921	507.63	80.00	64.62	.....	7.26	579.51	.....
100% Federal Rate	185	517,623	652.10	100.00	.....	.....	5.01	657.11	.....
Hold Harmless	35	69,464	456.70	69.51	.....	329.49	158.88	945.07	.....
High Cost Hospitals	1,640	4,259,861	649.03	97.08	.....	27.20	15.52	691.75	.....
100% Federal Rate	1,425	3,846,137	664.09	100.00	.....	.....	9.25	673.35	.....
Hold Harmless	215	413,723	508.96	71.69	.....	280.11	73.75	862.82	.....
Total Hospitals	4,843	11,005,868	568.83	87.69	36.16	12.61	11.31	628.91	.....
FY 2000 Payments per Discharge:									
Low Cost Hospitals	3,203	6,814,738	$573.54	90.68	$29.43	$2.32	$11.72	$617.01	4.71
Fully Prospective	2,983	6,221,683	568.06	90.00	32.23	.....	8.39	608.68	5.03
100% Federal Rate	190	542,491	643.37	100.00	.....	.....	17.97	661.34	0.64
Hold Harmless	30	50,564	499.44	74.17	.....	312.08	354.68	1,166.20	23.40
High Cost Hospitals	1,640	4,303,107	641.55	97.57	.....	22.65	25.76	689.96	−0.26
100% Federal Rate	1,432	3,901,155	653.77	100.00	.....	.....	15.41	669.18	−0.62
Hold Harmless	208	401,953	522.90	75.31	.....	242.47	126.27	891.65	3.34
Total Hospitals	4,843	11,117,846	599.86	93.41	18.04	10.19	17.16	645.25	2.60

We project that low capital cost hospitals paid under the fully prospective payment methodology will experience an average increase in payments per case of 5.03 percent, and high capital cost hospitals will experience an average decrease of 0.26 percent. These results are due to the change in the blended percentages to the payment system to 90 percent adjusted Federal rate and 10 percent hospital-specific rate.

We project that low capital cost hospitals paid under the hold-harmless payment methodology will experience an average increase in payments per case of 23.40 percent over FY 1999. Because this group of hospitals consists of such a small number of hospitals, when determining the percentage change over FY 2000, a slight change in the number of hospitals in that group (35 hospitals in FY 1999 compared to 30 hospitals in FY 2000) results in a large percentage change. That is, the five hospitals that left this group from FY 1999 to FY 2000 were lower cost hospitals, so that there are fewer hospitals in this group over which to distribute their total capital payments. As a result, the remaining hospitals in this group are projected to receive a larger increase in payments over FY 1999.

For hospitals paid under the fully prospective payment methodology, the Federal rate payment percentage will increase from 80 percent to 90 percent and the hospital-specific rate payment percentage will decrease from 20 to 10 percent in FY 2000. 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 71.69 percent to 75.31 percent. We estimate the percentage of hold-harmless hospitals paid based on 100 percent of the Federal rate will increase from 86.9 percent to 87.3 percent. We estimate that the few remaining high cost hold-harmless hospitals (208) will experience an increase in payments of 3.34 percent from FY 1999 to FY 2000. This estimate differs from our projection (8.38 percent) in the proposed rule; in the proposed rule, we estimated a larger increase in exception payments for these hospitals between FY 1999 and FY 2000 than we are now projecting in this final rule.

We expect that the average hospital-specific rate payment per discharge will decrease from $64.62 in FY 1999 to $32.23 in FY 2000. This is mostly due to the decrease in the hospital-specific rate payment percentage from 20 percent in FY 1999 to 10 percent in FY 2000.

We have made no changes in our exceptions policies for FY 2000. As a result, the minimum payment levels are—

- 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 increase from 1.80 percent of total capital payments in FY 1999 to 2.66 percent of payments in FY 2000. The projected distribution of the exception payments is shown in the chart below:

Estimated FY 2000 Exceptions Payments

Type of hospital	Number of hospitals	Percent of exceptions payments
Low Capital Cost	171	42
High Capital Cost	216	58
Total	387	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 (ESTIMATED FOR FY 2000)

	(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	4,843	4.9	33.5	61.6
Large urban areas (populations over 1 million)	1,546	5.2	41.1	53.6
Other urban areas (populations of 1 million or fewer)	1,167	6.5	41.0	52.4
Rural areas	2,130	3.8	23.8	72.4
Urban hospitals	2,713	5.8	41.1	53.1

TABLE IV.—DISTRIBUTION BY METHOD OF PAYMENT (HOLD-HARMLESS/FULLY PROSPECTIVE) OF HOSPITALS RECEIVING CAPITAL PAYMENTS (ESTIMATED FOR FY 2000)—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)	
0–99 beds	670	7.2	33.3	59.6
100–199 beds	927	7.9	47.6	44.6
200–299 beds	552	4.7	41.8	53.4
300–499 beds	422	1.2	39.3	59.5
500 or more beds	142	3.5	38.0	58.5
Rural hospitals	2,130	3.8	23.8	72.4
0–49 beds	1,187	3.1	17.2	79.7
50–99 beds	568	5.1	28.7	66.2
100–149 beds	223	6.3	36.3	57.4
150–199 beds	87	0.0	32.2	67.8
200 or more beds	65	1.5	47.7	50.8
By Region:				
Urban by Region	2,713	5.8	41.1	53.1
New England	148	1.4	27.7	70.9
Middle Atlantic	415	4.1	34.9	61.0
South Atlantic	402	5.7	52.5	41.8
East North Central	463	5.4	31.5	63.1
East South Central	158	9.5	48.1	42.4
West North Central	181	4.4	39.2	56.4
West South Central	332	11.7	58.1	30.1
Mountain	124	2.4	53.2	44.4
Pacific	443	5.2	34.8	60.0
Puerto Rico	47	4.3	25.5	70.2
Rural by Region	2,130	3.8	23.8	72.4
New England	52	1.9	23.1	75.0
Middle Atlantic	77	6.5	19.5	74.0
South Atlantic	279	1.4	34.4	64.2
East North Central	282	2.1	20.2	77.7
East South Central	267	3.0	32.6	64.4
West North Central	491	3.3	16.3	80.4
West South Central	338	5.0	26.6	68.3
Mountain	200	8.0	17.5	74.5
Pacific	139	5.8	24.5	69.8
Large urban areas (populations over 1 million)	1,624	5.0	41.1	53.8
Other urban areas (populations of 1 million or fewer)	1,165	6.5	40.6	52.9
Rural areas	2,054	3.9	23.4	72.7
Teaching Status:				
Non-teaching	3,731	5.1	32.9	61.9
Fewer than 100 Residents	870	4.7	36.2	59.1
100 or more Residents	242	2.5	32.2	65.3
Disproportionate share hospitals (DSH):				
Non-DSH	2,997	4.9	29.3	65.8
Urban DSH:				
100 or more beds	1,383	5.0	44.1	50.9
Less than 100 beds	87	8.0	23.0	69.0
Rural DSH:				
Sole Community (SCH/EACH)	158	5.1	22.8	72.2
Referral Center (RRC/EACH)	60	3.3	48.3	48.3
Other Rural:				
100 or more beds	49	4.1	40.8	55.1
Less than 100 beds	109	2.8	25.7	71.6
Urban teaching and DSH:				
Both teaching and DSH	715	3.8	36.9	59.3
Teaching and no DSH	331	5.7	32.3	61.9
No teaching and DSH	755	6.5	48.5	45.0
No teaching and no DSH	988	6.4	40.9	52.7
Rural Hospital Types:				
Non special status hospitals	842	1.9	24.3	73.8
RRC/EACH	154	1.9	42.2	55.8
SCH/EACH	647	7.6	21.0	71.4
Medicare-dependent hospitals (MDH)	354	1.7	16.9	81.4
SCH, RRC and EACH	57	10.5	26.3	63.2
Type of Ownership:				
Voluntary	2,821	4.5	32.9	62.6
Proprietary	732	8.5	57.8	33.7

TABLE IV.—DISTRIBUTION BY METHOD OF PAYMENT (HOLD-HARMLESS/FULLY PROSPECTIVE) OF HOSPITALS RECEIVING CAPITAL PAYMENTS (ESTIMATED FOR FY 2000)—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)	
Government	1,257	3.7	21.0	75.3
Medicare Utilization as a Percent of Inpatient Days:				
0–25	375	5.3	28.5	66.1
25–50	1,770	5.2	35.9	58.9
50–65	1,885	4.8	32.6	62.6
Over 65	779	4.4	33.0	62.6

As we explain in Appendix B of this final rule, we were not able to determine a hospital-specific rate for 79 of the 4,922 hospitals in our database. Consequently, the payment methodology distribution is based on 4,843 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 33.5 percent in FY 2000.

Table IV indicates that 61.6 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 chart ''Capital Transition Payment Methodology for FY 2000,'' shown previously in section VII.B.2 of this impact analysis, takes into account 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 (72.4 percent and 75.3 percent, respectively by payment classification) are being paid under the fully prospective payment methodology. This is a reflection of their lower than average capital costs per case. In contrast, only 33.7 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 2000 actuarial model to estimate the potential impact of our changes for FY 2000 on total capital payments per case, using a universe of 4,843 hospitals. The individual hospital payment parameters are taken from the best available data, including: the April 1, 1999 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 2000 payment policies. Columns 3 and 4 show estimates of payments per case under our model for FY 1999 and FY 2000. Column 5 shows the total percentage change in payments from FY 1999 to FY 2000. 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 0.28 percent decrease in the Federal rate, a 0.5 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 80 percent to 90 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 2.6 percent in FY 2000, despite the effect of the 0.9 percent decrease attributable to the reduction in the Federal rate and other factors (which include changes in the adjustment to the Federal rate, the increase in case mix, and the other components of column 6 of table V).

Our comparison by geographic location shows that urban and rural hospitals will experience slightly different rates of increase in capital payments per case (2.5 percent and 3.2 percent, respectively). This is due to the differing impact on urban hospitals relative to rural hospitals (-1.1 percent and 0.2 percent, respectively) from Federal rate changes alone. Urban hospitals will gain approximately the same as rural hospitals (3.6 percent and 3.0 percent, respectively) from the effects of all other changes.

Most 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 80 to 90 percent). Changes by region vary from a low of 0.4 percent decrease (West South Central urban region) to a high of 5.2 percent increase (West North Central rural region).

By type of ownership, government hospitals are projected to have the largest rate of increase of total payment changes (3.7 percent, a 4.2 percent increase from the effects of all other changes and a 0.5 percent decrease due to Federal rate changes). Payments to voluntary hospitals will increase 2.7 percent (a 3.6 percent increase from the effects of all other changes and a 0.9 percent decrease due to Federal rate changes), and payments to proprietary hospitals will increase 0.7 percent (a 2.2 percent increase from the effects of all other changes and a 1.5 percent decrease due to Federal rate 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 FYs 1999 through 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 2000 compared to the effects of reclassification for FY 1999, we show the average payment percentage increase for hospitals reclassified in each fiscal year and in total. For FY 2000 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 2000 as a whole are projected to experience a 3.7 percent increase in payments (a 3.5 percent increase attributable to the effects of all other changes and a 0.2 percent increase attributable to Federal rate changes). Payments to nonreclassified hospitals will increase less (2.5 percent) than reclassified hospitals (3.7 percent) overall. While payments to reclassified hospitals will increase (0.2 percent) from the Federal rate changes, payments to nonreclassified hospitals will decrease by 1.1 percent from the Federal rate changes. However, they will both gain about the same from the effects of all other changes (3.5 percent compared to 3.6 percent).

TABLE V.—COMPARISON OF TOTAL PAYMENTS PER CASE

[FY 1999 Payments Compared to FY 2000 Payments]

	Number of hospitals	Average FY 1999 Payments/case	Average FY 2000 Payments/case	All changes	Portion attributable to federal rate change
By Geographic Location:					
All hospitals	4,843	629	645	2.6	−0.9
Large urban areas (populations over 1 million)	1,546	729	745	2.2	−1.1
Other urban areas (populations of 1 million or fewer)	1,167	616	634	3.0	−1.0
Rural areas	2,130	418	432	3.2	0.2
Urban hospitals	2,713	681	698	2.5	−1.1
0–99 beds	670	499	506	1.4	−1.0
100–199 beds	927	597	613	2.8	−1.0
200–299 beds	552	649	663	2.2	−1.0
300–499 beds	422	701	723	3.1	−1.0
500 or more beds	142	899	917	2.0	−1.4
Rural hospitals	2,130	418	432	3.2	0.2
0–49 beds	1,187	343	358	4.6	0.6
50–99 beds	568	391	409	4.5	0.3
100–149 beds	223	436	448	2.8	0.3
150–199 beds	87	451	464	2.9	0.0
200 or more beds	65	535	539	0.8	−0.4
By Region:					
Urban by Region	2,713	681	698	2.5	−1.1
New England	148	691	721	4.3	−0.2
Middle Atlantic	415	752	766	1.8	−1.3
South Atlantic	402	665	690	3.8	−0.9
East North Central	463	638	659	3.3	−0.5
East South Central	158	629	643	2.2	−1.1
West North Central	181	669	691	3.4	−1.2
West South Central	332	669	672	0.4	−2.0
Mountain	124	648	660	1.8	−0.8
Pacific	443	755	768	1.7	−1.4
Puerto Rico	47	293	296	1.0	−1.6
Rural by Region	2,130	418	432	3.2	0.2
New England	52	499	516	3.5	0.0
Middle Atlantic	77	441	455	3.1	−0.2
South Atlantic	279	435	445	2.5	−0.1
East North Central	282	427	438	2.6	0.2
East South Central	267	385	398	3.5	0.6
West North Central	491	405	427	5.2	0.8
West South Central	338	375	385	2.5	−0.1
Mountain	200	439	454	3.4	0.4
Pacific	139	495	513	3.6	−0.8
By Payment Classification:					
All hospitals	4,843	629	645	2.6	−0.9
Large urban areas (populations over 1 million)	1,624	722	738	2.2	−1.1
Other urban areas (populations of 1 million or fewer)	1,165	614	633	3.0	−1.0
Rural areas	2,054	415	429	3.3	0.2
Teaching Status:.					
Non-teaching	3,731	524	538	2.7	−0.7
Fewer than 100 Residents	870	661	676	2.3	−1.1
100 or more Residents	242	951	978	2.8	−1.1
Urban DSH:					
100 or more beds	1,383	721	739	2.5	−1.1
Less than 100 beds	87	503	503	0.1	−0.4
Rural DSH:					
Sole Community (SCH/EACH)	158	371	385	3.7	0.8
Referral Center (RRC/EACH)	60	474	484	2.1	0.0
Other Rural:					
100 or more beds	49	378	386	2.1	0.2
Less than 100 beds	109	327	342	4.8	1.2
Urban teaching and DSH:					
Both teaching and DSH	715	794	813	2.4	−1.2
Teaching and no DSH	331	680	699	2.8	−1.1
No teaching and DSH	755	596	613	2.8	−1.0

TABLE V.—COMPARISON OF TOTAL PAYMENTS PER CASE—Continued

[FY 1999 Payments Compared to FY 2000 Payments]

	Number of hospitals	Average FY 1999 Payments/case	Average FY 2000 Payments/case	All changes	Portion attributable to federal rate change
No teaching and no DSH	988	564	577	2.2	−1.0
Rural Hospital Types:					
Non special status hospitals	842	369	382	3.5	0.4
RRC/EACH	154	484	496	2.5	−0.3
SCH/EACH	647	410	427	4.0	0.3
Medicare-dependent hospitals (MDH)	354	344	360	4.6	0.4
SCH, RRC and EACH	57	489	502	2.6	0.5
Hospitals Reclassified by the Medicare Geographic Classification Review Board:					
Reclassification Status During FY99 and FY00:					
Reclassified During Both FY99 and FY00	370	546	563	3.0	−0.7
Reclassified During FY00 Only	127	528	563	6.7	3.6
Reclassified During FY99 Only	146	518	508	−2.0	−4.3
FY00 Reclassifications:					
All Reclassified Hospitals	498	543	563	3.7	0.2
All Nonreclassified Hospitals	4,319	640	656	2.5	−1.1
All Urban Reclassified Hospitals	83	715	745	4.1	−0.7
Urban Nonreclassified Hospitals	2,604	680	697	2.4	−1.1
All Reclassified Rural Hospitals	415	479	496	3.5	0.6
Rural Nonreclassified Hospitals	1,715	377	388	3.0	−0.3
Other Reclassified Hospitals (Section 1886(D)(8)(B))	26	456	470	3.0	1.8
Type of Ownership:					
Voluntary	2,821	643	661	2.7	−0.9
Proprietary	732	625	630	0.7	−1.5
Government	1,257	552	572	3.7	−0.5
Medicare Utilization as a Percent of Inpatient Days:					
0–25	375	762	781	2.4	−1.5
25–50	1,770	724	740	2.2	−1.1
50–65	1,885	567	585	3.1	−0.8

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 used the capital acquisition model from the start of prospective payments for capital costs through FY 1997. We now have 6 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, 1999 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), PPS–XII (cost reporting periods beginning in FY 1995), PPS–XIII (cost reporting periods beginning in FY 1996), and PPS–XIV (cost reporting periods beginning in FY 1997). In addition to model payments, we use the April 1, 1999 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 1999 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	145
Provider-Specific and Audit File	4,777
Total	4,922

Of the 4,922 hospitals, 105 had unusable or missing data or had no cost reports available. For 23 of the 105 hospitals, we were unable to determine a hospital-specific rate from the available cost reports. However, there was adequate cost information to determine that these hospitals were paid under the hold-harmless methodology. Since the hospital-specific rate is not used to determine payments for hospitals paid under the hold-harmless methodology, there was sufficient cost report information available to include these 21 hospitals in the analysis. We were able to estimate hospital specific amounts from the PPS–IX cost report data for an additional two hospitals and from the PPS–X cost report data for one more hospital. Hence, we were able to use 26 of the 105 hospitals. We used 4,843 hospitals for the analysis. Seventy-nine hospitals could not be used in the analysis because of insufficient information. These hospitals account for less than 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 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 first two 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 the 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 cost 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 1998 (the MedPAR data year) and later, we use the number of discharges from the MEDPAR data. Some hospitals had considerably more discharges in FY 1998 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 1998 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 1998 MedPAR file using the FY 2000 DRG relative weights included in section VI. of the Addendum to this final rule. The case-mix index is increased each year after FY 1998 based on analysis of past experiences in case-mix increases. Based on analysis of recent case-mix increases, we estimate that case-mix will decrease 0.5 percent in FY 1999. We project that case-mix will increase 0.5 percent in FY 2000. (Since we are using FY 1998 cases for our analysis, the FY 1998 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 1999, the budget neutrality adjustment factors were 1.00294 for the national rate and 1.00233 for the Puerto Rico rate.

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 and earlier since the geographic adjustment factor for Puerto Rico was implemented in 1998.

To determine the factors for FY 2000, we first determined the portions of the Federal national and Puerto Rico rates that would be paid for each hospital in FY 2000 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 1999 DRG relative weights and the FY 1999 geographic adjustment factor to estimated aggregate Federal rate payments based on the FY 1999 relative weights and the FY 2000 geographic adjustment factor. In making the comparison, we held the FY 2000 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 0.99857 for FY 2000 should be applied to the previous cumulative FY 1999 adjustment of 1.00294, yielding a cumulative adjustment of 1.00151 through FY 2000. For the Puerto Rico geographic adjustment factor, an incremental budget neutrality adjustment of 0.99910 for FY 2000 should be applied to the previous cumulative FY 1999 adjustment of 1.00233, yielding a cumulative adjustment of 1.00143 through FY 2000. We apply these new adjustments, then compare estimated aggregate Federal rate payments based on the FY 1999 DRG relative weights and the FY 2000 geographic adjustment factors to estimated aggregate Federal rate payments based on the FY 2000 DRG relative weights and the FY 2000 geographic adjustment factors. The incremental adjustment for DRG classifications and changes in relative weights would be 0.99991 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 FY 2000 would be 1.00142 nationally, and 1.00134 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	0.99944	1.00335	1.00279	1.00294	0.99898	1.00335	1.00233	1.00233
2000	0.99857	0.99991	0.99848	1.00142	0.99910	0.99991	0.99901	1.00134

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 addon 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 FYs 1992 through 1999, the final factors for FY 2000, and the estimated factors that would be applicable through FY 2004. We caution that these are estimates for FYs 2001 and later, and are subject to revisions resulting from continued methodological refinements, receipt of additional data, and changes in payment policy. We note that in making these projections, we have assumed that the cumulative national DRG/GAF budget neutrality adjustment factor will remain at 1.00142 (1.00134 for Puerto Rico) for FY 2000 and later because we do not have sufficient information to estimate the change that will occur in the factor for years after FY 2000.

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	1.0028	.9392	.....	378.10
2000	0.30	.9730	N/A	.9985	.9402	.....	377.03
2001	0.50	.9636	N/A	[5] 1.0000	[5] .9402	.....	375.26
2002	0.50	[6] 1.0000	N/A	1.0000	.9402	.....	391.38
2003	0.50	[6] 1.0000	N/A	1.0000	.9402	[4] 1.0255	403.38

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)
2004	0.50	[6] 1.0000	N/A	1.0000	.9402		405.40

[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 2000 by hospitals subject to the prospective payment system and those excluded from the prospective payment system. Section 1886(b)(3)(B)(i)(XV) of the Act sets the FY 2000 percentage increase in the operating cost standardized amounts equal to the rate of increase in the hospital market basket minus 1.8 percent for prospective payment hospitals in all areas. Section 1886(b)(3)(B)(iv) of the Act sets the FY 2000 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 1.8 percentage points. Under section 1886(b)(3)(B)(ii) of the Act, the FY 2000 percentage increase in the rate of increase limits for hospitals excluded from the prospective payment system ranges from the percentage increase in the excluded hospital market basket to 0 percent, 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 1999 forecast of the FY 2000 market basket increase of 2.9 percent for hospitals subject to the prospective payment system, the updates in the standardized amounts are 1.1 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 1.1 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 2.9 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, 1999 report, MedPAC stated that the legislated update of market basket increase minus 1.8 percentage points would provide a reasonable level of payment to hospitals. Although MedPAC suggests that a somewhat lower update could be justified in light of changes in the utilization and provision of hospital inpatient care, the Commission does not believe it is necessary to recommend a lower update for FY 2000. MedPAC did not make a separate recommendation for the hospital-specific rates applicable to sole community and Medicare-dependent, small rural 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 2000 update factors recommended by the Secretary as Appendix D of the May 7, 1999 proposed rule (64 FR 24852).

Under section 1886(e)(4) of the Act, we recommended that an appropriate update factor for the standardized amounts was 0.0 percentage points for hospitals located in large urban and other areas. We also recommended an update of 0.0 percentage points to the hospital-specific rate for sole community hospitals and Medicare-dependent, small rural hospitals. These figures are consistent with the President's FY 2000 budget recommendations. We stated that we believe our recommended update factors would ensure that Medicare acts as a prudent purchaser and provide incentives to hospitals for increased efficiency, thereby contributing to the solvency of the Medicare Part A Trust Fund.

In the proposed rule, we recommended that hospitals excluded from the prospective payment system receive an update of between 0 and 2.6 percentage points. The recommended update for excluded hospitals and units was equal to the increase in the excluded hospital operating market basket less a percentage between 0 and 2.5 percentage points, or 0 percentage points, depending on the hospital's or unit's costs in relation to its rate-of-increase limit. For the proposed rule, the market basket rate of increase was forecast at 2.6 percent. This recommendation was consistent with the President's FY 2000 budget, although we noted that the market basket rate of increase was forecast at 2.7 percent when the budget was submitted.

II. Secretary's Final Recommendations for Updating the Prospective Payment System Standardized Amounts

We received seven comments concerning our proposed recommendations, two of which commented directly on the update recommendation. Our final recommendations for the operating update for both prospective and excluded hospitals do not differ from the proposed. However, the second quarter forecast of the market basket percentage increase is 2.9 for prospective payment hospitals (up from 2.7 estimated in the proposed rule) and 2.9 for excluded hospitals and units (up from 2.6 estimated in the proposed rule).

Comment: Several commenters expressed support for our proposal to update hospital payment rates on October 1, 1999, rather than delaying the update because of concerns about ''Year 2000'' (Y2K) systems issues. One commenter, while acknowledging that we are required to use the factors set in current law to update payment rates, expressed concern that an update to the rates less than the full market basket rate of increase is inadequate, forcing hospitals to forego technological advances that may improve quality and patient outcomes. Another commenter believes that the proposed updates would place more financial hardship on hospitals, in particular teaching hospitals, by freezing or reducing payment rates.

Response: We appreciate the support from commenters. As the one commenter noted, we are required by section 1886(b)(3) of the Act, as amended by the Balanced Budget Act of 1997 (BBA), to update rates for FY 2000 by the estimated increase in the hospital market basket minus 1.8 percentage points. Our latest available data show that hospital costs per case are continuing to decline while payments per case are increasing, resulting in high average Medicare profit margins across all hospitals. Therefore, we believe that the update to payment rates specified by law for FY 2000 is sufficient to allow hospitals to continue providing Medicare beneficiaries with efficient care of high quality. We will continue to monitor the financial performance of hospitals as newer data become available and will adjust our future update recommendations to Congress as appropriate.

Comment: MedPAC stated that while HCFA's proposed update recommendation of zero percentage points is within the range that MedPAC adopted in its own recommendation, the Commission believes

that the update specified in law is appropriate because the effects of the BBA are not yet fully evident. Reducing payments below the level prescribed by law would not be prudent, at least for FY 2000. MedPAC further stated that it will monitor the financial performance of hospitals under BBA during the coming year.

Response: As we stated in the proposed rule, we believe that our recommendation (an update of zero percentage points) is an appropriate response to current trends in health care delivery, including the recent decreases in the use of hospital inpatient services and the corresponding increase in the use of hospital outpatient and postacute care services. Furthermore, as a prudent purchaser of health care for Medicare beneficiaries, we believe it is important that we maintain incentives to hospitals to provide high quality care efficiently. Like MedPAC, we, too, will continue to monitor the financial performance of hospitals and adjust future update recommendations as appropriate.

III. Secretary's Final Recommendation for Updating the Rate-of-Increase Limits for Excluded Hospitals

We received one comment concerning our proposed recommendation for updating the rate-of-increase limits for excluded hospitals.

Comment: MedPAC recommended adding 0.4 percentage points to the market basket forecast before applying the update formula to account for technical improvements that hospitals must make related to Y2K-related computer problems. MedPAC believes Y2K-related computer malfunctions could potentially compromise patient care by interrupting service continuity, thereby creating substantial liability exposure for hospitals. Therefore, HCFA should increase the market basket forecast to account for the additional costs hospitals will incur in making computer system improvements to avoid Y2K problems.

Response: Our final recommendation is that hospitals and hospital units excluded from the prospective payment system receive an update using a market basket increase estimate of 2.9 percentage points. This update is consistent with the updates provided to the prospective payment hospitals. We note that under our update framework for excluded hospitals and units, the analysis indicates identical findings to those for prospective payment system hospitals regarding changes in productivity, scientific and technological advances, practice patterns, and case-mix for FY 2000. We believe these updates will ensure that Medicare acts as a prudent purchaser and will provide incentives to hospitals for increased efficiency. Thus, using the statutory target amount update formula, the update factor for an excluded hospital or unit will be between 0.4 percent and 2.9 percent, or 0.

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